Joint Committee of CCGs

2nd November 2017 – 1.00pm – 3.00pm

Venue: Main Lecture Theatre, Ground Floor, Moor Lane Mills, Morecambe Bay CCG, Lancaster, LA1 1QD

Agenda

Timings	Item No	Item	Owner	Action	Format
Standing Items					
1.00pm – 1.05pm	1	Welcome and Introductions	Phil Watson	Information	Verbal
	2	Apologies	Phil Watson	Information	Verbal
	3	Declarations of Interest	Phil Watson	Information	Verbal
1.05pm – 1.20pm	4	• Minutes from the following meetings for ratification: o 7th September 2017 o 6th July 2017 o 2nd March 2017 • Revised Joint Committee of CCG's Terms of Reference	Phil Watson Carl Ashworth	Information Support	Paper Paper
	5	Action Matrix Review For noting, the removal of items from the Action Matrix as follows: • Evaluation and Hurdle Criteria review – this is being picked up via the Care Professionals Board • Integrated Diagnostics – this is being picked up via the Provider Group as part of the work around the Carter Review	Phil Watson	Information	Paper
	6	Any Other Business Declared	Phil Watson	Information	Verbal
For Discussion/Recommendations					
1.20pm – 1.40pm	7	Local Maternity Services Plan	Vanessa Wilson	Support	Presentation
1.40pm – 2.05pm	8	Transforming Care	Debbie Nixon	Decision	Paper
2.05pm – 2.30pm	9	Urgent and Emergency Care Transformation Funding	David Bonson	Support	Paper
2.30pm – 2.45pm	10	Capital and Estates Briefing	Gary Raphael	Support	Paper
2.45pm - Formal meeting closed					
2.45pm – 3.00pm	Continue with Questions from the Public		All	Discussion	Verbal
For information only					
The next Joint Committee of CCG's meeting will be held on: Thursday 11th January 2018 – 1.00pm – 3.00pm – venue to be confirmed			Phil Watson	Information	Verbal

Apologies should be sent to Sue Hesketh - susan.hesketh1@nhs.net or 01253 951490

Directions and parking

By train:

From Lancaster train station the offices are approximately a 10 minute walk. Lancaster train station has two exits. If arriving by train from the south, turn left out of the station onto Meeting House Lane. If arriving by train from the north, turn right out of the station building and continue onto Meeting House Lane. Turn left on Meeting House Lane and continue downhill into the city centre. At the end of the road (Waterstones should be on your right) use the pedestrian crossing to cross the road and continue forward onto the pedestrianised Market Street. At the next crossroads (Carphone Warehouse should be on your left), turn left onto Cheapside, then when you reach the end of the pedestrianised area, turn right onto Church Street, passing Stonewell Tavern on your left and a taxi rank on your right. At the end of Church Street you will see Pizza Margarita across the road. This cobbled street is Moor Lane. Use the pedestrian crossing to cross the road and head up Moor Lane. The CCG buildings are about 400m up this road on the right, a very large visible NHS sign is located at the top of one of the Mills.

By car:

From the south leave the M6 at Junction 33 and turn right at the roundabout at the top of the slip road heading towards Lancaster. Continue for three miles, passing Lancaster University on your right. Continue to a set of traffic lights at a crossroads with the Boot and Shoe pub on the right. After the traffic lights turn next right (immediately after petrol station) onto Barton Road (which merges into Bowerham Road) then turn right at the first roundabout onto Coulston Road. Proceed straight across at the crossroads onto Moor Lane.
NHS Morecambe Bay CCG is about 100 yards on your left down the hill.

From the north leave the M6 at Junction 34 and turn left onto Caton Road heading into Lancaster. Continue along Caton Road passing a petrol station on the right. When the road splits into two lanes, just before the traffic lights at the start of the one way system, take the first left onto Bulk Road. Continue on Bulk Road for about 150 yards passing five exits on the left, as the road starts to go downhill and bend to the right, take the first left hand turn which is the sixth exit. After 50 yards take the first left on to Alfred Street and follow the road past public car parks (road becomes Edward Street). When you get to the end of this road, turn left on to Moor Lane. Take the first right into Moor Lane Mills.

Please also note that there will be some limited free parking available at Moor Lane Mills, however, please still bring some change for the public car parks in case there are no spaces. Public car parks are listed below.

Parking

Lancaster City Council (40 spaces) Moor Mills 3 Bulk Street Lancashire Lancaster LA1 1QJ	2 Hours£2.40 3 Hours£2.80 4 Hours£3.50
Lancaster City Council (50 spaces) Moor Mills 2 Bulk Street Lancashire Lancaster LA1 1PU	2 Hours£2.40 3 Hours£2.80 4 Hours£3.50
Lancaster City Council (100 spaces) Edward Street Lancashire Lancaster LA1 1QH	3 Hours£2.40 5 Hours£3.90
Lancaster City Council (30 spaces) Lodge Street Lancashire Lancaster LA1 1QW	3 Hours£2.40 5 Hours£3.90

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	8th December 2016		
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 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 Chairs of:
	  ○ The Care Professionals Board
	  ○ 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 and every member practice of the Group 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.

I. 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 the Clinical Commissioning Groups (JCCCGs)

Minutes of the Joint Committee of the Clinical Commissioning Groups
held on Thursday 2nd March 2017, 1pm – 3pm
at the University of Central Lancashire, 53 Degrees Hall, Preston, PR1 7BQ

Chair	Phil Watson (PW)	Independent Chair	JCCCGs	Attended
Voting Members	Alex Gaw	Chair	Lancashire North CCG	Apologies
	Andrew Bennett	Chief Officer	Lancashire North CCG	Attended
	Chris Clayton	Chief Clinical Officer	Blackburn with Darwen CCG	Attended
	David Noblett	Lay Member	Greater Preston CCG	Attended
	Sumantra Mukerji	Chair	Greater Preston CCG	Attended
	Doug Soper	Lay Member	West Lancashire CCG	Attended
	Marie Williams	GP Member	Blackpool CCG	Apologies
	Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Attended
	Gora Bangi	Chair	Chorley South Ribble CCG	Attended
	Graham Burgess	Chair	Blackburn with Darwen CCG	Attended
	Mark Youlton	Chief Officer	East Lancashire CCG	Apologies
	Mary Dowling	Chair	Fylde and Wyre CCG	Attended
	Paul Kingan	Chief Finance Officer	West Lancashire CCG	Attended
	Phil Huxley	Chair	East Lancs CCG	Apologies
	Roy Fisher	Chair	Blackpool CCG	Attended
	Tony Naughton	Chief Clinical Officer	Fylde and Wyre CCG	Apologies
	Michelle Pilling	Deputy	East Lancashire CCG	Attended
	Adam Janjua	Deputy	Fylde and Wyre CCG	Attended
	Kirsty Hollis	Deputy	East Lancashire CCG	Attended
Non-Voting Members	Allan Oldfield	Chief Executive Officer	Fylde Council	Apologies
	Amanda Doyle	Accountable Officer	Healthier Lancs & South Cumbria	Attended
	Andrew Bibby	Director for Specialised Services	NHS England	Apologies
	Andy Curran	Medical Director	Healthier Lancs & South Cumbria	Attended
	Dean Langton	Chief Executive Officer	Pendle Council	Apologies
	Gary Hall	Chief Executive Officer	Chorley Council	Attended
	Gary Raphael	Finance Director	Healthier Lancs & South Cumbria	Attended
	Harry Catherall	Chief Executive Officer	Blackburn Council	Attended
	Jane Higgs	Director of Operations	NHS England	Apologies
	Jo Turton	Chief Executive Officer	Lancashire County Council	Apologies
	Kim Webber	Chief Executive	West Lancs Borough Council	Apologies
	Lawrence Conway	Chief Executive	South Lakeland District Council	Attended
	Neil Jack	Chief Executive Officer	Blackpool Council	Apologies
	Samantha Nicol	Programme Director	Healthier Lancs & South Cumbria	Apologies
	Sir Bill Taylor	Chair	Healthwatch	Apologies
	Diane Wood	Chief Executive	Cumbria County Council	Apologies
	Mike Wedgeworth	Deputy	Healthwatch	Attended
	David Tilleray	Deputy	West Lancs Borough Council	Attended
	Sakthi Karunanithi	Deputy	Lancashire CC	Attended
	Steve Thomson	Deputy	Blackpool Council	Attended
In attendance	Jacquie Allan	Exec Support Officer	Healthier Lancs & South Cumbria	Attended
	Dionne Standbridge	Director	Pennine Lancashire	Attended
	Peter Tinson	Chief Operating Officer	Fylde and Wyre CCG	Attended

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

		ACTION
17-03-1	**Welcome and Introductions** The Chair welcomed the members of the Committee to their second formal meeting. He explained the status of the meeting and that the Committee had invited members of the public to observe what happens at these important decision making meetings. He clarified that this was a meeting held in public but not a public meeting, although the members of the public would be allowed to ask questions relating to agenda items at the end of the meeting. He explained to the members of public the voting rules of the JCCCGs.	**Info**
17-03-2	**Apologies and Quoracy** Apologies were received from Alex Gaw, Jane Higgs, Dean Langton, Sam Nicol and Allan Oldfield. All other non-attendees sent deputies as above. The meeting was declared quorate. ***RESOLVED: The Chair noted the apologies.***	**Info**
17-03-3	**Declarations of Interest** The Chair requested that the members declare any interests relating to items on the agenda. The Chair reminded those present that if, during the course of the discussion, a conflict of interest subsequently became apparent, it should be declared at that point. ***RESOLVED: No declarations of interest were notified.***	**Info**
17-03-4	**Minutes from the previous meeting held on the 2nd February 2017** The minutes of the meeting were reviewed, and amendments proposed. Mary Dowling said that she had some changes to suggest and offered to do this outside of the meeting to save time. This was agreed. The Chair asked that with the changes, the Committee accept the final minutes as a true and accurate account of the meeting. ***RESOLVED: The minutes of the meeting were accepted as a true and accurate record of the meeting on the 2nd February 2017.***	**Info**
17-03-5	**Action Matrix Review** The Action Matrix from the previous meeting was reviewed and all of the outstanding items would be covered on the agenda, with the exception of reference 17-01-9 Evaluation and Hurdle Criteria which would be on a future agenda. The Committee also noted that the final version of the Terms of Reference for the Committee were awaited and this should remain as an action. ***RESOLVED: The action matrix was reviewed and the outstanding issue noted.***	**Info**

17-03-6	**Any Other Business Declared:** The Chair asked the members of the Committee if they had any other business they wished to declare for discussion at the end of the meeting. ***ACTION: Mr Doug Soper asked that the work plan for the Committee be discussed.***	**Info**
17-03-7	**Programme Board Feedback** Amanda Doyle, Chief Officer for the Healthier Lancashire and South Cumbria Programme gave an update on the main topics of discussion from the recent Programme Board meeting. The planned change to the Programme Management team had taken place and the role of the externally contracted team would now be undertaken by Carl Ashworth's team from the Commissioning Support Unit, who were already supporting collaborative programmes across Lancashire and South Cumbria. Consequently the structure and contacts will change while the central team is being established. Once finalised the contact list will be issued to the members of the JCCCGs. Karen Smith from Blackpool Council had been appointed as the Senior Responsible Officer for the Regulated Care Workstream. She had given a detailed presentation to the Programme Board on the workstream and had identified issues that could be influenced locally at STP level, rather than nationally. There was also a presentation on the Third Sector. Stewart Lucas from Mind discussed how the voluntary sector can connect with the Local Delivery Plans and Sustainability and Transformation Plans. David Houston from Trinity Hospice then spoke about hospices and the opportunities that existed to engage with them. Lancashire currently has 8 hospices. Neil Greaves gave an update on the public facing narrative for the change programme and the Senior Responsible Officers had received the latest draft, which was included on the JCCCGs' agenda. Declan Hadley presented a paper on integrated diagnostics and asked the Programme Board to support the proposal to create an integrated diagnostics workstream. He sought commitment from all the organisations identified to participate in the proposed collaborative arrangements. All the organisations at the meeting agreed to sign up to the proposal and Declan was tasked to put a group together to own the work, establish a clinical leader and then take their proposal to the Provider Group, prior to reporting back to the Programme Board. An update on this will be reported to the JCCCGs in August 2017. Amanda then concluded with a brief update on the work plan which is in the process of being completed. At this point a question was asked about the current position of STPs as there had been a lot of press speculation about them being in	**Info**

	different positions. Amanda confirmed that we are in a strong position and the plan we have and the work we are doing is supported nationally. It was agreed that a more detailed discussion would be more appropriate in a development session. This led to the question about the members of the Committee receiving copies of the Programme Board Papers, which was not agreed. The Programme Board does not meet in public therefore the papers from that meeting do not go in the public domain. Once the minutes from the Programme Board have been ratified, these can be issued to the JCCCGs members for information. ***ACTION: Once the Central Team has been established a contact list will be issued to the members of the JCCCGs.*** ***ACTION: An Integrated Diagnostics Paper update to be presented at the August 2017 JCCCGs meeting.*** ***RESOLVED: Once the Programme Board minutes have been ratified, these may be issued to the members of the JCCCGs.***	
17-03-8	**Communications and Engagement** Neil Greaves discussed the "Delivering the Message" document, which he had distributed to the members of the JCCCGs. He confirmed that Senior Responsible Officers for each of the workstreams had also been closely involved in ensuring that the content sufficiently explained what was happening and they had indicated the changes that they wanted making to the document. He then gave the Committee the opportunity to voice any suggestions they had to improve the document. On the whole the document was felt to be compelling, effective and well mapped out. Several members made comments to improve key elements of it and these would be reflected in the final document as far as possible. One of the main suggestions was that the documents could be more sensitively worded by emphasising that health improvements are important and can also lead to financial benefits. The Healthier Lancashire and South Cumbria Programme was described as part of a collaborative effort among organisations across Lancashire and South Cumbria but the JCCCGs considered that it was much more and in particular had responsibilities to develop a new vision for health and care services across the region. A request was made for an animated version to be created once the final document is produced as this would assist older adults and people with learning disabilities to understand the issues. It was felt this was an important document to reach out and engage not only the general public but also the third sector, local councillors and our local MP's.	

