Healthier Lancashire & South Cumbria

Formal Joint Committee of CCGs –Part I agenda
Thursday 05 November 2020 13:00-14:30 - MS Teams Teleconference
Agenda

Item	Description	Owner	Action	Format
Routine Items of Business				
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Minutes of Previous Meeting and Actions	Chair	Approve	Attached
3.	Declarations of Interest	Chair	Note	Verbal
4.	Key Messages including introduction to David Flory, ICS Independent Chair	Dr Amanda Doyle	Note	Verbal
Sustainability				
5.	CAMHS Redesign - Checkpoint 7 report	Hilary Fordham	Approve	Attached
6.	Managing phase 3 and wave 2	Carl Ashworth/Gary Raphael	Note	Verbal
7.	L&SC Medicines Management – Ratification of Guidance	Brent Horrell	Approve	Attached
8.	COVID - Temporary Service Changes	Emily Kruger	Note	Attached
9.	JCCCGs Work Programme Update	Andrew Bennett	Approve	Attached
Building the Future System				
10.	Report from the Commissioning Reform Group	Andrew Bennett	Discuss	Attached
11.	Consolidated Performance and Quality Report	Linda Riley/Helen Curtis/Kathryn Lord	Approve	Attached
For Information				
12.	Minutes from the Commissioning Reform Group • 8 September 2020	Andrew Bennett	Note	Attached
Any Other Business				
13.	Any Other Business	Chair	Note	Verbal

Date and Time of the Next Joint Committee:
Thursday 03 December 2020, 13:00-15:00, MS Teams

Draft – Subject to ratification at the next meeting

Minutes of a Formal Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs) Held on Thursday, 3 September 2020 via Microsoft Teams Videoconference

Part I

Present		
Roy Fisher	Vice Chair (Chaired the meeting) Chair	Joint Committee of CCGs Blackpool CCG
Kevin Toole	Lay Member	Fylde and Wyre CCG
David Bonson	Chief Operating Officer	Blackpool CCG/Fylde and Wyre CCG
Graham Burgess	Lay Chair	Blackburn and Darwen CCG
Denis Gizzi	Chief Officer	Chorley and South Ribble CCG/ Greater Preston CCG
Dr Sumantra Mukerji	Clinical Chair	Greater Preston CCG
Debbie Corcoran	Lay Member	Greater Preston CCG
Geoff O'Donoghue	Lay Member	Chorley and South Ribble CCG
Dr Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG
Hilary Fordham	Chief Operating Officer	Morecambe Bay CCG
Dr Richard Robinson	Chair	East Lancashire CCG
Julie Higgins	Chief Officer	East Lancashire CCG
Paul Kingan	Chief Finance Officer	West Lancashire CCG
Doug Soper	Lay Member	West Lancashire CCG
In Attendance		
Jane Cass	Locality Director	NHS England and Improvement
Elaine Collier on behalf of Gary Raphael	Head of Finance	Lancashire and South Cumbria ICS
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Sue Stevenson	Chief Operating Officer	Healthwatch Cumbria/Lancashire
Lawrence Conway	Chief Executive	South Lakeland District Council
Sarah Callaghan	Director of Education	Lancashire County Council
Dr Amanda Doyle (from Item 11)	Chief Officer	Lancashire and South Cumbria ICS
Dr Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Andrew Bennett	Executive Lead Commissioning	Lancashire and South Cumbria ICS
Carl Ashworth (left during Item 7)	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Peter Tinson (arrived during Item 7/left after Item 8)	Director of Collaborative Commissioning	Lancashire and South Cumbria ICS
Emily Kruger-Collier	Head of Programme Management Office	Lancashire and South Cumbria ICS
Rebecca Higgs	Business Support to Dr A Doyle	Lancashire and South Cumbria ICS
Louise Talbot	Secretary to the Governing Body	Blackpool CCG Minutes taken on behalf of the Lancashire and South Cumbria ICS

Routine Items of Business	
1.	**Welcome, Introductions and Apologies** **Welcome and Introductions -** The Committee Vice Chair, Roy Fisher (Chaired the meeting) welcomed members to the meeting of the Joint Committee of CCGs (JCCCGs) held virtually via Microsoft Teams videoconference. Andrew Bennett explained that there was a requirement for the meeting to be held with a formal status, therefore, it was a public meeting and the papers had been published on the website. There was an opportunity for members of the public to ask questions via the website however, Andrew advised that as mid-morning, no questions had been received. Should any questions be received, an individual response would be provided. **Apologies for Absence –** Apologies had been received from Gary Raphael, Dr Adam Janjua, Katherine Fairclough, Jerry Hawker, Louise Taylor, Dr Lindsey Dickinson, Neil Jack and Jackie Hanson. Members were advised that Dr Doyle was taking part in a national call and would join the meeting later.

2.	**Minutes of the Previous Meeting Held on 2 July 2020, Matters Arising and Actions** **Minutes -** Richard Robinson had been omitted from the previous minutes and Andrew Bennett had sent apologies which had been omitted. The Secretary would amend the minutes accordingly. **ACTION: LJT (√)** **RESOLVED: That subject to the amendment to be made, the minutes of the meeting held on 2 July 2020 be approved as a correct record.** **Matters Arising -** The matters arising log was reviewed and members noted the actions that had been completed. Other matters arising that had a completion date of 3 September 2020 continued to be in progress and would be reviewed at the next meeting. The Secretary would update the log accordingly. **ACTION: LJT (√)** Andrew Bennett reminded members that a standard item relating to the cell logs of decision-making was now included on both the ICS Board and the JCCCGs agendas in order that members were aware of the decisions taken by the cells. Elaine Collier referred to the item on the log relating to a report that was due to be submitted to the committee detailing allocations for the next financial year. Guidance on financial envelopes was still awaited however, once received, a report would be submitted to a future meeting of the committee. Elaine advised that there was likely to be a potential reset of allocations for 2021/22 with a pace of change, but guidance was still awaited. Doug Soper sought a progress update on the capital allocations discussed at the previous meeting. Elaine advised that allocations for capital for the current year have been set and that FIG had discussed setting up a group across Lancashire and South Cumbria to review how it could evidence/lobby for Lancashire having more of a fair share. Members were reminded that £215m capital allocations were made available during 2020/21 and some schemes were being progressed. Roy Fisher asked if accrual was allowed for capital schemes and Elaine advised that it is only for work in progress and with evidence to state that the work has been completed. Elaine further advised that that they would look to broker the capital in Lancashire and South Cumbria and a piece of work will be undertaken on month six however, if the funding isn't used, they would look to broker it across the North West for it to be returned in 2021/22.
3.	**Declarations of Interests** **RESOLVED: That all members of the Joint Committee of CCGs employed by a CCG declare a collective financial interest in respect of the item relating to commissioning reform. The Chair acknowledged that the committee discussion to be held would be to receive an update on current work and endorse the next stage.**
4.	**Key Messages** **Phase 3 Letter -** Andrew Bennett advised that the since the meeting held on 2 July 2020, the imminent publication of the phase 3 letter was expected. The letter was published on 31 July 2020 and the month of August was used as a planning month to address the requirements within the letter. Andrew further advised that the phase 3 letter, therefore, framed a number of areas to be discussed later in the meeting. **RESOLVED: That the Joint Committee of CCGs note the key message.**

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Sustainability	

5.	**COVID-19 Updates**
	(a) Phase 3 Planning Update – Carl Ashworth presented a summary in respect of the phase 3 recovery and the planning and expectations from August 2020 through to March 2021. He highlighted the following:
	• ICS submitted portfolio of draft plans on 1 September 2020:
	  • System activity, performance and workforce plan template
	  • Cancer service plan
	  • Mental health service plan
	  • Winter plan – system flow assessment
	• In addition, an explanatory narrative was submitted to provide an explanation of the key elements of the delivery plans that drive the patient activity and performance figures; to set out how key services will be restored inclusively to help address health inequalities; and outline key challenges, risks and mitigating actions for a group of high priority service areas. Carl advised that a copy of the narrative had been shared with the ICS Board and a summary of the key aspects of the submitted activity and performance plans were included within the report.
	• In respect of the timescales of the development of phase 3 plans, Carl advised that at the time of the submission of the draft templates, further work was required to test and finalise the ICS approach to safely restoring services whilst planning to meet the demands of winter and a potential surge in demand arising from COVID-19 infections. He informed members, therefore, that on that basis the plans were considered to be 70% complete at the time of submission to the regional team on 1 September 2020 and subsequent presentation to the ICS Board the previous day.
	• The report detailed what has been taken account of within the plans so far and what remained to be completed.
	• Work would continue to be undertaken on further iterations of the plans, taking into account regional and national feedback up to the point where final drafts would be shared with ICS system leaders for sign off on 16 September 2020 prior to submission to the regional team on 21 September 2020.
	• Reference was made to the 'Table of what's in/what's not' and of particular note, taking into account 111First and the impact on A&E.
	• Carl explained that in parallel to the work on the phase 3 templates, UEC colleagues were also developing winter plans that would take account of various escalation scenarios.
	• Carl advised that for the 1 September 2020 submission, in line with national and regional guidance, the ICS team worked with providers to ensure that the base case was reflected in the activity templates. There was accompanying narrative that identified the broad measures that will have to be taken as a system in order to maintain the activity estimates made in the base case. Yet to be undertaken were detailed assessments of the measures to ensure continued patient safety, and maintenance of elective services under the scenarios described above. This would be included in the final submissions to the regional team.
	• Information was provided which modelled the impact of the acute bed numbers under the base case and the more likely second wave scenario.
	• As part of the portfolio of the phase 3 plans, the ICS was asked to complete bespoke mental health planning templates that seek to provide assurance that the planned spend both meets the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) investment expectations. Carl explained that initial analysis showed that planned investment met the MHIS expectation but did not meet the LTP expectations and consequently the mental health planning submission would fail. It had been agreed that the planning submission would be amended to reflect the delivery of all the LTP expectations which equated to additional investment of

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£5.7m (recognising that the implementation of the NTW recommendations has resulted in an investment above LTP expectations in some areas, eg crisis pathway). The additional investment would be the priority for the system resource as we move into the financial regime for the second half of the year.