	The communication and engagement teams from Lancashire and South Cumbria had all been involved in creating the document and a revised version was being taken to focus groups for final discussion. This would then be circulated to the Committee members and it was agreed that Amanda Doyle could sign off the document on behalf of the JCCCGs. ***ACTION: For the Committee to forward any additional comments to Neil Greaves for inclusion in the amendments.*** ***RESOLVED: The Committee agreed that Amanda Doyle could sign off the document* once the changes had been made.**	
17-03-9	**Local Delivery Plans (LDP) presentations from 2 areas**	
	Pennine Lancashire Chris Clayton introduced himself as the new Senior Responsible Officer for the Pennine Lancashire Local Delivery Area, replacing Sally McIvor. He took the opportunity to thank Sally for all of the input she had put into the programme. He outlined the programme that had been running for approximately 18 months and the similarities across the Lancashire programmes. He spoke in detail about the Pennine Lancashire Case for Change and other issues including: health and wellbeing; care and quality; and finance and efficiency. The timeline for developing the new models of care was shown, with the scheduled consultation and implementation periods now being undertaken. He reported that significant and extensive programmes of communication and engagement were taking place with the public, workforce and politicians, including via social media. The health improvement priorities included respiratory, cardiovascular, frailty, mental health, psychological support, cancer, children and maternity, musculoskeletal and end of life. He emphasised that Pennine Lancashire are working together to design an accountable care system, with a memorandum of understanding already signed. There is a governance framework in place and regular meetings are in progress. It had been agreed that the new model of care has to be in place before organisation structures are reviewed. He concluded by suggesting that the 'ask' of the STP from Pennine Lancashire is: a. Clarity over the District General Hospital offer for Pennine Lancashire residents a. Determining the tertiary specialist network offer for Pennine Lancashire residents b. Managing lead commissioner arrangements as we move towards "accountable care" in LDPs and deciding how services that fall outside an LDP c. How we standardise enablers such as digital, workforce – should we do them once and implement at HL&SC level?	

	d. Standardisation on some elements of the programme which are implemented in LDPs – e.g. prevention / primary care? e. Can the STP / JCCCGs provide the scale required to ask important questions nationally e.g. social care funding? Chris Clayton stated that we cannot tackle all of the areas at once and these need to be planned. In view of some of the work that was being led by Andrew Bennett, he was tasked with drawing-up a draft description of what Accountable Care means, for distribution to members of the Committee. ***ACTION: Andrew Bennett to circulate a draft description of Accountable Care.*** ***RESOLVED: The presentation was received and noted.***	
	West Lancashire Paul Kingan, Chief Finance Officer for West Lancashire LDP presented an update on the programme. He highlighted that this LDP was relatively small and included 19 GP practices, 3 neighbourhoods and had a population of 112,000. All of the 19 practices have signed up to one federation. Due to the boundaries of the LDP, they also have to take into account both Merseyside and Greater Manchester STPs along with Lancashire and South Cumbria, because of the complicated mix of patient flows. The acute patient flows are largely towards Merseyside and Greater Manchester, but the community and local services are provided in Lancashire. The LDPs key focus is it's out of hospital strategy and Paul quoted the 1948 World Health Organisation definition that -*"Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity."* He displayed a slide highlighting the LDP strategy which covered: a. Community Services Transformation b. Primary Care Transformation c. Out of Hospital strategy "Building the future together" d. Health inequalities including Well Skelmersdale Paul discussed the links between the local delivery plan and the Healthier Lancashire and South Cumbria plan, and played a video on "Well Skelmersdale" and asked the Committee to consider the inter-relationships. The ask of the STP from West Lancashire is: a. How can we link this with the prevention workstream? b. How can we link this with the enablers?	

	c. How do we get the pace needed? ***ACTION: Paul Kingan to circulate the web link for the video.*** ***RESOLVED: The presentation was received and noted.***	
17-03-10	**Child and Adolescent Mental Health** Peter Tinson presented the Lancashire Children & Young People's Emotional Wellbeing & Mental Health Transformation Programme discussing the commitment to children and young people and highlighting the issue that 75% of mental health issues start by the age of 18. The programme has been in existence for 18 months and there is a full programme board in place. The plan for the programme was signed off in January 2016. The plan for 2017/18 has recently been refreshed and the funding which is spent collaboratively across the region had been identified. Through engagement in stakeholder workshops they had gained views on the experiences and needs of young children and currently produce a monthly bulletin to keep them informed on the work of the programme. Recent CAMHS patient surveys show that there is a high level of satisfaction and happiness from parents, carers and children for most aspects of the services, although there are still issues to be addressed including waiting times and lack of community venues. The programme acknowledges that although they have made a lot of progress there is still a lot more to undertake. The information presented covered Lancashire and Peter said that the scope of the programme in future has to include South Cumbria. ***RESOLVED: The presentation was received and noted.***	
17-03-11	**Any Other Business** The item requested by Doug Soper was covered in Amanda Doyle's opening points and no other business was noted.	**Info**
	Closing remarks The Chair thanked the Committee members for their attendance and noted that he was delighted at the interest shown from the General Public and closed the meeting prior to taking questions from the gallery. The date and venue for the next meeting are to be confirmed, but the Chair asked that the Committee members still keep the 6th April 2016 in their diaries.	

Topics discussed through the Public Questions:
STP documents and their clarity

Terminology used in documents received from NHS England
Minutes from meetings – availability on website
PWC report issued by Lancashire County Council
Bed situation and how it is being managed
Social Care cut backs and impact of closure of leisure centres
Federations of General Practices and accessibility
Clarification of financial information provided at last meeting

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

Minutes of the Joint Committee of the Clinical Commissioning Groups
held on Thursday 6th July 2017, 1pm – 3pm
at the Banqueting Suite, South Ribble Borough Council, West Paddock. Leyland, Lancashire, PR25 1DH

Chair	Phil Watson	Independent Chair	JCCCGs	Attended
Voting Members	Alex Gaw	Chair	Morecambe Bay CCG	Apologies
	Andrew Bennett	Chief Officer	Morecambe Bay CCG	Attended
	Chris Clayton	Chief Clinical Officer	Blackburn with Darwen CCG	Attended
	Debbie Corcoran	Lay Member	Greater Preston CCG	Attended
	Sumantra Mukerji	Chair	Greater Preston CCG	Apologies
	Doug Soper	Lay Member	West Lancashire CCG	Apologies
	Marie Williams	GP Member	Blackpool CCG	Apologies
	Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Attended
	Gora Bangi	Chair	Chorley South Ribble CCG	Attended
	Graham Burgess	Chair	Blackburn with Darwen CCG	Attended
	Mark Youlton	Chief Officer	East Lancashire CCG	Apologies
	Mary Dowling	Chair	Fylde and Wyre CCG	Attended
	Paul Kingan	Chief Finance Officer	West Lancashire CCG	Attended
	Phil Huxley	Chair	East Lancs CCG	Attended
	Roy Fisher	Chair	Blackpool CCG	Attended
	Adam Janjua	Clinical Lead Vice Chair	Fylde and Wyre CCG	Attended
Non-Voting Members	Allan Oldfield	Chief Executive Officer	Fylde Council	Attended
	Amanda Doyle	Accountable Officer	Healthier Lancs & South Cumbria	Apologies
	Andrew Bibby	Director for Specialised Services	NHS England	Attended
	Andy Curran	Medical Director	Healthier Lancs & South Cumbria	Attended
	Carl Ashworth	Service Director	Healthier Lancs & South Cumbria	Attended
	Dean Langton	Chief Executive Officer	Pendle Council	Apologies
	Gary Hall	Chief Executive Officer	Chorley Council	Attended
	Gary Raphael	Finance Director	Healthier Lancs & South Cumbria	Attended
	Harry Catherall	Chief Executive Officer	Blackburn Council	Attended
	Jane Higgs	Director of Operations	NHS England	Attended
	Dave Tilleray	Deputy Chief Executive	West Lancs Borough Council	Attended
	Lawrence Conway	Chief Executive	South Lakeland District Council	Apologies
	Karen Smith	Chief Executive Officer	Blackpool Council	Attended
	Sir Bill Taylor	Chair	Healthwatch	Attended
	Diane Wood	Chief Executive	Cumbria County Council	Apologies
	Sakthi Karunanithi	Deputy	Lancashire CC	Attended
In attendance	Jacquie Allan	Exec Support Officer	Healthier Lancs & South Cumbria	Attended
	Neil Greaves	Comms & Engagement	Healthier Lancs & South Cumbria	Attended
	Malcolm Ridgeway	Primary Care	NHS England	Attended
	Jackie Forshaw	Primary Care	NHS England	Attended
	Mark Spencer	Primary Care	NHS England	Attended

Healthier Lancashire & South Cumbria

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

		ACTION
17-07-1	**Welcome and Introductions** The Chair welcomed the members of the Committee to the formal meeting. He explained the status of the meeting and that the Committee had invited members of the public to observe what happens at these important decision making meetings. He clarified that this was a meeting held in public but not a public meeting, although the members of the public would be allowed to ask questions relating to agenda items at the end of the meeting. He explained to the Public that Lancashire Television would be filming the meeting. He had approved this to demonstrate our commitment openness and transparency in the JCCCGs when making decisions.	**Info**
17-07-2	**Apologies and Quoracy** Apologies were acknowledged and the meeting was declared quorate. ***RESOLVED: The Chair noted the apologies and declared the meeting quorate***	**Info**
17-07-3	**Declarations of Interest** The Chair requested that the members declare any interests relating to items on the agenda. The Chair reminded those present that if, during the course of the discussion, a conflict of interest subsequently became apparent, it should be declared at that point. ***RESOLVED: It was agreed that the "A vision from Primary Care Transformation" could contain items that could result in the GPs on the JCCCGs being conflicted.***	**Info**
17-07-4	**Minutes from the previous meeting held on the 2nd March 2017** The minutes of the meetings were reviewed, and amendments made. A discussion followed on the accuracy of the Terms of Reference (ToR), highlighted in point 17-03-04. It was noted that the version of the ToRs circulated most recently was not the final version approved by the Joint Committee. Work still needs to be completed to ensure all relevant conversations and actions from separate meetings between Capsticks and the CCGs were incorporated into the ToR. It was agreed that in line with the new governance proposals, the ToR would be revisited, and a sub group would finalise and recirculate the ToRs as a matter of urgency. Further revisions thereafter could be incorporated in the review planned for March 2019. With this action the members of the JCCCG were happy to proceed. The Chair asked that with the agreed changes and acknowledgement of the need to review the ToR, the Committee would accept the minutes of the meeting. ***RESOLVED: The minutes of the meetings were accepted subject to the relevant changes being made to the 2nd March meeting.***	**Info**

17-07-05	**Action Matrix Review** The Action Matrix from the previous meeting was reviewed. 17-01-09 Evaluation and Hurdle Criteria: Prior to purdah this was discussed at the Programme Board meeting and more work is required for the exercise to be completed. This will be presented at the September JCCCG. 17-03-07 Integrated Diagnostic paper: This has been deferred to October 2017. 17-03-09: West Lancashire LDP Presentation: This has been uploaded to the HLSC Website. 17-03-09: Accountable Care Systems: A description was forwarded as requested to members of the JCCCG with the agenda for the meeting. ***RESOLVED: The action matrix was reviewed and updated.***	**Info**
17-07-06	**Any Other Business Declared:** The Chair asked the members of the Committee if they had any other business they wished to declare for discussion at the end of the meeting. At this point Sir Bill Taylor reminded the Committee that it would be more helpful for the public if the Committee could refrain from using acronyms. This was agreed. The Chair added to the public that there would be time once the formal meeting had been closed for the audience to ask questions.	**Info**
17-07-07	**A Vision of Primary Care Transformation** Dr Malcolm Ridgway presented a slide deck on the vision for Primary Care. Key messages were: • A standardised primary care offer delivered in community settings where it is safe and cost effective do so, provided by integrated teams serving a population of between 30,000 to 50,000, 8am until 8pm, 7 days per week • The hypothesis is that it is expected that the amount spent on secondary care by CCGs will remain relatively static over the next four years. CCG growth funding will be channelled into primary care to manage increased demand and there will also be a necessity to invest in prevention, self-care and community resilience • Primary Care Networks (PCNs) are the simple first steps for GPs; these are collaborations between primary care providers developing a multidisciplinary team approach. These can become business units of MCPs or other Accountable Care Systems. There are already models across the HLSC footprint in varied stages of development and maturity • The NHSE Primary Care Transformation team is working with the LDPs and CCGs, utilising their local expertise. There will be funding available to co-produce plans around the practices and other providers integrating and working at scale to manage more people in the community. • A project completed in the Pennine Lancashire area has shown that a third of	**Info**

	admissions and emergency attendances could have been managed in the community There is a need for whole systems change, including Extensivist GPs working with specialist teams managing people in their own homes and Accountable Care Systems. Dr Mark Spencer commented that the final slide in the deck was most important referring to prevention and healthier communities. We need to focus on wellness rather than illness. Questions and answers followed: It was felt that training for GPs and the workforce was an important issue and should have been emphasised in the presentation. The way the workforce will have to operate going forward will be very different from what they are doing presently. There will be a need to work in an integrated way. The need to continue with GP trainers was considered central, to ensure the correct skill mix across the Lancashire and South Cumbria footprint. The importance of finance and the flow of funding were also discussed. Quality was stressed as the most important aspect, but efficiency, cost savings and continuity of services were also substantial issues. As there are decreasing numbers of GPs, there is a need to make changes to the model of care to mitigate this impact. Some of the current changes currently taking place within practices was likened to 'sticking plasters', when a whole service redesign is required to make then sustainable. The Primary Care team is now engaging with fellow professionals and stakeholders to propose the next steps. Sir Bill Taylor made the point that through Healthwatch any engagement events should be made available and put into the public domain Mr Neil Greaves confirmed that any events are also published on the Healthier Lancashire and South Cumbria website. **RESOLVED: The JCCCG noted the proposals and the next steps to move them forward.**	
17-07-08	**Governance of the STP – Issues for the JCCCGs** Mr Gary Raphael presented a paper explaining the rationale for changes to the Sustainability and Transformation Partnership (STP) governance structure, especially with respect to the relationship between a proposed STP Board and the Joint Committee of CCGs (JCCCGs). He explained that the structure had already been taken to several different forums and discussed in detail with Chief Executives and Chief Officers. The composition of the STP Board had been directed by NHSE and NHSI and for Lancashire and South Cumbria this had been interpreted as follows: • An executive lead from each of the LDPs/ACS	**Info**

- Up to five non-executive/lay members drawn from CCGs and FTs/NHS Trust
- A councillor representative from each of the four upper tier local authorities
- The STP lead and other, interim, STP executives
- A primary care provider representative
- Other officers and/or observers in attendance, as required

The final governance structure will need to be considered by NHSE and NHSI, for them to accept and endorse the recommendation
ns.

The Committee was asked to: note the content of the paper; endorse the proposals if possible; and note that formal proposals were to be made to boards and governing bodies within the next month to enable them to support the new governance arrangements.

Discussions followed with sections being highlighted from the report.

Point	Comment
10	Mandate – is this the correct wording STP cannot make decisions – this is not in relation to the STP it is in relation to the totalities of what the STP may tale on
5	Is a presumption?
14	Is there not the same conflict for providers?
Appendix 1	It was felt that the diagram was traditional and further work needed to be finalised. Greater clarity was required on the accountability and nature of relationships

In response to point 10, GR explained that there will be an element of mandate in the STP Board's work as both NHSE and NHSI will continue to hold organisations to account even as they align their functions with the STP and NHSE/I senior managers are likely to be on the Board in officer roles.

GR thought that he had made a factual point in paragraph 5. In the current governance arrangements the JCCCGs is the focal point of decision making but in the proposed new governance structure the STP Board brings together commissioner and provider perspectives and will be expected to lead strategy development and implementation.

GR explained the reason for identifying a constraint in the membership of the STP Board's non-executive membership: if the JCCCGs was to receive a 'referral' from the STP Board for a commissioning decision, it would surely be better not to have the same lay members reviewing the STPs Board's recommendations if they were on both bodies? GR did not think that any other STP Board or JCCCGs members could be in that position.

GR confirmed to the Committee that he would welcome any discussion outside of the meeting in order to refine the proposals and asked that any further comments be sent to him for response.

A final comment was that the STP Board should not be established as 'just another meeting' on top of everything else currently being done. It was suggested that greater

	efforts needed to be made to rationalise the number of meetings and forums across Lancashire and South Cumbria to enable us to make the new arrangements work better for us all. These sentiments were endorsed by all at the JCCCGs. The Committee thanked GR for the paper, acknowledging that it was a welcome explanation of the plans for the new STP Board. The Committee felt that the plans could be refined and looked forward to some further discussions over the summer period alongside CCG governing bodies and provider boards being asked to support refined proposals. **ACTION: The paper was noted and following today's discussion, the governance structure will be refined and forwarded to all Chief Executives and Accountable Officers of Trusts, CCGs and Local Authorities, so that they are able to provide formal feedback on the plans. This amendment was agreed.**	
17-07-09	**Development of proposals for delegated decision making in the Joint Committee of CCGs** Mr Andrew Bennett presented an update to the members on the development of proposals for delegated decision making from CCG Governing Bodies. The paper confirmed that CCG Accountable Officers are sponsoring the development of a common paper for each CCG's Governing Body which will set out proposed areas for delegated decision making to the Joint Committee. It is essential that the delegations requested were specific enough to enable CCG Governing Bodies to understand the scope and impact of decision making both on the STP as a whole as well as local health and care systems. The workstream leads had been asked to identify the delegated decisions and work is continuing to complete the drafting of this paper during July 2017. It is expected that a final version of the delegations paper will be available for consideration by CCG Governing Bodies during August and September. The papers were well received and the members were appreciative of a document to take back through their respective CCGs for comment. There were a few comments on the amount of time that was being taken to establish the committee. Mr Paul Kingan pointed out that although it sometimes felt that little progress had been made in fact the STP had already undertaken a lot of work and what we are trying to do through the decision making arrangement was to formally agree a process. **ACTION: Note the current development of proposals for delegated decision making to the Joint Committee of CCGs.**	
17-07-10	**Any other business** There was no other business raised at this point**.**	

	The next JCCCG Meeting will be held on the 7th September 2017 at Chorley Town Hall, Market Street, Chorley, Lancashire.	
	The Chair thanked the Committee members for their attendance and noted that he was delighted at the interest shown from the General Public and closed the meeting prior to taking questions from the gallery.	

Topics discussed through the Public Questions:

Access to papers prior to the meeting – it was confirmed that these should and will be posted on the website
The New STP Board
Self-Diagnosis
Public Health Education and new technology
Use of ANPs
Capturing success

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

Minutes of the Joint Committee of the Clinical Commissioning Groups
held on Thursday 7th September 2017, 1pm – 3pm
at Chorley Town Hall – Lancastrian Suite

Chair	Phil Watson (PW)	Independent Chair	JCCCGs	Attended
Voting Members **(One vote per CCG)**	Alex Gaw	Chair	Morecambe Bay CCG	Apologies
	Andrew Bennett	Chief Officer	Morecambe Bay CCG	Attended
	Chris Clayton	Chief Clinical Officer	Blackburn with Darwen CCG	Attended
	Sumantra Mukerji	Chair	Greater Preston CCG	Attended
	Doug Soper	Lay Member	West Lancashire CCG	Attended
	Susan Fairhead	GP Member	Blackpool CCG	Attended
	Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Attended
	Gora Bangi	Chair	Chorley South Ribble CCG	Attended
	Graham Burgess	Chair	Blackburn with Darwen CCG	Attended
	Mark Youlton	Chief Officer	East Lancashire CCG	Apologies
	Jackie Hanson	Director of Quality and Performance	East Lancashire CCG	Attended
	Tony Naughton	Chief Clinical Officer	Fylde and Wyre CCG	Attended
	Mary Dowling	Chair	Fylde and Wyre CCG	Attended
	Paul Kingan	Chief Finance Officer	West Lancashire CCG	Attended
	Phil Huxley	Chair	East Lancashire CCG	Attended
	Debbie Corcoran	Lay Member for Patient & Public Involvement	Greater Preston CCG	Attended
	David Bonson	Chief Operating Officer	Blackpool CCG	Attended
In attendance	Amanda Doyle	STP Lead	Healthier Lancs & South Cumbria	Attended
	Andrew Bibby	Director for Specialised Services	NHS England	Attended
	Andy Curran	Medical Director	Healthier Lancs & South Cumbria	Attended
	Carl Ashworth	Service Director	Healthier Lancs & South Cumbria	Attended
	Gary Hall	Chief Executive Officer	Chorley Council	Attended
	Gary Raphael	Finance Director	Healthier Lancs & South Cumbria	Attended
	Jane Higgs	Director of Operations	NHS England	Attended
	Lawrence Conway	Chief Executive Officer	South Lakeland District Council	Attended
	Sir Bill Taylor	Chair	Healthwatch	Attended
	Debbie Nixon	SRO Mental Health	Healthier Lancs & South Cumbria	Attended
	Neil Jack	Chief Executive	Blackpool Council	Attended
	Sakthi Karunanithi	Deputy	Lancashire County Council	Attended
	Hannah Milton	Business Support	Healthier Lancs & South Cumbria	Attended

Healthier Lancashire & South Cumbria

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

		ACTION
17901	**Welcome and Introductions** The Chair welcomed the members of the Committee to the formal meeting. He explained the status of the meeting and that the Committee had, for the first time, invited members of the public to a drop-in session prior to the meeting, in order to give them the opportunity to ask questions in advance of the meeting. He added that there would still be an option to ask questions when the meeting had finished. The Chair acknowledged Chris Clayton's departure from the Committee and thanked him on behalf of the Committee and other colleagues for all his efforts and hard work, both in Pennine Lancashire and also the wider STP. The Committee wished him well in his future role.	**Info**
17902	**Apologies and Quoracy** Apologies were received from Alex Gaw, Roy Fisher, Marie Williams and Mark Youlton. These were acknowledged and the meeting was declared quorate. ***RESOLVED: The Chair noted the apologies and declared the meeting quorate***	**Info**
17903	**Declarations of Interest** The Chair requested that the members declare any interests relating to items on the agenda. The Chair reminded those present that if, during the course of the discussion, a conflict of interest subsequently became apparent, it should be declared at that point. ***RESOLVED: None declared***	**Info**

17904	**Minutes from the previous meeting on 6th July 2017 – amendments were discussed as follows:** • Page 1 – Organisation name incorrect for Dr Sumantra Mukerji - ***Amendment:*** change to Greater Preston CCG. • Page 2 - Minute from the Joint Committee meeting in March regarding the Terms of Reference – ***Amendment:*** It was noted that the version of the Terms of Reference circulated most recently was not the final version approved by the Joint Committee. It was therefore agreed that the most recent version of the Terms of Reference would be recirculated to Committee members again, noting that further comments and revisions will be incorporated in March 2018 when they will be reviewed. • Page 3 – Primary Care Transformation item – ***Amendment***: Outcome of the discussion was that the JCCCG noted the proposals and the next steps to move them forward. • Page 5 second paragraph – governance item – ***Amendment:*** Mary Dowling suggested that the action on this item did not fully reflect the discussion that took place at the meeting and proposed that it should be as follows: 'ACTION: The paper was noted and following today's discussion, the governance structure will be refined and forwarded to all Chief Executives and Accountable Officers of Trusts, CCGs and Local Authorities, so that they are able to provide formal feedback on the plans.' This amendment was agreed.	**Info and action**

	It was noted that there are some outstanding changes to be made to the minutes from the Joint Committee meeting in March. Mary Dowling has provided comments outside of this meeting and these will be incorporated and the minutes will be brought back to the Joint Committee in November for formal ratification. ***RESOLVED: The minutes of the meetings were accepted subject to the relevant changes being made.***	**STP Admin Team**
17905	**Action Matrix Review** The Action Matrix from the previous meeting was reviewed as follows: 1. **Hurdle and Evaluation Criteria**: This item has been deferred to the next meeting. 2. **Integrated diagnostics update:** This item has been deferred to the next meeting. 3. **JCCCG Terms of Reference (ToR)** - Mary Dowling commented on the ToR and suggested that the Committee should have the final agreed version available to it. The general view was that because of the changes that are taking place in the various other associated groups, such as the STP Board being established and the change in emphasis on the Programme Board and the wider governance of the programme, it makes sense to wait until the end of the financial year to review these, once the new bodies have been in operation for a few months. Amanda Doyle agreed that the most recent ToR which are being worked to could be recirculated, *accepting that these would be reviewed in March 2018.* ***ACTION: Recirculate the most recent version of the ToR, once Mary's comments have been incorporated.***	**Info** **STP Admin Team**
17906	**Any Other Business Declared:** The Chair asked the members of the Committee if they had any other business they wished to declare for discussion at the end of the meeting. Gary Raphael stated that he would like to discuss the position on capital bids. The Chair added that there would also be an opportunity for the public to ask questions at the end of the formal meeting.	**Info**
17907	**Programme Overview** Carl Ashworth presented a paper on the STP Outline Work Programme for 2017/18. Amanda Doyle added that this is an STP level work programme and the purpose for the update was to provide the Committee with an understanding of the overarching programme activities and how the work in Local Delivery Partnerships (LDPs) fits with the wider STP strategy. STP's are expected to make progress across the following areas: 1. Establishing STP governance arrangements 2. Delivery and assurance of system performance against NHS Constitution and other	**Info**

targets
3. Achievement of system sustainability
4. Transformed services that manage future demand in a different way
5. Designing future commissioning/provider arrangements through ACS and strategic commissioning developments

So far, Senior Responsible Officers have identified decisions for the JCCCGs in 2017/18, to sign off clinical policies, agree process and evaluation criteria and agree a strategic commissioning model.