- In respect of out of hospital service plans, the challenges, risks and mitigating actions being planned to ensure that all expectations could be met had been included in the plan however, at present the impact upon project activity and performance had not been included in the plans.
- With regard to the financial implications, Carl explained that the ICS approach to finance at the current time is to assume no financial constraints for the measures providers can take for achievable options to meet NHS objectives (other than achieving best value for money). He further advised that this approach enables the system to understand the real financial impact of meeting the required targets. Achievable options (constrained by availability of staff) may still not be sufficient to meet all national requirements and understanding the cost of schemes will enable them to be prioritised. Members were informed that once the system has received its financial envelope, a re-assessment of our ability can be undertaken to meet our targets in the event that we are unable to proceed with lower priority schemes for financial reasons. The report provided examples of the costs of schemes that are not already included in block payments.
- A system workshop would be held the following week to bring together hospital and out of hospital perspectives to focus on closing the gap.

Carl drew members' attention to the summary of key points within the report:

- Recovery plans are at an early stage and need further refinement before submission of final plans in September.
- Restoration of elective work is constricted by available capacity such that, even for the base case scenario, 52 week waits will increase significantly by year end, although potential impact of use of IS has yet to befully reflected in plans.
- Impact of digital and other system efficiency improvements have not been fully reflected in plans as yet.
- Full impact of winter and other OOH schemes has yet to be reflected, although recovery expectations on OOH services are already significant and some of the winter schemes come at a cost yet to be secured.
- Base case model predicts shortfall of over 700 beds if all last year's activity returns – with a second wave of COVID, this would rise to over 1,000 beds, requiring significant step up in alternative approaches to demand management out of hospital.
- There is lack of clarity on the financial envelope – some £84m of schemes have been identified to cope with a further wave of COVID demand over the winter period.
- Impact of social distancing and IPC requirements plus redeployment of staff deemed high risk, willreduce staffing capacity by between 15%- 20%. Given this impact, and current level of vacancies and current/projected sickness absence, it is unlikely that we will have sufficient workforce of support the full restoration of service as per the Phase 3 Planning guidance.

Discussion ensued as follows:

Doug Soper made reference to the restoration of elective activity and sought clarification as to whether there were problems with one or two hospitals or whether there was a consistent inability to achieve the targets that the Department has set. Carl advised that this is a common challenge across all hospitals however, the scale varies between providers. He further explained that there is a reduction in theatre capacity in all Trusts and with the impact of infection control procedures, there isn't a confidence to start and put in place significant levels of activity.

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Carl advised that further consideration is being given to using Burnley, Chorley and Kendal hospitals more extensively as selective sites and also the potential utilisation of the independent sector. He anticipated further clarification on this position over the coming weeks.

Debbie Corcoran asked if there was a parallel communications strategy planned or in development so that patients understand the impact and access. Neil Greaves advised that this was currently being worked on collectively with colleagues across the region and is discussed at weekly calls with communication and engagement colleagues.

Dr Geoff Jolliffe provided two views regarding the escalating 52 week waits. Firstly as a commissioner, it is important that there is a plan to reduce and manage this as it is not acceptable for the public, although understandable. Secondly, from a clinician point of view, it seemed impossible to him under present circumstances to increase activity sufficiently unless it can be undertaken via demand management.

Lawrence Conway sought clarification as to where the district councils fit into the system. He was advised that district councils are actively engaged in each of the ICPs. Individual districts councils are also linked to the PCNs locally.

Kevin Toole asked if the Nightingale hospitals were referenced/included in the plans and Carl advised that they were working on the basis that that capacity was still available and still an opportunity. There still needed to be an awareness of this along with the opportunities for mutual aid across providers before potentially moving patients outside of the area. His understanding was that capacity will still be there until the end of the winter period.

David Bonson informed members that as part of the submission, a separate but related return was required as each A&E Delivery Board was required to complete and submit a local assurance template which would then be incorporated into a bigger template. He commented that there was an opportunity for sign off at the SLE meeting on 16 September 2020 as part of the whole planning return at that meeting.

Richard Robinson sought clarification as to who SLE is and how they link back to the process and to the governing bodies. Carl explained that the SLE is made up of Chief Executives of all Trusts, Accountable Officers of CCGs and Chief Executives of upper tier local authorities along with the ICS Executives.

The Chair stressed the importance that once the plans have been signed off by the SLE that the JCCCGs should have sight of them on a confidential basis. Carl advised that this was the intention and had been included in the recommendation to the committee. A final report would be submitted to the next meeting. Andrew Bennett further advised that the conversations with regional colleagues will continue to take place so it would be part of the next committee meeting agenda. **ACTION: CA/AB**

Graham Burgess commented that whilst he was comfortable to accept the special circumstances and that the decision on this occasion was being made outside of the usual governance processes, he stressed the importance of acknowledging that this was an exception rather than the rule. He went on to say that whilst he accepted the timescales and urgency and the type of decisions to be made whether the SLE was the appropriate way to make decision on bigger issues. It should not become common practice particularly in respect of items later in the agenda. Members concurred with the comments made.

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RESOLVED: That the Joint Committee of CCGs:

- **Note the key points raised and the draft status of the 1 September 2020 submission of the phase 3 plans.**
- **Support the proposal that the SLE meeting on 16 September 2020 is the point of system sign off of final plans.**
- **Receive a final report on the phase 3 plans at the October meeting of the JCCCGs.**

(b) Temporary Service Change – Emily Kruger-Collier gave a presentation on the assurance processes around temporary service changes across the system during the COVID-19 pandemic. She advised that at the beginning of the pandemic there was a need to respond and make critical and prompt decisions regarding temporary service changes as recognised by NHSE/I. Early decisions were made across NHS organisations in line with the guidance and legislation they are governed by.

Emily further explained that as the pandemic and the NHS level 4 status was sustained for a five month period, and now continues at level 3, the need and likelihood of additional, or existing temporary changes continuing, remains high. This has brought about the need for an assurance process to be established. Fortnightly submissions, and impact assessments are required by NHSE/I of the significant changes and is co-ordinated across organisations within Lancashire and South Cumbria. These are managed through the Hospital and Out of Hospital Cells as part of their command and control role to maintain oversight and assurance.

Members were advised that due to the complexity and rigorous processes that would normally be applied to such service changes, legal advice was sought.

Assurance processes to protect organisations, and those impacted, have been developed to align with the guidance and requirements for significant temporary service changes.

Emily highlighted the significant service changes currently in scope for the Lancashire and South Cumbria-wide assurance. She advised that some services had been removed from the list as they had been restored. Emily confirmed that this is in addition to any local assurance processes in place.

Emily explained the proposed decisions, review and assessment process in respect of managing requests and reviewing temporary service changes and took members through the process flow. She also highlighted the assurance process which was adjoined to the review and assessment.

In respect of ICP lead roles and responsibilities, SLE members have identified leads from their respective ICP areas to support the assurance processes. They are the lead contact and oversee and co-ordinate temporary service change processes for the ICP area. They act as the gatekeeper for existing and any future proposed temporary service changes. They also support the development of temporary service change requests, and associated impact assessments for services and organisations across their respective area. The lead also contributes to Lancashire and South Cumbria-wide developments and reviews regarding temporary service changes.

With regard to permanent service changes, Emily explained that this is not within scope of this work and that there is an expectation from NHSE/I that **all** temporary service changes are to be restored. For any permanent service changes, the NHSE/I assurance process must be followed, as set out in the 'Planning, assuring, delivering service change' guidance. Members were advised that there is already a process in

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	place through the ICS decision-making framework which would apply to any permanent service changes and incorporates the requirements of NHSE/I. Emily drew members' attention to the next steps and advised that: • Quarterly impact assessments of significant temporary service changes were being undertaken for completion by 1 September 2020. • The development of a mini Standard Operating Procedure (SOP) with the identified ICP representatives to reflect the central and local assurance and monitoring processes. • The next update to the JCCCGs was scheduled for the November meeting as part of the assurance process**.** **ACTION: EK-C** Geoff O'Donoghue made reference to the closure of Chorley and South Ribble Hospital A&E Critical Care within the list presented and sought clarification on Emily's involvement in that particular process. Emily explained that in respect of individual service changes, discussions are held with CCGs, providers and NHSE/I colleagues and the information captured throughout the temporary service change. Jane Cass explained that there is a clear and robust process that the ICS follows and assured members that quarterly impact assessments are undertaken for the services listed. Dr Sumantra Mukerji made reference to the patient impact assessment form and outcomes and sought clarification as to what steps had been taken in terms of patient impact. Emily advised that public and patient impact is a significant part of the impact assessment, they are reviewed by the cells and any queries or further messages to be put in place are fed back to the providers as part of the assurance role, including patient impact. She further explained that it is the provider responsibility to undertake the patient impact assessment and put in place the necessary provisions or mitigations prior to the service change being initiated. **RESOLVED: That members of the committee note the report.**

6.	**Finance Report** Elaine Collier spoke to a circulated report which reported on the month 4 financial performance for the L&SC system in the context of the current finance regime and the response to COVID-19. She advised that the report had been written for the ICS Board and included updates on capital, ICS central functions and the scheme of delegation, which were not relevant but may be of interest to the JCCCGs. The Chair asked that in order to avoid confusion in the future, that any recommendations within a report for another meeting should be removed and only those pertinent to the relevant meeting should be included. This was noted. As at month 4 organisations continued to claim top up payments to ensure they could report a monthly breakeven position. The report included a summary which showed that CCGs had claimed £68.3m at the end of July to top up their allocations for cost pressures incurred, including £34.6m of COVID-19 related costs. Trusts claimed £90m over and above their block payments and planned top up levels, for cost pressures incurred and income shortfalls including £72.7m of COVID-19 related costs. Elaine explained that the new finance guidance and financial envelope for the second half of the year was awaited however, it was anticipated that it would be received during September. She advised members that notification of a new elective incentive process had been received which took effect from 1 September 2020. In order to help accelerate the return to near-normal levels of non-COVID-19 health services and to

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	make full use of the capacity available between now and winter, notification has also been received stating that with effect from September, block payments will flex to reflect expected elective activity levels. It was deemed that the resources provided through the nationally determined finance arrangements were sufficient to fund performance levels of 80% elective procedures in September, rising to 90% in October; and 100% of last year's outpatient attendances from September to March. However, the financial impact of this on the L&SC system had still to be worked through and would need to be reflected in future plans and financial forecasts. Doug Soper made reference to the 25% reduction in the block payments given on activity which could incur a financial problem. Elaine advised that this was likely to be the case however, further information was needed to calculate the impact. Paul Kingan made reference to the delegations section of the report and whilst it was not a decision for the JCCCGs, he sought clarification about whether this would apply to decisions made about allocating the financial envelope that the ICS will receive for the second half of the year. Elaine explained that this section related to the ICS central functions budgets only. **RESOLVED: That the Joint Committee of CCGs note the report.**

7.	**SEND – Post Inspection Report (Lancashire)**
	Julie Higgins reminded members of the committee of the Lancashire SEND inspection revisit which took place on 9-12 March 2020. The OFSTED and CQC inspectors found sufficient progress had been made in seven of the 12 areas however, insufficient progress had been made in five of the 12 areas. The five areas have significant implications for health, and the DfE/NHSE/I are now to oversee an Accelerated Progress Plan that will deliver the required improvements over the next 12 months from 1 October 2020.
	