The role of the JCCCGs in 2018/19 will be to sign off clinical policies and the short list of options for consultation.

An MOU (Memorandum of Understanding) has been agreed between NHS England and the STP, which aligns regulatory responsibilities to support the work of the STP. NHS Improvement had not yet agreed their input to the MOU.

Amanda Doyle commented that this will be a fluid piece of work, in that as people agree delegations to the Joint Committee, the work around those decisions will be added to this work plan.

Mary Dowling expressed a concern regarding the decision making role of the Joint Committee in the context of the proposed STP governance arrangements.

Amanda Doyle commented that the Committee can only be responsible for things that the individual CCGs delegate to it. She added that the role of the Joint Committee is really important in relation to some of the major issues, but unless the individual CCGs delegate the decision making around those things to the Committee, the work required cannot be progressed effectively. Amanda also suggested that as the STP matures and develops, the responsibilities for the Joint Committee are likely to increase. Mary Dowling said that it was her understanding that delegation had already occurred through the terms of reference of the Joint Committee and the Committee now awaited the proposals/business cases on the major issues it needed to decide.

Amanda Doyle and Mary Dowling agreed to discuss this further outside of this meeting.

Amanda stated that the Committee should be taking some responsibility for performance management in relation to the priority areas – including quality. At present, no CCG has led Amanda to believe that they are willing to delegate their own responsibility for this to the Committee; however, Amanda added that she would welcome CCG's that would like to pursue a conversation about this.

Phil Huxley queried how we would enable clinicians to engage in conversations if we are dealing with things more centrally via the Committee. Amanda added that we need to widen our engagement to people at all levels and bring their comments and feedback to the process.

Mary Dowling congratulated Carl Ashworth on the work which had gone into his paper and added that it was very helpful in taking things further forward. She remained

	concerned that the role of the Joint Committee was not adequately reflected particularly in relation to delivery and assurance of system priorities. The paper was well received and members were appreciative of the clarification this provides. ***RESOLUTION: The paper was noted.***	
17908	**Urgent Care Presentation** Andrew Bennett introduced the presentations, highlighting the impacts of the Five Year Forward View in relation to commissioning. Lancashire and South Cumbria have an opportunity to develop new approaches to commissioning as follows: • Collective: STP-wide e.g. through the Joint Committee. • Place-based: in local health and care "accountable care" systems. • Integrated: aligning resources and priorities with NHS England, Local Government and commissioning support services. The next steps were outlined as follows: • A proposal has now gone to CCG Governing Bodies requesting delegated decision making into the Joint Committee for specific areas. • A Commissioning Development Strategy will now be developed – encompassing the next 2-3 years. • Two case studies to be presented today – Urgent and Emergency Care and Mental Health. David Bonson thanked Andrew for setting the scene and commenced his presentation on Urgent and Emergency Care. Key messages were discussed as follows: • Urgent Care is a whole system – not just A&E services. • Urgent and Emergency Care Plan – There are seven key priorities which will deliver transformation of Urgent and Emergency Care. These are: 1. NHS 111 Online – being tested and rolled out during 2017. 2. NHS 111 Calls – by the end of 2017/18 the percentage of calls receiving clinical advice will exceed 50%. 3. GP Access – by March 2019, patients will have access to evening and weekend appointments with general practice. 4. Urgent Treatment Centres – standardise approach nationally. These facilities will open 12 hours per day and will be staffed by clinicians, with access to simple diagnostics. 5. Ambulances – are currently under extreme pressure. Ensure right vehicles are despatched as quickly as possible and move to a hear and treat/see and treat model. 6. Hospitals – Emergency departments are very congested. Ensure that only patients that need to be there are there and others are screened and signposted to the most appropriate service. 7. Hospital to Home – Move on to home/more appropriate care setting at the	**Info**

earliest opportunity. A lot of work is going on regarding delayed transfers of care (DTOC).

- Urgent Treatment Centres - national service specification was published in July 2017. The aim is to have 150 Urgent Treatment Centres in place by 2017, with full coverage by December 2019. Key components of the specification are:
  - GP led service as part of multidisciplinary workforce
  - Open at least 12hrs a day, 7/365
  - Direct booking from NHS111, ambulance services, GPs and "Walk in"
  - Access to simple diagnostics and X-ray facilities

- Performance –The national expectation is that we achieve the standard of 90% of people seen within the 4 hour period by September 2017 and 95% by March 2018.

Amanda Doyle thanked David for the presentation and asked if he could be more specific about the action that needs to be taken immediately.

David responded by suggesting that there is a need to do a stock take of contracts for CCG's and providers, in order to move this work forward, in terms of where we are now against the national specification. There is a deadline for the end of September 2017. This is a very specific 'ask'. The Lancashire and South Cumbria Urgent Care Workstream is co-ordinating this piece of work.

David added that there is a need to quickly think about what the commissioning arrangements would look like to deliver the requirements described in the service specification. Lead commissioner arrangements are linked with the delegated decisions work.

There will also be a requirement to work collaboratively with providers around the function of the whole of urgent care, with an integrated approach to managing the workforce to deliver this effectively.

There is also a plan to use business intelligence to track the patient journey, to help with understanding patterns, demand and risks.

The Chair asked if there were any questions.

A discussion took place around recent A&E performance, which is currently a risk across the whole system. We are in a very challenged position and there is a need to focus on what we are going to do about it. Lancashire and South Cumbria have an opportunity to work collectively to improve performance across the system.

Geoffrey O'Donoghue asked whether the presentations could be circulated with the papers for the Joint Committee. Amanda responded to state that the NHS England Urgent Care Specification has already been cascaded and that the presentations that are used, do not always tell the full story, as they are used as a tool to aid full explanation and therefore there could be a risk of confusion and misinterpretation if they were on the website.

	The Joint Committee is asked to agree the following:- *To proceed with the stock take of existing contracts with CCG's and Providers to take this work forward.* ***RESOLUTION: The Joint Committee agreed this.***	
17909	**Mental Health Presentation** Debbie Nixon and Andrew Bibby presented a slide deck, which built on David Bonson's Urgent Care presentation. Debbie explained that the Mental Health Five Year Forward View is very explicit and sets a complex direction of travel in the following priority areas: • Children and young people's mental health • Perinatal mental health • Adult mental health: common mental health problems • Adult mental health: community, acute and crisis care • Adult mental health: secure care pathway • Health and justice • Suicide prevention In addition to the Mental Health Five Year Forward View, there is a requirement to deliver a Mental Health Delivery Plan, which is aimed at monitoring performance and delivery through one function. This is very prescriptive, particularly around workforce and the delivery of outcomes. There are some really clear milestones that need to be delivered. There will be a consistent high quality offer for mental health services, regardless of where people live. There will be a tiered approach to services as follows: • Tier 1 services – neighbourhood level • Tier 2 services – Local Delivery Partnerships • Tier 3 services – STP level • Tier 4 services – STP or inter STP There is currently significant variation across Lancashire and South Cumbria which needs addressing. There will be a consistency around the 'what' but local flexibility about the 'how' (taking account of incidence; population density; demography; geography). There are also a range of services that are in the main commissioned by NHS England – including children, health and justice, secure services for adults, inpatient services and perinatal services. There will be equitable access for the whole population. The tier approach aims to deliver seamless transition for patients, irrespective of where they are from. There is also a huge opportunity around prevention and reducing demand, supporting people in communities to play an active role in their health and care.	**Info**

	We have seen recent improvements in our performance in mental health and we have been rewarded for this, in that we have received capital resource to improve perinatal inpatient services, hospital liaison and transformation resource for improving access. We have an opportunity for greater collaboration across the whole patch, to help us to progress at pace, improve clinical outcomes, utilise workforce effectively, manage performance through a single system and increase our overall productivity and efficiency. Lancashire and South Cumbria are doing well against some of the performance indicators, but we are not achieving all. Step changes are required to achieve national priorities and mandates. We need to look at things to implement collectively or consistently. Debbie suggested a slight amendment to the 'ask' of the Joint Committee as outlined below. ***The JCCCG is asked to agree the following:*** *To receive a detailed proposal for a revised operating model for the commissioning of mental health services. This aims to implement the national mental health and wellbeing strategy.* ***RESOLUTION: The Joint Committee agreed this.***	
17910	**Any other business** **1. Capital** Gary Raphael presented a slide deck on the Capital Bid. He explained that we had been successful previously, despite the tight timescales we had to refine and submit the bids. Wave 1 success: • Mental Health Inpatient scheme affecting Burnley and Chorley hospitals (£5m to £10m scheme) • A&E development at Blackburn Hospital (£5m to £10m scheme) Gary explained that as part of Wave 2 (September 2017), we will be submitting a Lancashire & South Cumbria pathology scheme, covering all four acute trusts with an estimated cost of £31m. In addition to the pathology scheme, we had decided to make NHS England and NHS Improvement aware of the priority schemes for Lancashire and South Cumbria, in relation to urgent and emergency care services, in effect, the pipeline of developments that were not yet ready for wave 2 submission, but would be next in line.	