	Members were advised that although the revisit was conducted in March, the publication of the letter was delayed due to COVID-19, and was published on 5 August 2020.
	
	Hilary Fordham reminded members that Morecambe Bay CCG has a lead role for SEND across the ICS. She was reporting on the Lancashire county inspection report and it was noted that the other three upper tier authorities had previously been inspected. She stressed the importance of this being for the whole of the ICS and not just Lancashire and that there was a learning for everybody within the ICS.
	
	Hilary took members through the presentation and highlighted the following:
	
	• Sufficient progress had been made in the following seven areas:
	  • Strategic leadership and vision across the partnership
	  • Effective engagement with parents and carers
	  • Systems and processes of identification
	  • Quality of education, health and care plans
	  • Strategy to improve outcomes of children and young people with SEND
	  • Proportion of children and young people with EHC plans permanently excluded from school
	  • Inequalities in provision based on location
	
	Carl Ashworth left the meeting. Peter Tinson joined the meeting.
	
	• Insufficient progress made in the following five areas:
	  • Leaders understanding of the local area

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- Weak joint commissioning arrangements that are not well developed or evaluated
- Absence of effective diagnostic pathways for autism spectrum disorders (ASD) across the local area
- Poor transition arrangements in 0-25 healthcare services
- Inaccessible Local Offer, and the quality of information published is poor

Hilary pointed out that the within the report, the inspectors did recognise that significant work had taken place however, there was more to do.

In respect of the CCG commissioning priorities, Hilary made reference to the ongoing strengthening of joint commissioning arrangements and in particular, highlighted to committee members the possible financial impact which may need to be revisited with a view to seeking support from all of the CCGs.

In respect of the ASD pathway, the plan will last for a year and there needs to be a commitment to this.

With regard to the transition arrangements in 0–25 healthcare services, whilst these services are commissioned, it appears to sit with paediatric services and there is often no corresponding service provision for adults. Hilary stressed the importance of ensure there is a process for supporting families through that process.

The other CCG commissioning priority related to health contributions to the Local Offer website.

Linking to the CCG commissioning priorities, Hilary drew members' attention to the health provider priorities.

Hilary took members through the next steps with DfE and NHSE/I in respect of the timelines and governance processes.

- Final report was published on the OFSTED website – 5 August 2020
- Communicated with all partners and media – 5 August 2020
- Submission of Accelerated Progress Plan to DfE and NHSE/I for outstanding action – 30 September 2020
- Establishment of a H&WB sub-committee for local scrutiny
- Monitoring by DfE and NHSE/I for the five areas where insufficient progress has been made – at six and 12 months
- For all other areas of ongoing improvement, a broader improvement plan to be developed, agreed and monitored by the SEND Partnership Board.

Hilary informed members that the JCCCGs was asked to nominate two Non-Executive members to join the sub-committee alongside the LCC Cabinet members for Health and Wellbeing and Children and Young People. It was suggested that they be drawn from the Fylde Coast and Central Lancashire which would give coverage at Governing Body level across the ICS (Pennine Lancashire and Morecambe Bay already being covered by the lead Accountable Officer and Lead Director respectively). Kevin Toole put his name forward on behalf of the Fylde Coast CCGs and the committee Chair, Roy Fisher, was comfortable with the proposal. In respect of Central Lancashire, this would be taken outside of the meeting and fed back to Andrew Bennett who would then inform Hilary accordingly. **ACTION: AB/HF (√)**

Committee members were advised that the SEND partnership will discuss the broader and wider plan at the next meeting to ensure the journey is followed through.

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	Sarah Callaghan highlighted to members that we have as a local area 12 areas of action which is very unusual (typically only around five areas normally). She commented on the level of work that had been undertaken since November 2017 and since the inspection is phenomenal which is the word the inspectors used in their findings. Sarah further explained that although it was disappointing that not all 12 areas had made significant progress, the infrastructure was not in place originally and a tremendous amount of work has taken place to build on the relationships and put processes in place in order to work collaboratively. She finally commented that although there was a way to go, the feedback was that the ambition is there which was clearly evident and also evident from parents and carers. Julie Higgins reinforced both points made commenting that there is a really good leadership and delivery team around this and it has taken time to be built up. There were also extra pressures due to COVID-19 in family situations and it was important to focus on this as it does make a big difference in ensuring the services are right. **RESOLVED: That the Joint Committee of CCGs:** • **Note the positive improvements highlighted by OFSTED and the CQC.** • **Note the position regarding the continuing areas of significant concern where insufficient progress was made.** • **Support the priorities for delivery under the Accelerated Progress Plan for Lancashire, including recognition of the need to implement waiting list recovery plans for ASD across the whole ICS.** • **Note that two Non-Executive members would join the sub-committee of the Health and Wellbeing Board which will undertake the monitoring of the Accelerated Progress Plan. Kevin Toole would represent the Fylde Coast and the representative from Central Lancashire would be advised outside of the meeting.**
8.	**Mental Health Investment Position** Peter Tinson took members through the report relating to phase 3 mental health planning guidance for 2020/21 which was published alongside the *'Third phase of the NHS response to COVID-19'* correspondence received on 31 July 2020. Peter highlighted the key points from the guidance and informed members that there is a requirement to submit a number of bespoke mental health planning templates in accordance with the overarching phase 3 national planning timeline. He explained that the templates seek to provide assurance that the planned spend both meet the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) investment expectations. He commented that whilst Lancashire and South Cumbria CCGs investment meets the MHIS expectation, it does not meet the LTP expectations and consequently the mental health planning submission would fail. Peter drew members' attention to a table within the report which was a comparison of LTP expectations, planned investment and variance. Peter informed members that over the last few weeks, the national mental health and finance leads have been increasingly clear about the MHIS and LTP expectations and the consequences of them not being met, including regulatory interventions. He further explained that the LTP expectations, planned investments and variance should also be considered within the context of an historic underinvestment in mental health services when compared to recognised national benchmarks.

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	Members were informed that the position was recently discussed by a number of Lancashire and South Cumbria ICS executives, CCG mental health lead commissioners and Lancashire and South Cumbria NHS Foundation Trust executives who agreed that the planning submission would be amended to reflect the delivery of all the LTP expectations and a paper prepared for the JCCCGs consideration. Peter explained that it effectively equated to additional investment of £5.7m and CCGs were being asked to support this investment. It was recognised that the implementation of the Urgent Mental Health Pathway recommendations has resulted in an investment above LTP expectations in some areas, eg crisis pathway. Peter informed members that a set of investment principles had been drawn up with CCG mental health lead commissioners and colleagues from Lancashire and South Cumbria NHS Foundation Trust. CCGs were asked to support the principles contained within the report. Paul Kingan made reference to the priorities from allocations for the second half of the year and sought clarification as to whether they would potentially reduce investment in other areas such as cancer services and whether it would be a pass over of money to providers or would CCGs have control as to how the money is to be spent. Peter acknowledged the first point made commenting that it would reduce the overall resource. He explained that the idea behind the principles is to ensure that the investment is effectively targeted across appropriate providers. Peter provided an example of where services could be mobilised very quickly. He further commented that it would be an 'open book' approach as to how the resource is used. Andrew Bennett commented that there is a very strong national leadership of this agenda and a clear expectation that the money does buy extra services for communities with rising demand. **RESOLVED: That the Joint Committee of CCGs:** • **Support the investment of an additional £5.7m to meet these expectations.** • **Support the principle that the investment is the top priority for the system resource as we enter into the financial regime for the second half of the year.** • **CCGs supported the investment principles which will be progressed by CCG lead mental health commissioners with Lancashire and South Cumbria NHS Foundation Trust and other provider colleagues and with CCG Chief Finance Officers' support.** *Peter Tinson left the meeting.*
9.	**JCCCGs' Work Programme Update** Andrew Bennett reminded members that the previous formal meeting of the committee which was held in March was prior to the COVID-19 pandemic. At that meeting, the committee agreed the work programme and had resubmitted it to CCG Governing Bodies. Due to the pandemic and the associated pause, the work within the programme had been severely affected. Andrew informed members that the intention was to go back out to leads to ask what their reasonable expectations are for the committee to consider for the remainder of the financial year. **ACTION: AB**

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	RESOLVED: That the Joint Committee of CCGs receive the update and note the work to be undertaken to review and address the areas within the committee's work programme.
10.	**Report from the Commissioning Reform Group (CRG)** Andrew Bennett informed members that the purpose of the report was to provide the committee with an update of the business discussed by the Commissioning Reform Group (CRG) during its meetings in July and August 2020. Committee members were advised that the report asked them to note that a number of further actions would be taken with oversight from the CRG. Andrew made reference to the phase 3 letter/guidance and the expectations in respect of system reform. He also made reference to the letter issued by the Regional Director, Bill McCarthy, to system leaders with a request that an ICS implementation plan on system reform be drawn up for submission to the Regional Director by the start of October. Andrew explained that the plan would need to be agreed over the next month. He also emphasised the useful dialogue that had taken place with ICP Programme Directors who have offered to create a common narrative to support ICP development – this offer has been supported in principle by the CRG. Andrew identified a number of next steps that the CRG will need to take which included reviewing progress on the actions set out within the report. He advised members that it was imperative that a refreshed programme and timeline be developed by the CRG in which the key actions and decision points related to commissioning reform are identified. These would be incorporated within the wider system reform plan required by the ICS. Graham Burgess made reference to the workshop being arranged by the Commissioning Support Unit (CSU) to produce proposals for consolidated quality and performance reporting for consideration by the Joint Committee of CCGs. He expressed concern about the CSU convening the workshops as there would potentially be a conflict of interest if colleagues from the CSU are involved in providing advice and also taking views. It might be perceived that if the CSU is leading the process, it may result in them securing further work and Graham asked how it could be phased. Andrew advised that the workshop would be organised by the ICS and CSU colleagues would be invited to participate. Graham pointed out the nuance of driving the work programme but they could also benefit from the work programme. The Chair commented that the same issue had been raised at the CRG meeting and it was suggested that the workshop could take place as a recommendation from the CRG on behalf of the CCGs and manage the conflicts of interests. Committee members were comfortable with this approach. **RESOLVED: That the Joint Committee of CCGs:** • **Note the report from the Commissioning Reform Group** • **Note that a workshop would be arranged by the ICS, as recommended by the Commissioning Reform Group on behalf of the CCGs to produce proposals for consolidated quality and performance reporting for consideration by the Joint Committee of CCGs. Also noting the management of conflicts of interest in respect of the Commissioning Support Unit's involvement.** • **Note that the Commissioning Reform Group will prepare further implementation plans about other functions which can be consolidated.**

Draft

	• **Note the actions being taken by ICP Programme Directors to develop a narrative and timeline for the further development of Integrated Care Partnerships in the wider context of system reform.** ***Dr Amanda Doyle arrived at the meeting.***

For Information	
11.	**Minutes of the Commissioning Reform Group – 14 July 2020** **RESOLVED: That the Joint Committee of CCGs receive the minutes of the meeting.**
12.	**COVID-19 Cell Logs:** **(a) Hospital** **(b) Out of Hospital** **(c) Joint Cell Logs** Members were advised the cell logs were provided for information in order that committee members had sight of the decisions being made. Doug Soper commented that whilst he appreciated the sharing of the information, there was a statement on the logs that they were confidential and should not be shared. This would need to be taken into consideration particularly as the meeting papers, although a virtual Part I meeting, were available on the website. This was noted and would be actioned accordingly. **ACTION: AB/NG (√)** Clarification was sought in respect of decisions made and whether they were undertaken as a majority or a vote and whether there were conflicts of interest or, whether they were they still being worked up. Dr Amanda Doyle advised that the cells were set up to deliver mandated actions from NHSE/I who had asked that certain areas be delivered on the footprint of Lancashire and South Cumbria rather than a CCG decision on something new. She further advised that there are spending commitments and ultimately, the lead of the cell reports directly to Bill McCarthy. Decisions are, therefore, made on behalf of NHSE/I. **RESOLVED: That the Joint Committee of CCGs note the cell logs and receive the update.**

Any Other Business	
13.	**Any Other Business** There were no issues.

Date, Time and Venue of Next Meeting
The next Formal meeting would be held on Thursday, 5 November 2020 at 1.00pm-3.00pm via Microsoft Teams videoconference.

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Joint Committee of CCGs - Matters Arising Log – 5 November 2020

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
JCCCG200702-07	An options appraisal for quality improvement and nursing leadership resourcing across Lancashire and South Cumbria to be brought to a future JCCCG meeting for further consideration	Jackie Hanson	In progress	05.11.2020	In progress.
JCCCG200702-08	Protection mechanisms to be put in place for audit purposes when reporting decisions through the cells and for auditor recommendations to be sought in terms of best practice.	Dr Amanda Doyle	In progress	05.11.2020	In progress.
JCCCG200702-09	A report detailing allocations for the next financial year to be shared with the JCCCG for investment purposes.	Gary Raphael	In progress	05.11.2020	Reported at September meeting – awaiting guidance.
JCCCG200702-10	ICS Implementation Plans	Andrew Bennett/Carl Ashworth	In progress	05.11.2020	Final report to be submitted to the next meeting.
JCCCG200702-11	Non-Executive representation on the SEND Health and Wellbeing Sub-committee	Hilary Fordham/Andrew Bennett	In progress	05.11.2020	Representative for Central Lancashire to be discussed and agreed outside of the September meeting. Update - Debbie Corcoran agreed to be the representative. Action to be closed.

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
JCCCG200702-12	Temporary Service Change Update	Emily Kruger-Collier	In progress	05.11.2020	Next update to be submitted to the November meeting.

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Title of Paper	CAMHS THRIVE Redesign – Evaluation Panel Final Report		
Date of Meeting	5 November 2020	Agenda Item	5

Lead Author	Dawn Haworth	
Contributors	Peter Tinson, Hilary Fordham	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	Yes
Executive Summary	In August 2017, following CCB approval, the Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) Transformation Programme Board initiated a project to redesign CAMHS in Lancashire and South Cumbria in line with THRIVE. This report describes the background to the project including the case for change, the approach taken and some of the achievements that have resulted from the project. The report also introduces the final report of the evaluation panel (Appendix B) and seeks agreement from Joint Committee to the panel's recommendations. Joint Committee are asked to note that a number of updates have been provided to the Collaborative Commissioning Board (CCB) at key stages throughout the project. The final report of the evaluation panel was presented to Collaborative Commissioning Board on 13th October 2020 and the recommendations were endorsed.	
Recommendations	Joint Committee are requested to: • Support the output of the evaluation grading • Note the panel agrees that the proposed model meets the THRIVE mandate • Note the small additional update required to the Transition Policy • Ask the CYPEWMH Partnership Board to set up a framework to oversee the implementation, monitoring and reporting • Ask CCB to ensure the CCG financial leads work with the Care Partnership to agree the financial envelope and financial model.	

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Joint Committee of Clinical Commissioning Groups (JCCCGs)

Next Steps	A report from the MHLD&A the financial plan to be presented to \a future meeting of JCCCGs			
Is this a level 1 or Level 2 decision?	Level 1	Yes	Level 2	
Equality Impact & Risk Assessment Completed	Yes. An EIRA has been produced and signed off by the MLCSU Equalities Team. The EIRA was reviewed by the Evaluation Panel as part of the evaluation process.			
Patient and Public Engagement Completed	Yes. Extensive engagement and co-production with children, young people, families, carers and wider stakeholders was undertaken throughout the development of the model. Reports from the co-production and engagement process were reviewed by the Evaluation Panel as part of the evaluation process			
Financial Implications	Yes. A Financial Modelling Template was reviewed by the evaluation panel. Further work is recommended between Commissioners and the Care Partnership in response to this.			
Risk Identified	Yes			
If Yes: Risk	There is a risk that no financial envelope is agreed meaning that the model cannot be implemented.			
Report Authorised by:	Hilary Fordham			

Joint Committee of Clinical Commissioning Groups (JCCCGs)

CAMHS THRIVE REDESIGN – EVALUATION PANEL FINAL REPORT

1. Introduction

1.1 In August 2017, the Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) Transformation Programme Board, following CCB approval, initiated a project to redesign CAMHS in Lancashire and South Cumbria (LSC) in line with THRIVE.

1.2 The project aimed to address a number of significant challenges that were being faced by the system in relation to CYPEWMH services including the need to

- increase access to CAMHS in line with national access targets
- improve waiting times for children, young people and families who need to access CAMHS
- ensure that services are designed and delivered to respond to the needs and aspirations of children, young people and families
- address unwarranted variations across the Integrated Care System (ICS) in relation to our service offer, the outcomes delivered and investment levels

1.3 In June 2017, following a detailed options appraisal, CCB agreed the scope and approach for the redesign as:

- Scope: the scope of the project will include all NHS funded services (partially or fully) that could or should deliver activity towards the new national CAMHS access target
- Securing the provider: the redesigned model of service (the clinical model) will be commissioned via direct negotiation (contract variation) with existing providers (through a clear and rigorous commercial roadmap).

1.4 Since October 2017, the three NHS CAMHS providers in LSC: Blackpool Teaching Hospitals NHS Trust, East Lancashire Hospitals NHS Trust and Lancashire and South Cumbria Foundation Trust have come together to form the Care Partnership. The Care Partnership have worked collaboratively with 13 third sector providers and the 8 CCGs across LSC to develop a redesigned model for CAMHS services through a process of engagement and co-production with children, young people, families and wider stakeholders. The key requirements of the redesigned model were agreed by CCG commissioners and are set out in the Mandate which is underpinned by THRIVE (see Appendix A).

1.5 THRIVE is a conceptual framework for CAMHS, developed by mental health professionals from the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust, first published in 2014 and updated in 2015 and 2016. THRIVE presents five needs-based groupings for young people with mental health issues and their families: Thriving; Getting Advice; Getting Help; Getting More Help; Getting Risk Support. It provides an integrated and person-centred approach to CAMHS for the young person and their families which emphasises prevention, building emotional resilience and promoting good mental health. The aspiration to implement THRIVE in LSC was first set out in the Transformation Plans for Lancashire and Cumbria in 2016.

2. Engagement and Co-production

2.1 The Care Partnership partnered with the 'Lancashire and South Cumbria HealthWatch Collaborative' to facilitate a comprehensive co-production methodology with inclusive 'reach' across the LSC geographical footprint. The concept of 'Co-production' was key to the design methodology throughout the project, where young people and parents worked side by side with professionals in every event, providing challenge and offering their ideas. This coproduction was further enhanced by taking a wider approach to communicating and engaging with larger numbers of individuals including via digital channels.