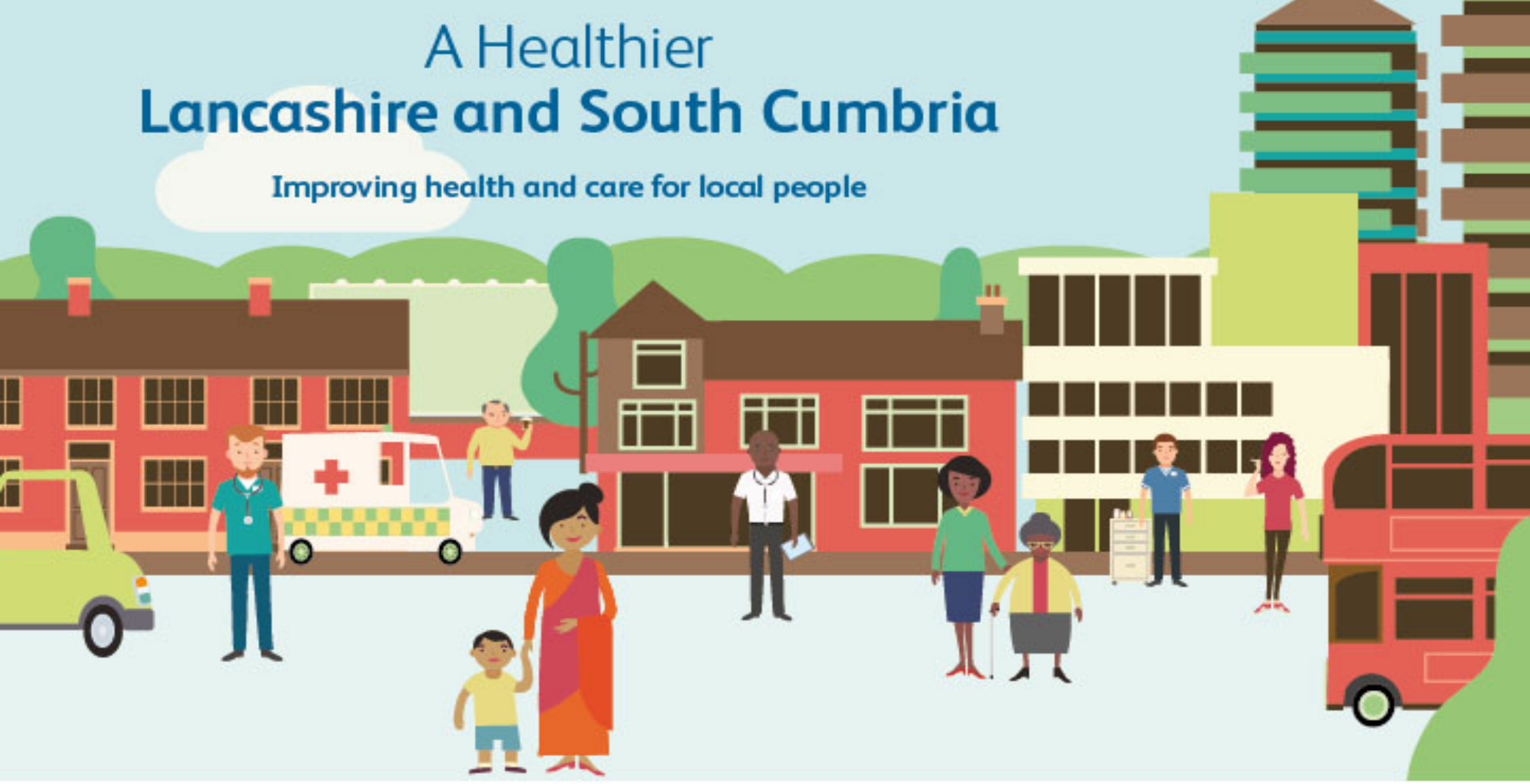
	The relevant submission was still in development, but so far the benefits and costs of this could be outlined as follows: • Improvements to A&E and RTT (Referral to Treatment Time) • Improvements to cancer treatment • Patient experience improved in A&E • Costs circa £35m over next 2 years ***The Joint Committee is asked to support the following:-*** *Submission of this bid.* ***RESOLUTION: The Joint Committee supported this.***	
	2. The next Joint Committee meeting – incorrect date on the agenda The Chair stated that the date of the next Joint Committee meeting was outlined incorrectly on the agenda. He confirmed the correct date as 2nd November 2017 – 1.00pm – 3.00pm – Morecambe Bay CCG - The Lecture Theatre, Moor Lane Mills, Moor Lane, Lancaster, Lancashire, LA1 1QD. A message will be communicated to the public via the website and via Local Delivery Partnership communication channels.	
The next JCCCG Meeting will be held on: 2nd November 2017, 1.00pm – 3.00pm - Morecambe Bay CCG - The Lecture Theatre, Moor Lane Mills, Moor Lane, Lancaster, Lancashire, LA1 1QD		
	The Chair thanked the Committee members and members of the public for their attendance and closed the meeting prior to taking questions from members of the public.	

Topics discussed through the Public Questions:

1. Access to papers prior to the meeting, difficulties accessing the website and publicising the Joint Committee meetings dates via different channels.
2. Our confidence in achieving success.

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

Ref	Subject	Owner	Update	Status	Complete
17905	Terms of Reference	CA	It was agreed that in line with the new governance proposals, the ToR would be revisited and a sub group would agree the ToR and recirculate.		
17909	Mental Health Presentation	DN/AB	To receive a detailed proposal for a revised operating model for the commissioning of mental health services. This aims to implement the national mental health and wellbeing strategy.		



Joint Committee of CCGs

Local Maternity and Newborn System Board and Plan

Healthier Lancashire & South Cumbria

Purpose of the presentation

- Understand the new ways of working across Lancashire and South Cumbria and the establishment of the Local Maternity and Newborn Systems Board
- Understand the scale of undertaking to deliver the ambition of the Better Births report from the National maternity review by 2020/21
- The Joint Committee is asked to **support** this high level plan

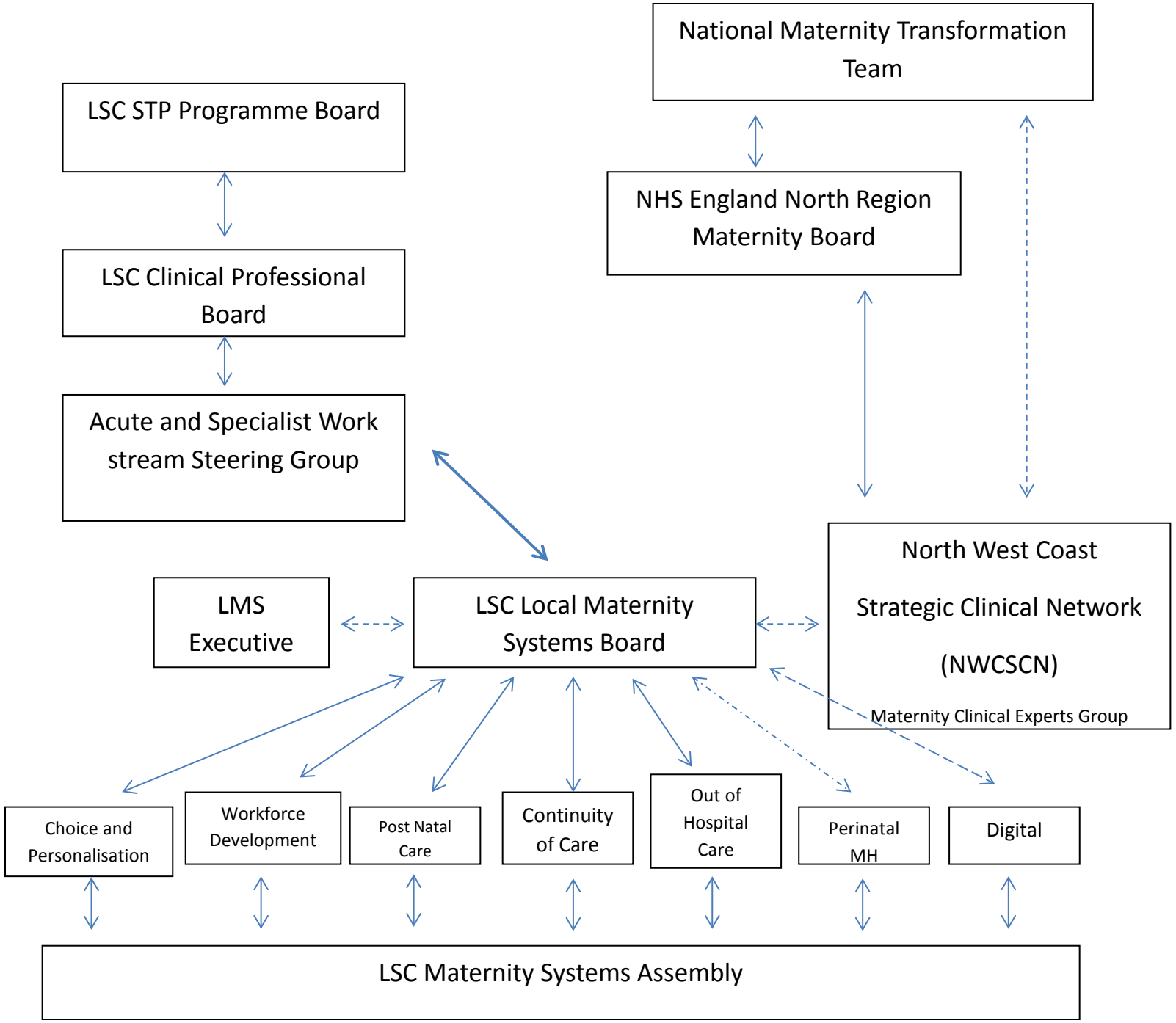
Brief context

- 17,726 births across LSC 2016/17
- Offer full choice of birth setting
- 4 providers of maternity care – 12 settings + Home Births
- Demographics from urban to rural covering 3500 square miles
- Workforce challenges
- Interdependencies

Key messages/discussion points

- Developing the Local Maternity Systems Board
- Key Task to deliver Better Births across LSC by the end of 2020/21
  - Improving choice and personalisation
  - Improving safety of services
  - NHS Personal Maternity Care Budget
  - Continuity of Carer
  - Working with SCN
  - Development of Maternity Voices

  Partnerships


National Maternity Transformation Team
LSC STP Programme Board
NHS England North Region Maternity Board
LSC Clinical Professional Board
Acute and Specialist Work stream Steering Group
North West Coast Strategic Clinical Network (NWCSCN)
Maternity Clinical Experts Group
LMS Executive
LSC Local Maternity Systems Board
Choice and Personalisation
Workforce Development
Post Natal Care
Continuity of Care
Out of Hospital Care
Perinatal MH
Digital
LSC Maternity Systems Assembly

Key tasks

- **By 31 March 2017,** local commissioners, providers and service users should work collaboratively to establish a Local Maternity System that is coterminous with the footprint of the Sustainability and Transformation Plan.
  - **In place and Terms of Reference agreed**

- **By October 2017**, the Local Maternity System should have established a shared vision and local maternity transformation plan to implement *Better Births* by 2020/21.
  - **Submitted for peer review regionally (13th October)**
  - **Signed off by LMSB 11th October**

Implementing *Better Births*

A resource pack for Local Maternity Systems

Five Year Forward View

March 2017

Vision

- *'Our vision is of a maternity and newborn service where women and their family experience safe, compassionate and personalised care that is based on the best available evidence, and every woman has access to information about the whole maternity system in order to enable her to make informed choices about her care; and where she, her family and baby can access support that is centred around their personalised needs and circumstances.*

- *Staff working within maternity and newborn services will be supported to deliver care as part of high performing multi professional teams in well led organisations where the culture encourages innovation and creativity and removes professional and organisational barriers.'*

Recommendations and next steps/actions

- Establish working arrangements with Strategic Clinical Network
- Governance
- Recruitment of Project Manager and Family Engagement Officer
- Support the work stream chairs to deliver elements of the plan and route decisions through the LMS to National Transformation Board and LSC STP structures.
- Ensure connectivity with interdependent services i.e. Neonatology, Paediatrics and Gynaecology

Joint Committee of Clinical Commissioning Group's

Title of Paper	Lancashire and South Cumbria Transforming Care Partnership CCG Commissioned Beds: Model of Care Recommendations Briefing Paper		
Date of Meeting	2nd November 2017	**Agenda Item**	8

Lead Author	Debbie Nixon	
Purpose of the Report	For Approval	x
Executive Summary	The Transforming Care Programme (TCP) is a national Learning Disabilities (LD) programme aimed at improving the health and care of people with learning disabilities and / or Autistic Spectrum Disorder (ASD) across England. It has been jointly commissioned by NHS England (NHSE), the Local Government Association and the Association of Directors of Adult Social Services (ADASS). The programme sits within the 5 Year Forward View 2014, which sets out the change agenda for the NHS for the next 5 years and Next Steps on the NHS 5 Year Forward View March 2017. This paper provides an update on progress and sets out a proposal to develop a revised strategic plan and undertake a public consultation regarding the future model of care and CCG commissioned inpatient configuration.	
Recommendations	1. The Joint Committee is asked to note the contents of the paper and to agree a timeline, which will include a public consultation on the model of care including options for CCG commissioned inpatient provision. 2. The Joint Committee is asked to agree to the establishment of a Task and Finish Group, to undertake this work and formally report back to the Committee on progress.	
Equality Impact & Risk Assessment Completed		Yes – this will be undertaken as part of the public consultation
Patient and Public Engagement Completed		Ongoing
Financial Implications		Yes
Risk Identified		Yes
If Yes : Risk		A risk assessment will be undertaken as part of the Technical Appraisal, depending on discussions with NHS England regarding the use of the Calderstones site.
Report Authorised by:		Amanda Doyle

Lancashire and South Cumbria Transforming Care Partnership
CCG Commissioned Beds: Model of Care Recommendations

1. Introduction & Background

1.1. The Transforming Care Programme (TCP) is a national Learning Disabilities (LD) programme aimed at improving the health and care of people with learning disabilities and / or Autistic Spectrum Disorder (ASD) across England. It has been jointly commissioned by NHS England (NHSE), the Local Government Association and the Association of Directors of Adult Social Services (ADASS). The programme sits within the *5 Year Forward View 2014,* which sets out the change agenda for the NHS for the next 5 years and *Next Steps on the NHS 5 Year Forward View March 2017.*

1.2. Since 2015, there has been a range of supporting documentation provided to enable areas to drive forward change. These include: *Service model for commissioners of health and social care services, October 2015, Model service specifications* 2017 and *Building the Right Home 2016*.