2.2 In 2019 Cumbria, Northumberland, Tyne and Wear NHS Trust (CNTW) were engaged to underpin the design phase and support the completion of the THRIVE model. NTW undertook a series of site-based analyses of existing services to review the current state and interfaces including future proofing and demand analysis. Running concurrently to the site-based analyses NTW facilitated a series of five design workshops with stakeholders to build on the co-production work.

3. Evaluation

3.1 In February 2018, the CYPEWMH Transformation Board approved proposals for the evaluation of the clinical model against the THRIVE Mandate, including evaluation criteria.

3.2 The proposal was evaluated at the end of each of the three phases of the project with detailed feedback provided to the Care Partnership following each evaluation. This has then been used by the Care Partnership as the basis for further engagement and co-production of the model. The project timeline is presented in Appendix B.

3.3 In phase I the evaluation panel considered the initial draft of the clinical model. In phase II they considered a further iteration of the clinical model alongside a draft Transition and Implementation Plan. In phase III, the panel considered the final clinical model, draft Transition and Implementation (T&I) Plan and draft Financial Modelling Template (FMT).

3.4 In phases I and II, the proposed model was evaluated by a Core Panel made of up representatives from CCG Commissioners, Clinicians, Local Authorities and Public Health. There were also children and young people's panels, a family and carers panel and a stakeholder panel (which included VCFSE, faith groups and schools) who contributed to the evaluation process.

3.5 In phase III, in light of capacity constraints created by the ongoing COVID response and restoration activity, it was agreed to proceed with a streamlined evaluation process. Submissions were evaluated by a core panel made up of the following representatives:

- CCG Commissioner x 2
- Clinical Lead for the CYPEWMH Programme
- Local Authority

3.6 Remaining members of the evaluation panel confirmed their agreement to support the recommendations of the core panel. Further detail regarding the core evaluation panel is included in the attached Evaluation Panel Final Report (Appendix B).

3.7 It should be noted that, following the phase II evaluation process, it was agreed not to re-engage children and young people's evaluation panels, the parents and carers evaluation panel or the stakeholder evaluation panel in the phase III evaluation since all had indicated they were satisfied with the clinical model at that stage and the T&I plan and FMT were felt to be a matter for commissioners to consider and agree.

3.8 At all phases, in order to ensure the independence and integrity of the evaluation process, panel members were not permitted to contribute to the co-production or development of the clinical model in any way.

3.9 This paper introduces the final report of the evaluation panel (see Appendix C – separate attachment) following the phase 3 submission and sets out recommendations for agreement by the Joint Committee of CCGs.

4. Key Achievements

4.1 The CAMHS Redesign project represents a new approach to service redesign with commissioners and providers collaborating to develop an agreed service model, co-production underpinning all aspect of the development and robust evaluation by an independent panel of commissioners and stakeholders. As a new approach this has offered some benefits to the system which it is helpful to consider.

4.2 The clinical model which has been developed reflects the THRIVE conceptual framework and is a good reflection of the mandate. It has support across commissioners and providers and, most importantly is rooted in the extensive co-production and engagement which was undertaken with CYP, families and wider stakeholders.

4.3 Strong relationships have formed between the 3 NHS Trusts and VCFS providers who have worked together closely to develop the model and considered within that how they might more effectively work together to deliver services going forward. Levels of trust between partners has increased and a real willingness to explore new ways of collaborating to deliver change collaboratively has developed.

4.4 The project has seen commissioner and provider roles becoming more integrated which can be considered a real test case for new ways of working. The Collaborative Commissioning Board was particularly keen to highlight the benefits of the collaborative nature of this work and encourage the Provider Collaborative to use this methodology in relation to other services.

4.5 Staff are committed to delivery of the redesigned model having been heavily engaged throughout the co-production.

4.6 CYP and families are optimistic about the future, having given positive feedback from the co-production process.

5. Conclusion

5.1 The redesign of CAMHS in LSC has been an in-depth and intensive piece of work which has been underpinned by extensive engagement and co-production and a robust independent evaluation process. It has resulted in a sound clinical model which responds to the challenges that lead to the project being initiated. There is further work to do to confirm an investment plan and, alongside this, to prioritise implementation for the various elements of the plan.

5.2 Considerable effort, energy and commitment across partners has enabled this piece if work to be completed and signed off by the evaluation panel. It is now incumbent upon partners in the system to continue to work with the Care Partnership, through existing governance structures, to support the implementation of the model to meet the needs and expectations of the children, young people, families and wider stakeholders who have contributed to its development.

6. Recommendations

6.1 The Joint Committee of CCGs are requested to:

- Support the output of the evaluation grading
- Note the panel agrees the proposed model meets the THRIVE mandate
- Note the small additional update required to the Transition Policy
- Ask the Mental Health, Learning Disabilities and Autism (MH, LD&A) sub cell to agree a delivery plan and routinely report progress via the OH Cell to the JCCCGs and ICS Board.
- Ask the CYPEWMH Partnership Board to work closely with the MH, LD&A sub cell to support continued engagement.
- Ask commissioning colleagues to work with the Care Partnership via the MH, LD&A sub cell to develop a proposed investment plan.

Dawn Haworth, Hilary Fordham, Peter Tinson

21.10.20

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Joint Committee of Clinical Commissioning Groups (JCCCGs)

APPENDIX A: CAMHS REDESIGN MANDATE

The Ask:

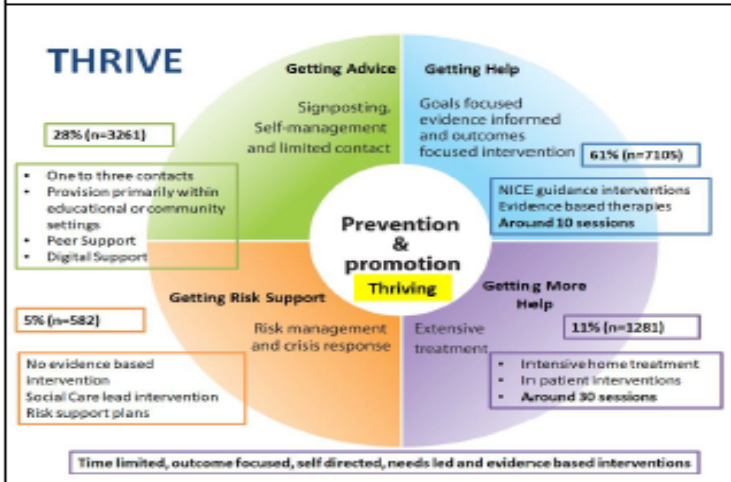
Providers are asked to collaborate with each other to clinically lead the co-production of a core service model for NHS funded Children and Young People's Emotional Wellbeing and Mental Health Services across Lancashire and South Cumbria in line with the following:

Must Do's:

a. Be co-produced with CYP, families, providers, commissioners and other stakeholders (see appendix A).
b. Reflect and respond to previous consultation (see EIRA) and incorporate ongoing engagement with CYP and families.
c. Offer quality services that result in positive patient experiences and deliver positive outcomes for children, young people and families in line with PREMS and PROMS.
d. Respond to the needs of our diverse communities and vulnerable groups (see EIRA).
e. Incorporate the use of digital therapies in line with evidence base and offering choice
f. Incorporate clinical support to online parenting groups and peer support based on recommendation in the ITHRIVE consultation e.g. closed Facebook groups with clinical input
g. Incorporate the full range of NHS funded interventions provided across sectors e.g. counselling (see appx D)
h. Reflect the THRIVE model: evidence based and outcomes led; options and information for children and young people in need but not in treatment; interventions are focused and time limited; and a clear approach to risk support.
i. Support delivery of the national access target (see appendix B).
j. Take referrals from birth up to 18th birthday and continue to support up to 19th birthday, as needed
k. Offer a clear single point of contact for CYP, families, schools and primary care including providing consultation and advice.
l. Offer clear referral pathways including self-referral.
m. Incorporate a single point of access to all elements of the THRIVE model including a 'warm handover' to other services
n. Offer a direct route from adult IAPT for 16-18s with common mental health conditions as part of 'getting help'. YP should only transition if it is clinically appropriate and reflects the YPs choice.
o. Incorporate a range of roles including the new PMHWs and CWPs.
p. Ensures workforce requirements are delivered in line with Stepping Forward to 2020/21.

Pathways to be included:

Pathways to be developed as part of the redesign, reflecting the national access target definition, the needs based groupings set out in THRIVE elaborated (p14) and NICE guidance. Pathways to include those delivered directly and those delivered in partnership with other services



Must Do's continued:

q. Offer 7-day CAMHS crisis response with access to out of hours' on-call services and places of safety alongside Core 24
r. Offer access to the service in a range of CYP friendly settings.
s. Provide intensive support in community settings for young people
   i. to help avoid escalation to crisis point
   ii. for those who are assessed as not meeting threshold MH in-patient service
   iii. to provide step-down care for those discharged from inpatient MH care
   Work with LA Social Care to establish alternative "safe places" to provide facilities for de-escalation, avoid CYP in crisis having to attend A&E or be on acute paediatric wards whilst awaiting assessment or whilst awaiting alternative provision.
t. Allow for innovation and continuous improvement in response to national and local standards while enabling place based delivery and local variation, where appropriate. This should include the Green Paper (December 2017).
u. Support a collaborative system and a positive culture around children and young people's mental health by working in partnership with non-NHS funded services that form part of the complementary offer; to tackle stigma and raise awareness; and positioning the new service within the context of an overall offer for 0-25.
v. Work in partnership with AMH and physical health services to ensure CYP and families are supported holistically and that services recognise and respond to the impact that AMH may have on CYP
w. CYP are appropriately supported across the system to transition in line with pan Lancashire Transitions procedure and NICE quality standards and learning from recent CQUIN.
x. Children and young people, who are vulnerable e.g. children looked after, young offenders, should have priority access to mental health assessments by specialist practitioners. An appropriate identification and triage system should be developed based on risk level and need. Access to subsequent treatment should be based on clinical need.