1.3. Lancashire and South Cumbria Transforming Care Partnership (TCP) is one of 48 across England. Its focus is to deliver the broad range of services described in the national plan *Building the Right Support.*

1.4. In 2015, Lancashire Collaborative Commissioning Board published its detailed Transforming Care Plan entitled *The Right Track.* This comprehensive document outlines Lancashire's aims to deliver safe, sustainable services to the local population with Learning Disabilities and / or Autism in accordance with National Directives and Local Drivers. It takes into account the findings of the 2014 "Bubb report" and the learning, principles and models still relevant from the *Six Lives* work following the *Death by Indifference* and the *Mansell* reports*.*

1.5. In April 2017, boundary changes at Morecambe Bay have meant that the Lancashire programme has widened its geographical footprint and consequently, has a need to refresh its Strategic Plan to reflect this. The vision and direction of travel for future services remains the same.

1.6. A public consultation led by NHS England, was undertaken as part of the Transforming Care Programme regarding the provision of Medium and Low secure provision currently on the Whalley Site (previously known as Calderstones). The final outcome has not been published, but is expected in Autumn 2017.

1.7. A North West Learning Disability and Autism Operational Delivery Network (ODN) has been established, funded via NHSE transitional funds, hosted by Lancashire Care NHS Foundation Trust.

The Network will support the three North West TCPs of Cheshire and Mersey; Greater Manchester and Lancashire and South Cumbria in their plans to transform care for people with Learning Disabilities and / or Autism. The ODN annual work plan has been developed and agreed to mirror the priorities of the TCPs. The key purpose of the ODN is to ensure that outcomes and quality standards are improved (in line with the Right Care principles) and that evidence based, networked patient pathways are agreed. The ODN will focus on supporting the activity of provider Trusts in service delivery, improvement and innovation, to deliver commissioned pathways, with a key focus on quality and equity of access to service provision.

2. Programme Update

Operational Elements and future of Discharge Coordinators

2.1. From the inception of the Transforming Care programme, the roles and responsibilities for Commissioners have grown significantly. The impact of this has seen LD Commissioners time shift from working on strategic objectives to becoming very operational.

2.2. In 2015, the TCP received its share of national transformation funding. It was agreed that a share of this would be allocated to Midlands and Lancashire Commissioning Support Unit, to provide additional support with discharge co-ordination. There are currently Four Full-time Band 7 Discharge Coordinators, who support commissioners discharge both Clinical Commissioning Group (CCG) and NHSE individuals and provide inpatient updates and assurance to the Programme. These posts will come to an end in March 2018 and a review and recommendations will be presented to a future meeting of the Collaborative Commissioning Board.

2.3. CCG and Social Care Commissions have come together to consider the day to day functions required to ensure delivery of programme going forward. It is agreed that there are the following work streams that need to be addressed

• Supporting the LD and / or Autism population, including: current inpatients, those living in the community and on the Dynamic Risk Register and on-going admissions and discharges, co-ordination and chairing of Care and Treatment Reviews (CTRs).
• Back office functions, including funding requests, updating Broadcare, presenting cases to panel and producing Lancashire wide monitoring information for the national team.

Children

2.4. The work that has been undertaken to date regarding children's LD and Special Educational Needs & Disabilities (SEND) services shows that there are increasing numbers of children and adolescents experiencing behavioural problems related to learning difficulties or ASD. It is important that we address the deficiencies in the current provision, to ensure that these young people do not become the next cohort of service users inappropriately placed.

2.5. At present, the STP has a number of workstreams that include elements of this work:

• Special Educational Needs and Disabilities (SEND) agenda, which is led by the Local Authorities, with significant health involvement.
• Vulnerable Children workstream as part of the Child and Adolescent Mental Health Services Transformation Board, led by health and supported by Local Authorities.
• Learning Difficulties Transformation Programme, joint arrangement.

Note for all areas there remain different arrangements in South Cumbria which will be worked through as part of the revised Strategic Plan.

2.6. Specialist Support Teams (SST)

As part of the Heads of Terms and Transaction Agreement for the Calderstones acquisition, it was agreed that Merseycare NHS Foundation Trust would provide the new SST service as an extension of the existing forensic contract, in line with the national specification. Merseycare NHS Foundation Trust is now recruiting to the SST service. The contractual and financial arrangements are being undertaken by The Specialist Commissioning Team at NHSE and East Lancashire CCG (as the two lead contractors). It is anticipated that this service will be mobilised from the Autumn 2017 and a full transition plan will be shared with the TCP.

2.7. In addition, a draft community service specification has been drawn up which follows an all age pathway and includes learning disability and / or autism. As part of the 2017-18 work programme, the North West Learning Disability and Autism Operational Delivery Network will support development of pathways and clinical ratification of the specification. It is essential that we integrate the work of the SSTs and the community teams, to ensure that we deliver a comprehensive and inclusive offer and this will be a key focus of the Transforming Care Service Model Delivery Group.

Specialist Acute Learning Disability Inpatient Services (SALDIS) – CCG commissioned beds

2.8. The national planning assumptions set out in Building the Right Support, specify that by March 2019, a range of inpatient provision should be in place to meet the national specification. For Lancashire, this range was from 10-16 beds, but this changed in April 2017 to give an indicative range of 16-24 beds.

2.9. The Lancashire provision was included in the Merseycare Acquisition and the preferred option of the Merseycare Strategic Partnership Board and CCG commissioners, is to deliver the CCG commissioned beds from a redeveloped unit on the Calderstones site. The Merseycare Acquisition Agreement was for a three year period, completing in March 2020. Discussions with the national Transforming Care Team have been ongoing and commissioners are awaiting confirmation that this will be accepted as an interim option. It is our intention to refresh the Strategic Plan and retest our planning assumptions regarding inpatient capacity and the new model of care. It is proposed that a Task and Finish Group is established to undertake this work and the timeline is attached at appendix 1.

3. Building The Right Home

3.1. The Pan – Lancashire Transforming Care Partnership has secured £10K funding from NHS England to develop a Housing Strategy and Action Plan for people with learning disabilities and/or autism in Lancashire.

The Housing Strategy will define the type and volumes of accommodation for people covered under the Transforming Care Programme, across the 4 Local Authorities in the Pan-Lancashire TCP and will be set out in the revised Strategic Plan.

4. Finance

4.1. In February 2017, a paper was presented to the CCB setting out a preferred option for a pan Lancashire pooled budget (PB), to include all relevant spend across the Learning Disability programme budget. This preferred option did not gain support, but it was agreed that Lancashire County Council and the six Lancashire CCGs would continue to work towards a pooled budget. At the time, the two unitary authorities were keen to explore arrangements as part of their local Better Care Funds. At this time the South Cumbria element was not part of the TCP.

4.2. Since then, a Finance Task and Finish Group has been established and following advice from Local Government Association and NHS England, we have agreed to work towards the following two phases –

- **Phase 1** - Work towards developing four local pools by April 2018 (to be determined what's in scope)
- **Phase 2** - Discussions regarding options to develop an integrated commissioning function as part of the emerging STP discussions

4.3. The PB would be developed on the basis of advice from NHS England that there would be a start in releasing monies on a named individual case basis, starting with inpatients admitted prior to 1 April 2016 as they are discharged. Once this was up and running, the next step might be all individuals as they are discharged - before moving towards wider service level costs and integrated commissioning. This agreement would be key to Local

Authorities agreeing to fund discharges into the community, with the flow of social care costs flowing from the NHS.

5. Summary

Work is progressing well and the TCP performed well at a recent national Board to Board meeting in September 2017. The key focus is to develop a revised Strategic Plan to take into account the boundary change in April 2017 and ensure that we have an ambitious and innovative plan for the STP moving forward.

6. Recommendations

- The Joint Committee is asked to note the contents of the paper and to agree a timeline which will include a public consultation on the model of care, including options for CCG commissioned inpatient provision.

- The Joint Committee is asked to agree to the establishment of a Task and Finish Group to undertake this work and formally report back to the Committee on progress.

Debbie Nixon
Senior Responsible Officer – Mental Health
24th October 2017

Appendix 1

Timeline for Delivery

Date Range	Activity
Oct 2017 – Jan 2018	- The North West ODN to undertake a review of the Strategic Plan and make clear recommendations on: The overall clinical model, including: - The number and categorisation of CCG commissioned beds - The number of sites - Clinical Standards and outcomes
November 2017	• Present the revised Strategic Plan to the JCCCG for sign off.
Feb 2018 – Sep 2018	• CCGs undertake a Technical Appraisal of the ODN recommendations including: - Model of Care - Options regarding beds and sites - Outcomes - Affordability - Evaluation Criteria.
Nov 2017 – August 2018	• Pre-Consultation will be undertaken throughout the process and a Communication and Engagement Plan will be developed.
Sep 2018 – Dec 2018	• Formal Public Consultation on the model of care (not the location of the sites) is undertaken.
Dec 2018 – Mar 2019	• Evaluation of Consultation and recommendations is developed.
March 2019	• Recommendations presented to JCCCG to include: - Consultation outcome and preffered option - Procurement plans.
April 2019	• Procurement undertaken
April 2020	• Contract awarded and mobilised

Joint Committee of Clinical Commissioning Group's

Title of Paper	Urgent and Emergency Care Delivery Funding and 2018/19 Core24 Drawn Down Update Paper		
Date of Meeting	2nd November 2017	**Agenda Item**	9

Lead Authors – Stephanie Gregory / Paul Hopley	
Purpose of the Report	For information
Executive Summary	Achieving the A&E wait targets for both the 4 hour and 12 hour standard remain a challenge across the Lancashire and South Cumbria STP with regard to Mental Health breaches. Following a Mental Health Risk Summit on 4th September 2017, it was agreed that an Urgent and Emergency Care bid would be submitted, supported by the STP, to help us deliver A&E targets. In addition, NHSE national team have allowed us to access 18/19 monies for Core 24 to implement key elements in year. Funding is summarised as follows: • Urgent and Emergency Care funding 2017/2018 - £367,911 • Core24 funding - £784,540 (to be confirmed with CCG's) The areas of focus will be around: • The indirect provision of a Mental Health triage line with NWAS and the Police, co-located at the Broughton Ambulance headquarters; • Providing increased cover for Mental Health Liaison at Furness General Hospital to move towards 24 hours a day/7 days a week provision • Establishing medical (Psychiatrists) cover to all Emergency Departments and the wider acute trust environment • Mental Health triage in all Lancashire A&Es
Recommendations	To support the contents of this paper and the funding allocations. To note the recurrent funding requirements for Core24 for 2018/19.
Equality Impact & Risk Assessment Completed	Not Applicable
Patient and Public Engagement Completed	Not Applicable
Financial Implications	Yes
Risk Identified	Yes
If Yes : Risk	In summary the risk relates to the 2018/19 financial year. This is due to us drawing down Core24 transitional monies ahead of planned implementation which will need to be replaced next year.
Report Authorised by:	David Bonson Debbie Nixon

Lancashire and South Cumbria

Sustainability & Transformation Partnership (STP)

Urgent and Emergency Care Delivery Funding and 2018/19 Core24 Drawn Down Update Paper

1. Introduction and Background

The Lancashire and South Cumbria STP (LSC STP) has already been successful in being awarded transformation funding for crisis and urgent care (Core 24) from April 2018.

The achievement of the national A&E wait targets for both the 4 hour (ie, 4 hours from arrival to transfer admission or discharge) and 12 hour (ie, from decision to admit to admission) standard have been extremely challenging for the Lancashire and South Cumbria STP with regard to Mental Health breaches. A Mental Health Risk Summit, chaired by NHS Improvement, NHS England and the STP Lead was held on 4th September 2017, where a number of key proposals were outlined. As a result of significant challenge and debate at the summit it was agreed an Urgent and Emergency Care (UEC) bid against non-recurrent funding identified by NHS England North, would be submitted supported by the STP to address the above issue (See appendix 1 for original supporting information for this bid).

In parallel to this submission for additional UEC funds, NHS England have agreed to allow the LSC STP to draw down the Core24 monies from December this year, to a maximum of 50% to bring forward implementation of key functions that will assist in emergency departments. It is important to note that the submission for the UEC bid was for additional services that were to further enhance and not included in the Crisis and Urgent Care model (Core24).

As part of the LSC STP, we will redesign and deliver a sustainable and consistent service which is compliant with all of the standards set out by the National Institute for Clinical Excellence (NICE) - Implementing the Evidence-based Treatment Pathway for Urgent and Emergency Liaison Mental Health Services for Adults and Older Adults.

The following outcomes would expect to be realised throughout the implementation of the Urgent Care Liaison Model.

- Improvements in patient satisfaction
- Improvements in family/carer satisfaction
- Improvements in referrer satisfaction
- A reduction in numbers of frequent attenders at A&E
- A reduction in numbers of serious untoward incidents
- A reduction in numbers of mental health-related A&E waiting time breaches (4 and 12 hour)
- Reduction in the number of cubicle hours occupied within A&E by a patient with a mental health need

In 2014/15 Lancashire Care Foundation Trust (LCFT) received 2.7 times more than the national average of referrals. During 2015/16, there was an increased demand in A&E, negatively impacting on the Mental Health Liaison Teams (MHLT). The STP have some of the highest alcohol related presentations nationally, which has a detrimental impact on MH services, and are procuring an innovative, third sector led approach which has been successfully piloted in a number of areas within the STP. The situation has been exacerbated by an increase of approximately 40% in Section 136 demand over the same period. Although, we have seen this plateau for 2 quarters of 2017, MH attendance has also increased with 33% of referrals not known to the MH Services.

The Mental Health contract for Lancashire was rebalanced for the commencement of 2017 with a full capacity and demand analysis having been undertaken. The analysis which used NHS benchmarking as its prime source of information defined the number of beds, the alternatives to admission required and also the requirement to develop demand management support with multiple agencies. This concluded that the bed model was sufficient to meet the local prevalence when all community services are in place.

The LSC STP have worked with the Acute Trusts to produce a gap analysis and action plan for each Accident and Emergency Department in the STP footprint to determine the gaps in provision for the Mental Health pathway. The gap analysis was based upon recommendations following a joint visit to the East Lancashire site by the Royal College of Psychiatrists and Royal College of Emergency Medicine and developed in conjunction with each Acute Trust.

UEC Submission

- The indirect provision of a Mental Health triage line with NWAS and the Police, co-located at the Broughton Ambulance headquarters; this is a key element of the pathway as we are receiving all 111 and 999 calls with a diversion service away from Accident & Emergency departments
- Providing increased cover for Mental Health Liaison at Furness General Hospital to move towards 24 hours a day/7 days a week provision
- Urgent and Emergency Care programme support costs

Core24 drawn down

- Establishing medical (Psychiatrists) cover to all Emergency Departments and the wider acute trust environment
- Mental Health triage in all Lancashire A&Es

This proposal would allow acceleration in delivery and progress of implementation of which the benefits and costings can be found in Appendix 2.

2. Mobilisation

We will commence recruitment, particularly to Psychiatry posts, immediately and recruitment will be to substantive posts to ensure consistency for implementation of CORE 24. This will increase the attractiveness of the posts, though anecdotally, these roles are in themselves attractive. We are aware of the risk being more around movement of high calibre staff from elsewhere in the Trust into these posts, and so will retain a broader Trust recruitment strategy. An additional benefit to substantive Psychiatrists will be the subsequent re-

introduction of junior doctor rotational cover to A&E, further bolstering medical capacity in Mental Health Liaison Teams.

Plans are progressing to work with a third sector partner to develop the crisis support units, this will allow for staff to be recruited to their positions using an alternative process for recruitment. The current staff within the CSU would then work with the third sector staff as well as the Mental Health Liaison Team to deliver the MH triage service as well as develop the crisis support unit to become a clinical decision unit..

This will require all providers (acute and mental health) to work in collaboration to ensure a robust workforce implementation plan is established and monitored to demonstrate the impact and delivery of the above identified outcomes. This would require monitoring through the normal contractual processes.

3. Governance and Monitoring

The progress on implementation and monitoring of KPIs will be undertaken by the A&E Delivery Board Network and the Mental Health and Organisational Resilience Group.

4. Recommendations

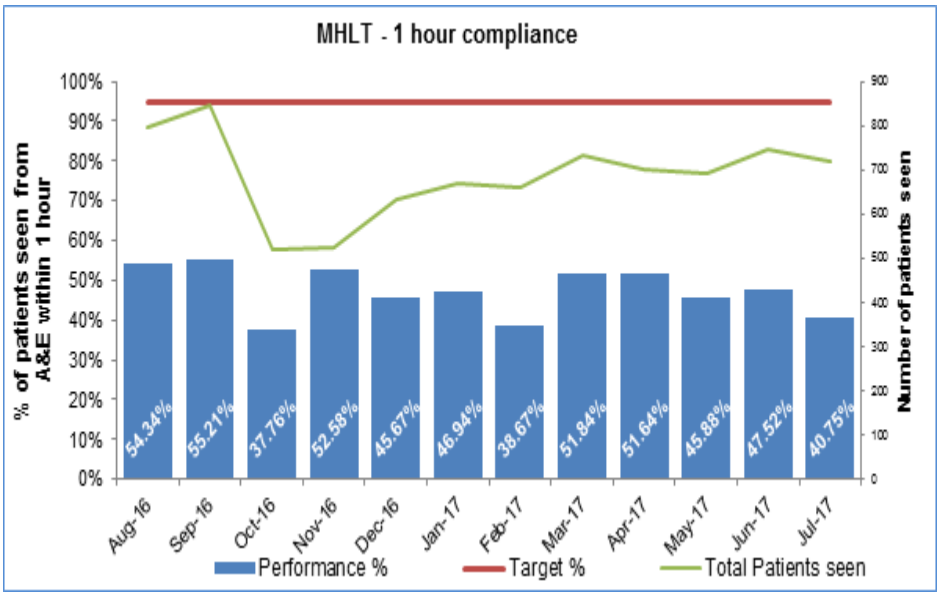
- To support the contents of this paper and the funding allocations.
- To note the recurrent funding requirements for Core24 for 2018/19.

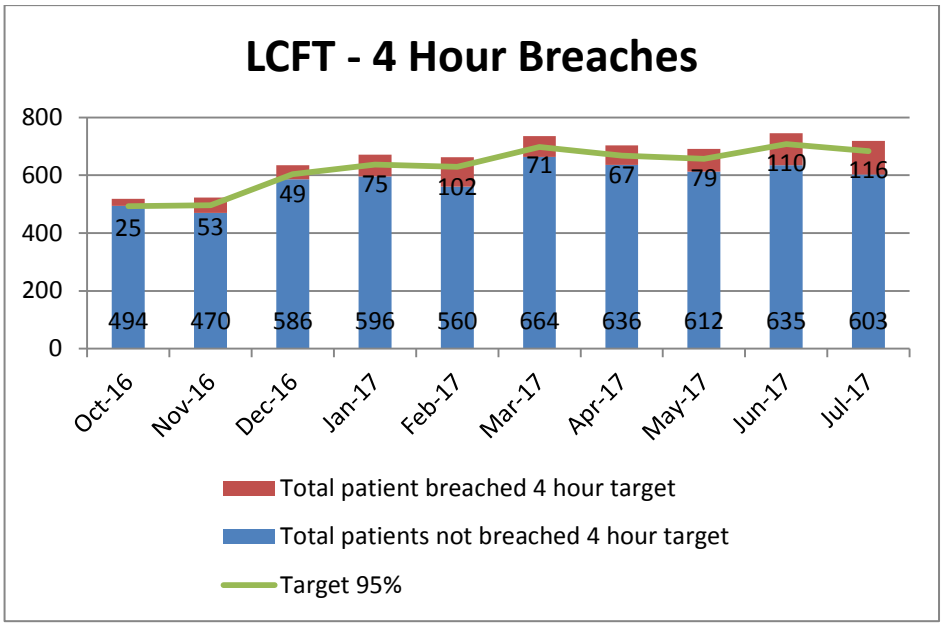
Stephanie Gregory, U&EC Network Support Lead

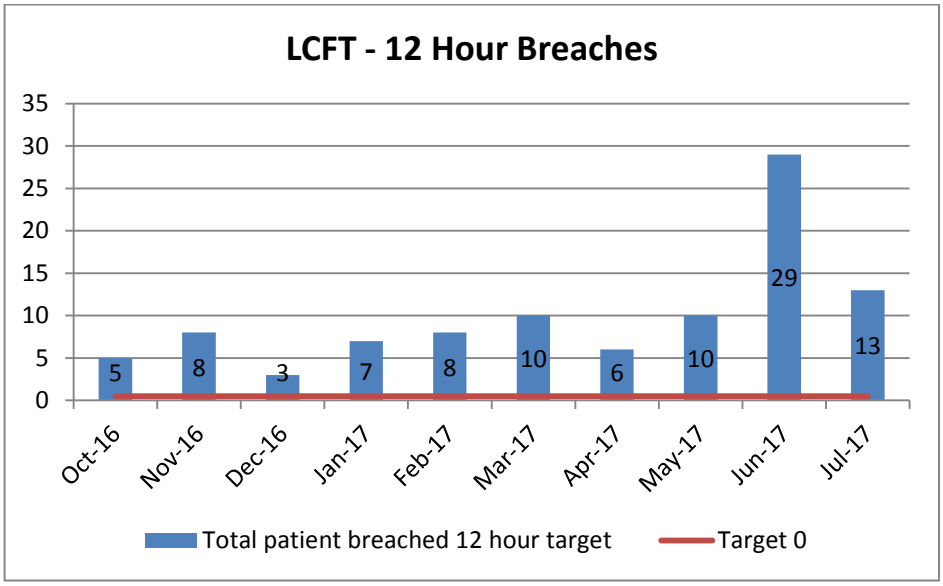
Paul Hopley – Deputy SRO, Mental Health

Appendix 1:

The below graphs demonstrate recent compliance with the target for Mental Health patients to be seen within 1 hour as well as the recent 4 and 12 hour breaches within A&E:







This data will be monitored throughout the timeframe of the schemes to evidence the reductions that the schemes will realise.

The table below outlines the information that will be captured to demonstrate the blocked cubicle hours, by Mental Health breaches in A&E departments. Royal Lancaster Infirmary and Furness General Hospital in Morecambe Bay has already completed this collection to provide an early indication of the potential benefits across the whole system covering the period from April to June 2017.

The other A&E departments across the STP footprint will start to collect this data from 1st October.

Hospital Trust	Total MH 4 hour Breaches	Total MH 12 hour Breaches (of the 4 hour breaches)	Total Cubical Hours Occupied by MH Breach Patients (calculated)	Total Number of Available Cubical hours for Majors (calculated)	% of Cubical hours used by MH Breach patients (Calculated)	Excess hours that could have been used for non-MH pts	How many non-MH pts could have been seen in the excess hours	How many non-MH pts could have been seen if none of the MH pts attended ED in that time
Royal Lancaster	150pts	13pts	1,772 hrs	19,440 hrs	9.1%	1,172 hrs	293pts to 586pts	443pts to 886pts
Furness General	42pts	1pt	320 hrs	15,552 hrs	2.1%	152 hrs	38pts to 76pts	80pts to 160pts

The Pennine Lancashire MH Triage Pilot that ran for 3 months this year. One of the outcomes of this pilot was that it reduced MH patients into the department by 33%. Of those who were admitted into the department the MH cubicle time reduced by 1.5 hours on average. Therefore, if applied to Royal Lancaster the patients admitted would have reduced to 109 from 163 and of those 109 admitted a total of 163 hours on total cubicle time would have been realised.

LCFT are in the process of developing a system, currently in use elsewhere in the organisation, to monitor key information. This will enhance our reports to be provided to monitor the realisation of the required outcomes. Monthly monitoring of the required outcomes would provide assurance of achievement of trajectory.

Previous experience of investing in triage has resulted in a reduction of around 33% in referrals to mental health teams within a month. Rapid assessment via MHLTs is anticipated to reduce Crisis Resolution and Home Treatment Team workloads freeing up time for them to focus on admissions.

Appendix 2:

These schemes will support improvement in the 4 hour target as we anticipate rapid triage and deflection from A&E departments. Other elements of the pathway are in progress for development however the schemes within this request will impact highest on performance but require to be commissioned to achieve sustainability. We will see a reduction in blocked cubicle hours which will have a material impact on the Acute Trusts ability to maintain flow through the A&E department, thus supporting their delivery of the A&E target.

The support to move patients in to an appropriate area will give an improvement in the 12 hour breach figures will be realised through these schemes as increased deflection will allow for a reduction in the demands on the Mental Health Liaison Teams. This will enable a wider change for the current Crisis Support Unit provision, over a phased period transferring them into a clinical decision unit to develop for the management of patients awaiting a Mental Health Inpatient bed.

Mental Health triage and 24 hour liaison service will provide a reduction in the waiting time for Mental Health assessments; in turn this improves patient flow by ensuring the patient is receiving the right care in the right place at the right time, which will result in overall improved patient experience. The service will support the delivery of the benefits described in our STP, including the aim to slow down demand and unnecessary activity in the Acute Trusts.