Performance and outcome measures and targets

1. **Access Target:** Included in THRIVE diagram above and CCG breakdown appendix B (Attached)
2. **Waiting List Measures:** Included as placeholders in FYFV MH dashboard and as part of national indicator set therefore may require further amendment once finalised nationally.
   a. Total number of CYP waiting for treatment by number of weeks waiting
   b. Average waiting time (days):
      i. from referral to treatment/intervention (National proposed 4 weeks – Green Paper Dec 2017)
      ii. from assessment to treatment/intervention
      iii. from referral to assessment
3. **Quality Measures**
   a. Transitions out of Children and Young People's Mental Health Services as per Commissioning for Quality & Innovation (CQUIN) 2017/18 specification, with a goal to improve the experience and outcomes for young people as they transition out of Children and Young People's Mental Health Services.
   b. Additional measures to be developed by providers
4. **Outcome measures:** based on the new indicator to be confirmed by NHSE
5. **Mental Health Service Data Set (MHSDS):** Compliance to the minimum MHSDS submission of 100% completeness and full compliance against data quality as per the NHS Digital provider level data quality report, with ambition to be fully conformant to MHSDS by 1st June 2018 as per the Information Standard Notice.

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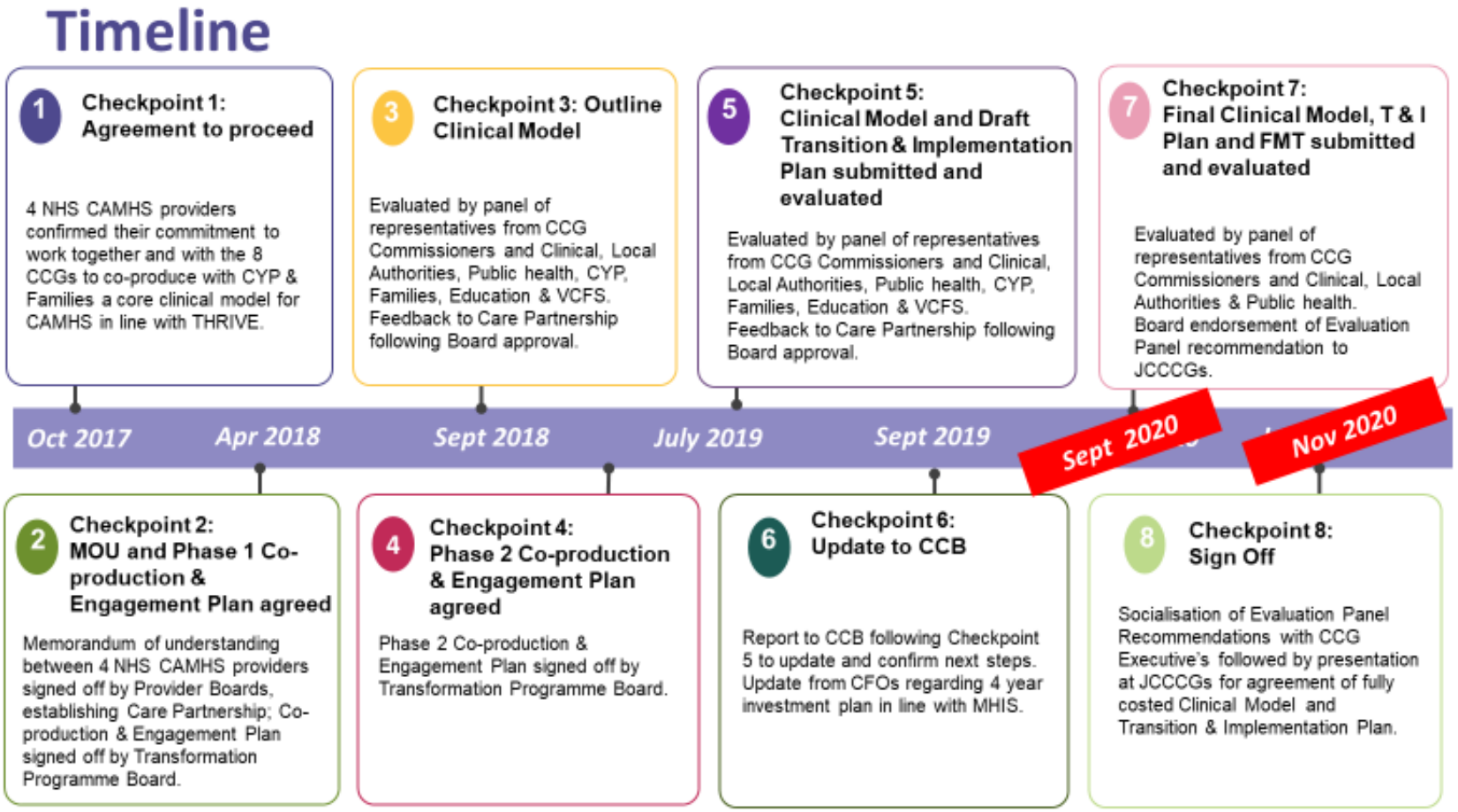
Joint Committee of Clinical Commissioning Groups (JCCCGs)

APPENDIX B: CAMHS REDESIGN PROJECT TIMELINE



Lancashire & South Cumbria Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan

Objective 5: CAMHS Redesign in Lancashire and South Cumbria in line with THRIVE

CONFIDENTIAL

Checkpoint 7 report:

Evaluation of Clinical Model, Transition & Implementation Plan and Financial Modelling Template

Redesigning CAMHS in Lancashire and South Cumbria in line with THRIVE

Background

In August 2017, the Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) Transformation Programme Board initiated a project to redesign CAMHS in Lancashire and South Cumbria in line with THRIVE. The scope and approach of the project are confirmed as:

a. Scope: the scope of the project will include all NHS funded services (partially or fully) that could or should deliver activity towards the new national CAMHS access target
b. Securing the provider: the new model of service (the clinical model) will be commissioned via direct negotiation (contract variation) with existing providers (through a clear and rigorous commercial roadmap).

NHS CAMHS provider organisations were tasked to work collaboratively with voluntary community and faith sector providers and with CCGs to co-produce a core model for CAMHS services across Lancashire and South Cumbria through a process of engagement and co-production with children, young people, families and wider stakeholders. For ease of reference, the group of provider and CCG representatives leading the co-production and engagement process will be referred to as the Care Partnership throughout this report.

In February 2018, the CYPEWMH Transformation Board approved proposals for the evaluation of the clinical model including evaluation criteria.

The phase I submission, consisting of a first draft of the Clinical Model, was evaluated in September 2018. Following feedback from the evaluation panel and further work, the phase II submission, consisting of a further iteration of the Clinical Model and a draft Transition and Implementation (T&I) plan was evaluated in August 2019. Further feedback was provided by the evaluation panel and work continued by the Care Partnership towards a planned submission date of March 2020 for the final Clinical Model, T&I plan and financial modelling template (FMT). Whilst the Clinical Model was signed off and submitted by the Care Partnership at the end of March, due to the COVID pandemic, the evaluation panel could not go ahead. The Care Partnership continued to work on the T&I Plan and the FMT and in late August it was agreed to proceed with the evaluation, though in a streamlined format.

Appendix A presents an overview of the previously agreed project timeline.

Evaluation Process

In light of capacity constraints created by the ongoing COVID response and restoration activity it was agreed to proceed with a streamlined evaluation process. Submissions were evaluated by a core panel made up of the following representatives:

- CCG Commissioner x 2
- Clinical Lead for the CYPEWMH Programme
- Local Authority

Remaining members of the evaluation panel confirmed their agreement to support the recommendations of the core panel. In order to ensure the independence and integrity of the evaluation process, panel members were not permitted to contribute to the co-production or development of the submission documents in any way. Panel members are detailed in appendix B.

It should be noted that following the phase II evaluation process it was agreed to not re-engage children and young people's evaluation panels, the parents and carers evaluation panel or the stakeholder evaluation panel (which included VCFSE, faith groups and schools) in the phase III evaluation since all

had indicated they were satisfied with the clinical model at that stage and the T&I plan and FMT were felt to be a matter for commissioners to consider and agree.

The evaluation process took place over one week with core panel members dedicating 1.5 days to the process. Panel members accessed all elements of the submission electronically, reviewed and graded these independently, submitting their gradings through a confidential online survey. The outcome of the survey was collated and fed into a half-day evaluation panel session, held via MS Teams, on 16th September. At the session, panel members discussed any elements of the submission which had not achieved a majority of green gradings in order to reach a consensus and to agree their recommendations.

Evaluation Findings

There is a total of 39 elements to the evaluated submission. The following summarises the current status following the phase III evaluation process:

36	**0**	**0**
Meets or exceeds expectations	Partially meets expectations and there is confidence in the providers' capacity to deliver the requirements within a reasonable timeframe subject to improvements in some elements	Does not meet expectations

Through this grading the panel is in agreement that the model is fit for purpose to move forward to implementation. However, one element, the Transition Policy, caused some concern both in its coverage and its lack of agreement as yet across the Care Partnership. The panel were unable to grade this element and would therefore like to offer to discuss this further with the Care Partnership to address these comparatively small issues but see no need for implementation to be delayed.

In addition to the above the panel also considered the Transition and Implementation plan and FMT but did not grade these, as further work will be needed as part of implementation.

Appendix C sets out a detailed summary of the evaluation and the final feedback to the Care Partnership from the evaluation panel. It should be noted that phase I and II evaluations also included feedback from children and young people's evaluation panels, from parents and carers evaluation panels and from stakeholder evaluation panels which included VCFSE, faith groups and schools.

Set out below are key themes from the Core Panel's evaluation following the Phase III evaluation.

Clinical Model

The panel recognises the considerable further work done by the Care Partnership across all elements of the model. In particular the panel welcomed:

- the amount of engagement within South Cumbria since the last submission
- the proposed approach to risk support and its agreement across the range of partners
- the quality of the documentation submitted

Transition & Implementation Plan

The Panel acknowledge that the Transition and Implementation Plan has the majority of the relevant items included. The Panel welcomed the proposal to bring implementation plans to the PRG prior to the Partnership Board.

The Transition and Implementation Plan clearly needs further development and should be fully developed across the whole Care Partnership and monitored through a mobilisation process. In recognition of this, the panel has not graded this. This should not delay progression to implementation.