Scheme	Sites	Benefit	Start Date	In-year Cost
Mental Health Access Line	• NWAS Broughton	Diversion of Mental Health 999 and 111 calls away from A&E. Reducing demand on NWAS as well as A&E departments. Potential savings 50% deflection of 111 calls (3900/year) = £177,450 (A&E tariff) 33% deflection of 999 calls (5792/year) = £175,691 (A&E Tariff) Total potential saving £353,141 A deflection of patients away from Mental Health Crisis teams of circa 33%, which will also have a direct impact on onwards presentation in to acute services and requirement	1st December 2017	£220,411

		for admission to a Mental Health inpatient unit		
24/7 Mental Health Liaison Service	• Furness General Hospital	Increasing liaison services in North Cumbria will ensure the experience for service users and carers will improve with timely assessments and interventions and will support the wider AE bed flow system.	1st December 2017	£83,000 There is a recurrent risk in this area that will be mitigated by local redesign work
UEC programme support	• NHS England	This will allow consistent NHS England support until end of October 2018	1st November 2017	£64,500

Total in year UEC funding for 2017/18 <u>£367,911</u>

Scheme	Sites	Benefit	Start Date	In-year Cost
A&E Mental Health Triage	• Royal Blackburn Hospital • Blackpool Victoria Hospital • Royal Lancaster Infirmary • Royal Preston Hospital	Early identification and diversion of non-mental health presentations to reduce demand/ increase responsiveness of Mental Health Liaison Teams. Use of the FROM-LP framework will ensure that the diagnostic coding of mental health in the acute hospital will improve. NHS Standard Contract CQUIN schemes will facilitate improvement in this area and include a 20% reduction in the frequent attenders.	1st December 2017	£224,214
Medical cover (Psychiatrist) in A&E and wider acute system	• Royal Blackburn Hospital • Blackpool Victoria Hospital • Royal Lancaster Infirmary • Royal Preston Hospital	Improved clinical leadership and decision making with A&E. Reduced waiting times. In turn reducing 4 hour breaches and facilitating discharges.	1st December 2017	£355,326
Older Adult Liaison	• Royal Blackburn	To allow service transition into CORE 24.		£205,000 (Pennine

(RAID) Transition	Hospital			Lancashire)

Total in year Core24 funding for 2017/18 £784,540

This is 2018/19 drawn down and therefore will need to be sourced within existing resources next year.

Joint Committee of Clinical Commissioning Group's

Title of Paper	Briefing for the Joint Committee of CCGs on STP capital issues		
Date of Meeting	2nd November 2017	**Agenda Item**	10

Lead Author	Gary Raphael
Purpose of the Report	For information
Executive Summary	This report is to apprise the JCCCGs of the process being undertaken across the STP to develop and submit an estates and capital strategy by the end of November 2017. The production of an estates strategy is essential, as without it, the STP will not be able to receive any NHS capital funding for its priority schemes, including those already supported in waves 1 and 2 of the recent, national capital transformation funding process (£325m was made available nationally). As part of waves 1 and 2, we have prioritised the following: • LCFT scheme for in-patient services at Chorley Hospital and consequential work to free up space at Burnley hospital • ED developments at RBH • Pathology collaboration scheme across Lancashire and South Cumbria We have also submitted a draft capital pipeline for urgent and emergency care to NHSE and NHSI. In considering capital bids from STP's, NHSE/I require certain criteria to be met. All schemes must: • Complete an NHSE/I business case process • Submit value for money calculations, which is used to scrutinise the business case documentation In addition to this, STP's must submit supporting estates strategies by late November 2017, which supports the bids. It is essential that the STP develops a robust estates strategy relatively quickly to support this process. The STP is holding a Lancashire and South Cumbria Estates Workshop on 3rd November 2017, for all organisations across the patch to gain an understanding of the national requirements and scope an estates strategy to be completed by late November 2017.
Recommendations	The Committee is asked to **support** this report.

Equality Impact & Risk Assessment Completed	Not Applicable
Patient and Public Engagement Completed	Not Applicable
Financial Implications	Yes
Risk Identified	No
If Yes : Describe risk	Not Applicable
Report Authorised by:	Amanda Doyle

Introduction

1. This report is to apprise the JCCCGs of the process being undertaken across the STP to develop and submit an estates and capital strategy by the end of November 2017. The production of an estates strategy is essential, as without it the STP will not be able to receive any NHS capital funding for its priority schemes, including those already supported in waves 1 and 2 of the recent, national capital transformation funding process (£325m was made available nationally).

Background

2. Earlier this year, NHSE/I advised the health service that £325m transformation fund capital was to be made available nationally to support capital schemes prioritised by STPs. The so called wave 1 tranche of schemes was limited to a smaller number of STPs (including Lancashire and South Cumbria), which were assessed as being more 'advanced' than other areas. The main criteria allowing schemes to be supported by NHSE/I were that they supported the priorities of the STP and that they were able to be implemented immediately, ideally the business cases having already been approved.

3. Nationally, STPs and organisational partners did not have sufficient time to be able to develop their bids, but the short timescales were justified by NHSE/I on the basis that if schemes were already at business case stage, it should have been possible to have submitted them quickly. On this basis, Directors and Finance from NHS Trusts and Chief Finance Officers from CCGs worked collectively with STP colleagues, to ensure that Lancashire and South Cumbria was able to articulate its priorities in line with the criteria.

4. The submission made in May 2017 identified two main schemes that NHSE insisted had to be submitted as four separate bids:
   - Completion of the mental health in-patient strategy - enabling facilities at Chorley hospital to be adapted to host in-patient services and changes at Burnley hospital to free up space for alternative uses
   - Development of a standard primary care streaming offer across Lancashire and South Cumbria for A&E services, coupled with a new IT system to allow NHS 111, NWAS, A&E and out of hours services, to be able to access patients' records in real time and enable them to be deflected from A&E attendance to an alternative (more appropriate) service, based on the care plan records of patients

5. Two of our Trusts in Lancashire and South Cumbria had already been successful in obtaining some funding for A&E primary care patient streaming from another pot of NHSE funding (although Morecambe Bay was subject to constraints associated with the Capped Expenditure Process), but East Lancashire and Blackpool Teaching Hospitals Trusts had not been successful and indicated their desire to access capital through the £325m capital pot – this was in line with STP priorities for urgent care services and was thus supported.

6. However, NHSE decided that the primary care streaming scheme was to be treated as four separate bids and subsequently advised the STP office that no IT schemes were going to be supported through the £325m transformation pot. We were also advised that Blackpool Teaching

Hospitals Trusts bid for primary care streaming funding would not be supported from the transformation fund pot. Blackpool Teaching Hospitals Trust was urged to reapply to access the Primary Care Streaming national capital pot and were successful the second time round. At that point there were only two schemes left for Lancashire and South Cumbria, the mental health scheme and the East Lancashire Emergency Department scheme.

7. These two were subsequently confirmed as successful, including East Lancashire Trust's inclusion of provision for developments within the emergency department at RBH behind the primary care streaming unit.

8. Around the same time as we were notified of the two successful bids for Lancashire and South Cumbria, all STPs were invited to submit bids for a wave 2 of capital transformation funding. The criteria for this tranche were tightened to include a need for all bids to achieve a positive return on investment (RoI), meaning that revenue cost savings greater than the capital applied on any scheme had to be generated over the life of the scheme. This requirement focused submissions on transforming services and generating revenue savings rather than replacing or developing obsolete or worn-out premises and assets, even if there were operational risks associated with the latter. It should be noted that it is also very difficult to achieve a positive RoI on IT schemes.

9. Based on the new criteria, the Lancashire and South Cumbria STP was able to identify the Pathology collaboration scheme of circa £31m for submission in wave 2.

The status of schemes supported by NHSE/I in waves 1 and 2

10. Although the STP has three schemes with an indication of support by NHSE/I within waves 1 and 2 of the national capital transformation funding programme, there are still a number of hurdles that have to be passed before NHS capital funding is actually allocated. Firstly, all schemes must complete an NHSE/I business case process. As part of the waves 1 and 2 submission process, all schemes had to submit nationally prescribed value for money (VFM) templates and this will be used to scrutinise existing business case documentation. Second, STPs must submit estates strategies by late November 2017, within which waves 1 and 2 schemes must be justified and prioritised. The quality of those plans could influence NHSE/I's view on the wave 1 and 2 submissions. In short, if the STP does not have an acceptable estates strategy, no organisation within the STP will receive NHS capital funds.

STP responses to the national bidding process

11. It appears that some STPs did not prioritise bids for capital in line with the criteria required by NHSE/I and therefore the size of their bids far exceeded their potential share of the national resources that are likely to be available. Just for the North of England the wave 2 bids totalled £882m. It is not yet clear what capital funds will be available for wave 2 schemes.

12. The Pathology Collaborative Team in Lancashire and South Cumbria also assisted the North Region to refine the process for the assessment of scheme bids and as part of that process, gained insights on the relative rank of a number of the best documented schemes. The Lancashire and South Cumbria pathology scheme ranked highly in the North Region's process, but other schemes did not meet the criteria, despite prioritisation within their STPs.

Perceived risks

13. Despite Lancashire and South Cumbria STP's compliance with national bidding criteria, we observed that some other STPs may not have done the same and we did not want to find that we had been disadvantaged. In order to demonstrate that we had a view on some of our key priorities (in the acute sector) and furthermore to signal to NHSE/I that there were some other key priorities that did not conform to NHSE/I criteria, such as the Lancashire Teaching Hospital critical care scheme, we decided to develop a capital pipeline for acute services. This draft pipeline document was submitted to NHSE/I on 15th September, in the same week that wave 2 submissions were being finalised nationally.

Next steps

14. Having developed this pipeline in short time, as an STP, we decided that we should take a similar approach to an estates strategy, which was timely as it has subsequently become clear that without an estates strategy, no NHS capital will be allocated to organisations within STPs. On 3rd November, the STP will be convening a workshop for all L&SC organisations to gain an understanding of the national requirements and scope an estates strategy to be completed by late November 2017. Appendix 1 is a copy of an email that was sent to Finance and Estates Directors on 22nd September, which describes the broad approach that would enable the STP to develop and submit an estates strategy by the end of November (this is an ambitious timescale).

15. The speed at which STPs are being asked to deliver important and substantial pieces of work, indeed things that have never before been achieved, is challenging us as an STP. Significantly, it is proving difficult to ensure that such submissions are moved through our collective governance processes within the short timescales that are available. Much of the work is of a financial nature and therefore Directors of Finance and Chief Finance Officers are involved in the work through the Finance and Investment Group.

16. The STP is also using the JCCCGs to report key elements of our work and this, ultimately, is the purpose of this report – to apprise the JCCCGs of the process we are adopting to develop the capital aspects of our collective plans. This report will also be sent to Trusts and Local Authorities for their information and to alert them to the work being undertaken on a wider estates strategy.

Recommendation

17. The Joint Committee of CCGs is asked to **support** the contents of this report.

Gary Raphael
STP Finance Lead

Appendix 1

Textual content of an email to Finance and Estates Directors on 22nd September 2017

Dear colleagues

You will be aware that last week the Lancashire and South Cumbria partners submitted a document to NHSE/I describing our estates pipeline for urgent and emergency care within the acute sector. We developed this outline pipeline very quickly in order to place Lancashire and South Cumbria in a stronger tactical position regionally and while completing it I think a consensus emerged that we must continue this work.

I want to propose that we build on this success to develop a more comprehensive estates strategy for Lancashire and South Cumbria. This is something we have been discussing for some time, but done little about so far.

What we are currently lacking is a top down perspective, nevertheless I think we have enough knowledge to develop an approach to a strategic plan that takes account of what we already know about our estate and anticipates a number of scenarios based on the developing aims of the STP and national policy.

For example, we know that there is an imperative to reduce the space occupied by administrative staff in clinical premises, so we ought to be developing plans to facilitate that change. Also, we are looking to develop integrated services outside of hospital. Etc.

I know that the acute workstream has not yet delivered a view about future configurations of services and neither has the primary care workstream, but there are other things that we know about, including the current plans of each organisation. Therefore I am proposing that we should be able at least to set the foundations for any subsequent strategy that could incorporate the outputs from the acute workstream and in the meantime gives an indication of potential scenarios. Also, we could examine the prospects for obtaining capital from non NHS sources, including via the local authority sector.

I have put Alistair Rose on alert, pending your responses to this proposal, to liaise with our strategic advisers from NHSPS and CHP in order to arrange a series of workshops to enable us to articulate our views about an estates strategy and develop its overall shape. This could provide the template for our technical estates and finance colleagues to be able to complete the necessary scenario descriptions in future iterations of our plans.

I am requesting the commitment of finance director and estates colleagues from each trust/CCG within LDPs to jointly develop a strategic estates plan for Lancashire and South Cumbria and this will also require making the necessary staff available over the next six to eight weeks. It will also require your attendance at two or three events, the first of which would be a scoping session to confirm our approach to the work.

I am certain that this is a challenging timescale, but I don't think we could do a much better job if we give ourselves more time. Undertaking this work quickly would also enable us to meet some national deadlines for an estates submission in November.

I have asked Alistair Rose to liaise with estates directors to apprise them of this proposal and will await responses before raising this with local authority colleagues.

Please can you confirm your support for the development of an estates strategy that starts now and attendance at an initial scoping session in the near future. If there is a better way of dealing with the requirement to develop an estates strategy across the STP I think we could examine that at the scoping session, but if a consensus on an alternative already exists, please can you let me know.

In any event, please can you let me have your views.

Thanks
Gary