Financial Modelling Template

The Panel acknowledge the costings have been completed and the further work that is planned. One example of discrepancy that the panel has identified is the wide-ranging overhead figures. Another example is the discrepancy between the operational plan of RAIS and the costings included within the FMT.

The Panel recognise that as part of the financial modelling and the model development that the Care Partnership had been sensitive to financial concerns by reducing to a manageable level the request for PMHWs to 1 per PCN which is below the nationally recommended number. The panel sees this as a pragmatic approach which should be recognised when the funding envelope is considered by CCB and JCCCG.

Given the status of this document, the panel have not graded and will be recommending that further work is undertaken by CCG finance colleagues.

Copy of the current financial envelope is attached at appendix D

General Comments

As the evaluation process commenced significantly prior to COVID, the process has been completed assuming non COVID situation. However, the panel recognises that the implementation of the model and the associated financial modelling will now need to take that into account. CCB and the Care Partnership need to recognise this.

The panel is really pleased to see that the Care Partnership approach covering the 3 NHS providers, commissioners and VCFS is maintaining its structure and positive outputs. We would like to see this approach continued as it gives a diversity of input into the service provision.

The panel believes it has completed its work to evaluate the proposed model against the THRIVE mandate. In terms of implementation, the panel recommends that the Mental Health, Learning Disabilities and Autism (MH, LD&A) sub cell receives this report, agrees a delivery plan and routinely reports progress via the OH Cell to the JCCCGs and ICS Board. It also recommends that the CYPEWMH Partnership Board receives the report and works closely with the MH, LD&A sub cell to support continued engagement with children, young people, families and wider stakeholders.

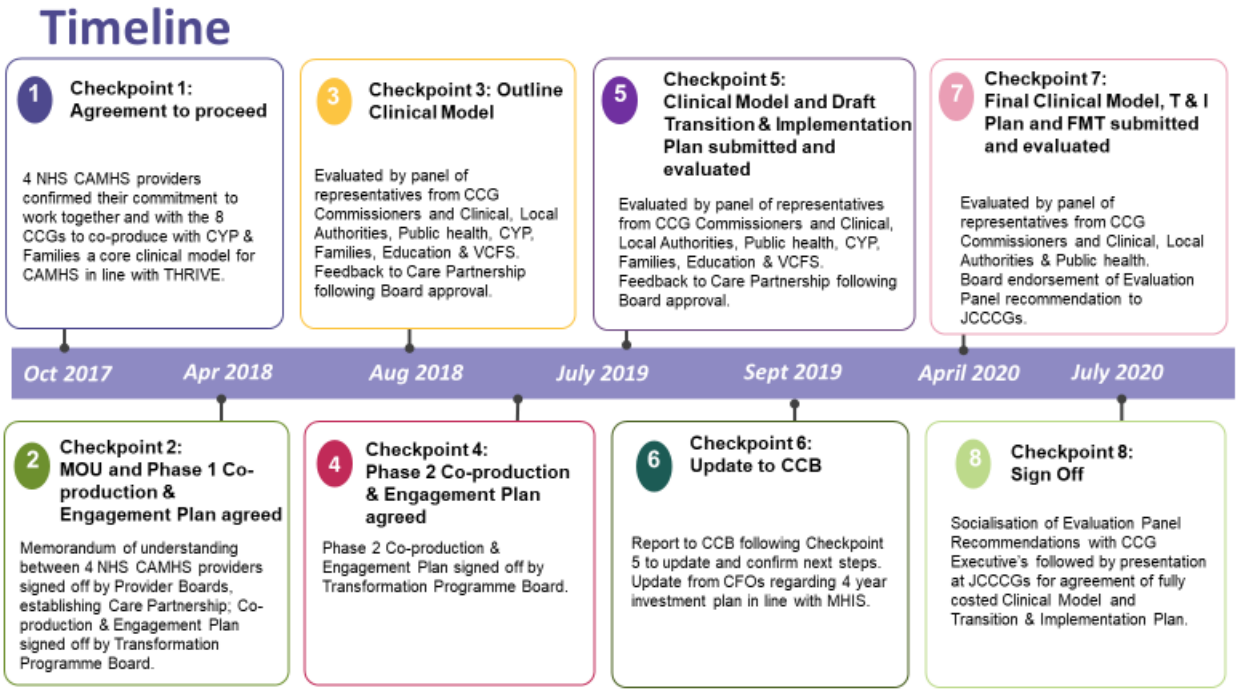
The panel recommends that commissioning colleagues work with the Care Partnership via the MH & LD, A sub cell to finalise the FMT and develop a proposed investment plan for agreement and prioritisation via the MH, LD&A sub cell.

Recommendations

CCB and Joint Committee of CCGs are asked to agree the following core panel recommendations:

- Note the output of the evaluation grading
- Note the panel agrees the proposed model meets the THRIVE mandate
- Note the small additional update required to the Transition Policy
- Ask the MH, LD&A sub cell to agree a delivery plan and routinely report progress via the OH Cell to the JCCCGs and ICS Board.
- Ask the CYPEWMH Partnership Board to work closely with the MH, LD&A sub cell to support continued engagement.
- Ask commissioning colleagues to work with the Care Partnership via the MH, LD &A sub cell to develop a proposed investment plan.

APPENDIX A - Timeline



APPENDIX B

Core panel

Name	Job Title	Organisation	Role on Panel
Hilary Fordham	Chief Operating Officer	Morecambe Bay CCG	Evaluation Panel Chair
Ros Bonsor	GP and Programme Clinical Lead	West Lancashire CCG	Clinical
Cathy Gardener	Commissioning Lead	Pennine CCGs	CCG Commissioner
Sharon Simpson	Senior Commissioning Manager - Children	Cumbria County Council	Local Authority
Remaining members of the panel confirmed their agreement to support the recommendations of the core panel:			
Nick Medway	Senior Integrated Governance Manager Risk / Assurance	Fylde Coast CCGs	Clinical
Kate Burgess	Commissioning Lead	Central CCGs	CCG Commissioner
Dave Carr	Head of Service - Policy, Information and Commissioning	Lancashire County Council	Local Authority
Judith Mills	Consultant in Public Health	Public Health Blackpool	Public Health / Local Authority
Kath Hughes	Head of Communications Service	Cumbria Partnership NHS Foundation Trust & North Cumbria University Hospitals NHS Trust	Comms & Engagement Adviser
Naz Saghir	Business Intelligence	Midlands and Lancashire	Business

	Officer	CSU	Intelligence Adviser
Douglas Brierley	Finance Support to the CYPEWMH Programme	West Lancashire CCG	Finance Adviser

APPENDIX C

Appendix%20C_20200916.pdf

APPENDIX D

CAMHS%20Finance%20Envelope%20for%2

Lancashire and South Cumbria
Children and Young People's
Emotional Wellbeing and Mental Health
Transformation Programme

Redesigning CAMHS in Lancashire and South Cumbria in line with THRIVE

Report to

- JCCCGs on 5th November 2020

@HealthyYM_LSC

Overview

- Background
  - The Case for Change
  - The Ask
  - The Approach
- Timeline and Key Milestones
- Key Achievements
- Evaluation Panel Recommendations

Background: The Case for Change

Why did CCGs agree to collaboratively Redesign CAMHS in LSC?

- Performance against National Access Target for CAMHS – now 100%
- Long waiting times/lists - anticipated Waiting Times Target 4 weeks
- Feedback from stakeholders
- Unwarranted variations - services, outcomes and investment
- Delivery of services and achievement of targets on the ICS Footprint
- Transformation Plan aspiration to implement THRIVE

Background: The Ask

Services in Scope

All NHS funded services (partially or fully) that could or should deliver activity towards the new national CAMHS access target

Securing the Model

Commissioning of a redesigned clinical model via direct negotiation (contract variation) with existing providers (through a clear and rigorous commercial roadmap)

Providers were asked to collaborate with each other, with VCFS providers and with CCGs to clinically lead the co-production of a core service model for NHS funded CYPEWMH Services (CAMHS) across Lancashire and South Cumbria

The Redesign Approach

The Care Partnership:

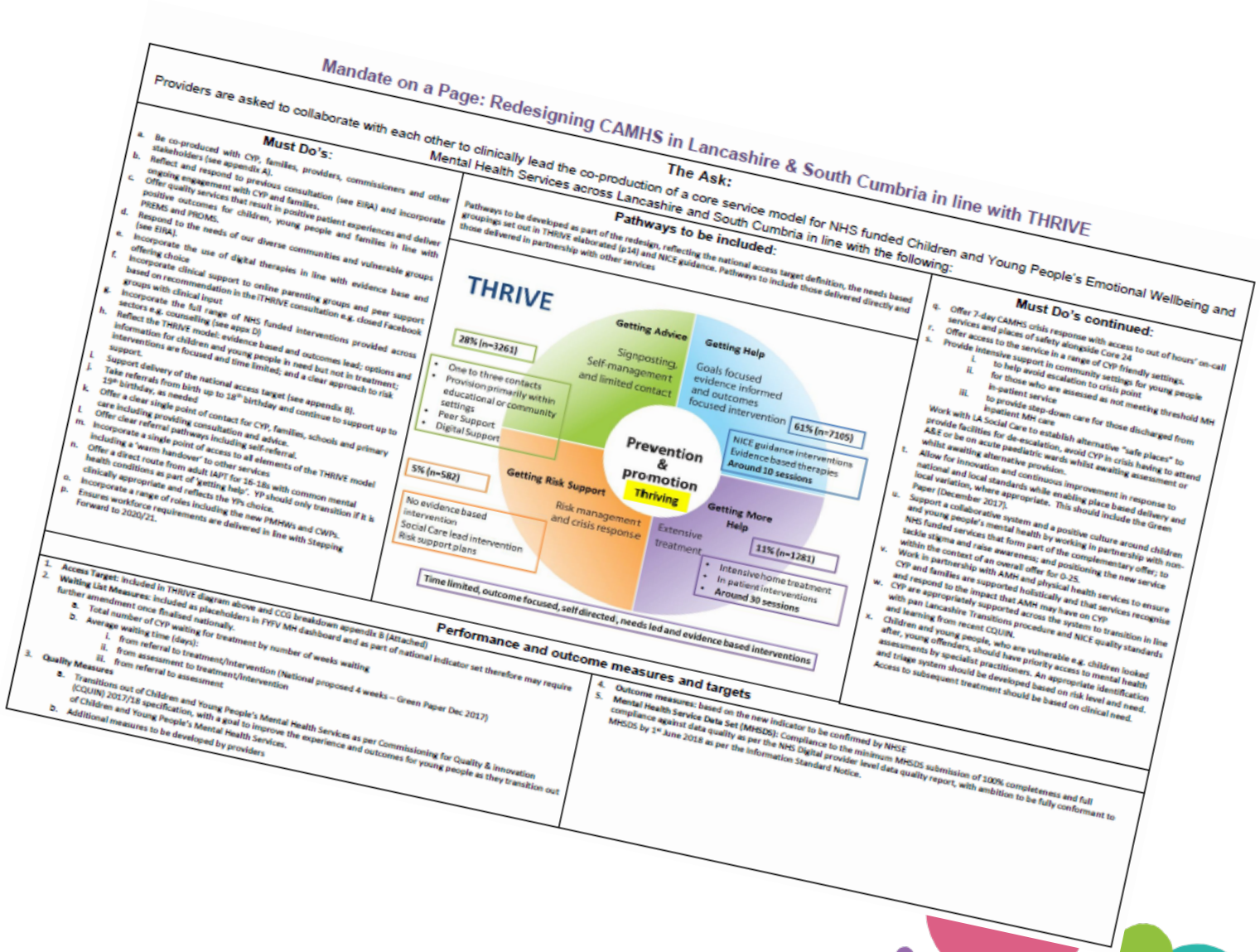
- 8 CCGs
- 3 NHS Trusts
- 13 VCFS Providers

- Co-production approach with children, young people, families, carers and other key stakeholders
- Significant clinical input from providers

Mandate on a Page

We gave the Care Partnership team a mandate which told them “what” the model needed to offer

The Care Partnership team were asked to work out “how” and to produce a proposed clinical model



Timeline

1 Checkpoint 1: Agreement to proceed

4 NHS CAMHS providers confirmed their commitment to work together and with the 8 CCGs to co-produce with CYP & Families a core clinical model for CAMHS in line with THRIVE.

3 Checkpoint 3: Outline Clinical Model

Evaluated by panel of representatives from CCG Commissioners and Clinical, Local Authorities, Public health, CYP, Families, Education & VCFS. Feedback to Care Partnership following Board approval.

5 Checkpoint 5: Clinical Model and Draft Transition & Implementation Plan submitted and evaluated

Evaluated by panel of representatives from CCG Commissioners and Clinical, Local Authorities, Public health, CYP, Families, Education & VCFS. Feedback to Care Partnership following Board approval.

7 Checkpoint 7: Final Clinical Model, T & I Plan and FMT submitted and evaluated

Evaluated by panel of representatives from CCG Commissioners and Clinical, Local Authorities & Public health. Board endorsement of Evaluation Panel recommendation to JCCCGs.

Oct 2017 | Apr 2018 | Sept 2018 | July 2019 | Sept 2019 | Sept 2020 | Nov 2020

2 Checkpoint 2: MOU and Phase 1 Co-production & Engagement Plan agreed

Memorandum of understanding between 4 NHS CAMHS providers signed off by Provider Boards, establishing Care Partnership; Co-production & Engagement Plan signed off by Transformation Programme Board.

4 Checkpoint 4: Phase 2 Co-production & Engagement Plan agreed

Phase 2 Co-production & Engagement Plan signed off by Transformation Programme Board.

6 Checkpoint 6: Update to CCB

Report to CCB following Checkpoint 5 to update and confirm next steps. Update from CFOs regarding 4 year investment plan in line with MHIS.

8 Checkpoint 8: Sign Off

Socialisation of Evaluation Panel Recommendations with CCG Executive's followed by presentation at JCCCGs for agreement of fully costed Clinical Model and Transition & Implementation Plan.

Key Achievements

- **Clinical model** reflects the spirit of THRIVE, is a good reflection of the mandate, has support across commissioners and providers and reflects the co-production with CYP, families and stakeholders. It provides a **solid foundation for implementation and to address the case for change**.
- Formation of **strong relationships** between the 3 NHS Trusts and VCFS providers – development of trust and keen to explore new ways of collaborating to deliver real change
- Commissioning and provider **roles integrating** – breaking new ground. This is a real test case for new ways of working. CCB keen to highlight to Provider Collaborative as an approach to other service areas
- **Staff are committed** to delivery having been heavily engaged throughout the co-production
- **CYP and families are optimistic** about the future – positive feedback from the co-production process – a lot of learning which will benefit the implementation phase and the wider system

CCB & JCCCGs are asked to:

- Support the output of the evaluation grading
- Note the panel agrees the proposed model meets the THRIVE mandate
- Note the small additional update required to the Transition Policy
- Ask the Mental Health, Learning Disabilities and Autism (MH, LD&A) sub cell to agree a delivery plan and routinely report progress via the OH Cell to the JCCCGs and ICS Board.
- Ask the CYPEWMH Partnership Board to work closely with the MH, LD&A sub cell to support continued engagement.
- Ask commissioning colleagues to work with the Care Partnership via the MH, LD &A sub cell to develop a proposed investment plan.

Healthy young minds

Lancashire and South Cumbria
Children and Young People's
Emotional Wellbeing and Mental Health
Transformation Programme

@HealthyYM_LSC

Questions?

Joint Committee of Clinical Commissioning Groups

Title of Paper	Lancashire and South Cumbria Medicines Management Group Recommendations: A briefing paper for the Healthier Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting		Agenda Item	7

Lead Author:	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	The Lancashire and South Cumbria Medicines Management Group (LSCMMG) has developed recommendations for medicine reviews, medicine pathway, medicine policy and the implementation of NICE technology appraisals for adoption across Lancashire and South Cumbria.	
Recommendations	That the JCCCGs ratify the collaborative LSCMMG recommendations on the following: - *VACOcast Diabetic Boot for the management of foot ulcers in the diabetic population.* - *Psoriasis: LSCMMG Biologic and High Cost Drug Commissioning Pathway (July 2020 update).* - *Over the Counter Items that Should not be Routinely Prescribed in Primary Care Policy (July 2020 update).* - *Rifaximin as second line antibacterial treatment for the treatment of Small Intestinal Bacterial Overgrowth.* - *Dibotermin alfa for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation AND use outside of the licensed indication for the treatment of non-union long bone fractures.* - *Request to change RAG status of Linezolid 600mg tablets for up to 14-day treatment of pneumonia and complicated skin and soft tissue infections on the recommendation of a microbiologist.*	

	- *Haemophilus type b and Meningococcal group C conjugate vaccine – Community Supply to Adults with Respiratory Conditions.* - *Melatonin prolonged release tablets (Circadin®) for the treatment of Rapid Eye Movement (REM) Sleep Behaviour Disorder (RBD) in Parkinson's Disease and Lewy Body Dementia.* - *Prescribing of Pregabalin for the treatment of Generalised Anxiety Disorder (GAD).* - *Oscillating Positive Expiratory Pressure Devices for Non – Cystic Fibrosis Bronchiectasis.* - *NICE Technology Appraisals (February to September 2020).*
Equality Impact & Risk Assessment Completed	Yes
Patient and Public Engagement Completed	No
Financial Implications	Yes
Risk Identified	No
If Yes: Risk	N/A
Report Authorised by:	XXXX

DEVELOPMENT OF LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP RECOMMENDATIONS:

1. INTRODUCTION

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

- *VACOcast Diabetic Boot for the management of foot ulcers in the diabetic population.*
- *Psoriasis: LSCMMG Biologic and High Cost Drug Commissioning Pathway (July 2020 update).*
- *Over the Counter Items that Should not be Routinely Prescribed in Primary Care Policy (July 2020 update).*
- *Rifaximin as second line antibacterial treatment for the treatment of Small Intestinal Bacterial Overgrowth.*
- *Dibotermin alfa for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation AND use outside of the licensed indication for the treatment of non-union long bone fractures.*
- *Request to change RAG status of Linezolid 600mg tablets for up to 14-day treatment of pneumonia and complicated skin and soft tissue infections on the recommendation of a microbiologist.*
- *Haemophilus type b and Meningococcal group C conjugate vaccine – Community Supply to Adults with Respiratory Conditions.*
- *Melatonin prolonged release tablets (Circadin®) for the treatment of Rapid Eye Movement (REM) Sleep Behaviour Disorder (RBD) in Parkinson's Disease and Lewy Body Dementia.*
- *Prescribing of Pregabalin for the treatment of Generalised Anxiety Disorder (GAD).*
- *Oscillating Positive Expiratory Pressure Devices for Non – Cystic Fibrosis Bronchiectasis.*
- *NICE Technology Appraisals (February to September 2020).*

2. DEVELOPMENT PROCESS

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

2.2 The review process includes the following key steps:

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

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

- *VACOcast Diabetic Boot for the management of foot ulcers in the diabetic population.*

VACO cast New Medicines Assessment JCCCGs.docx

- *Psoriasis: LSCMMG Biologic and High Cost Drug Commissioning Pathway (July 2020 update).*
  Psoriasis Biologic Treatment Guideline v 1.7 JCCCGs.docx

- *Over the Counter Items that Should not be Routinely Prescribed in Primary Care Policy (July 2020 update).*
  LSCMMG OTC Items that Should not be Routinely Prescribed in Primary Care Policy July 2020 JCCCGs.docx

- *Rifaximin as second line antibacterial treatment for the treatment of Small Intestinal Bacterial Overgrowth.*
  Rifaximin New Medicine Assessment JCCCGs.docx

- *Dibotermin alfa for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation AND use outside of the licensed indication for the treatment of non-union long bone fractures.*
  New Medicine Assessment Dibotermin alfa JCCCGs.docx

- *Request to change RAG status of Linezolid 600mg tablets for up to 14-day treatment of pneumonia and complicated skin and soft tissue infections on the recommendation of a microbiologist.*
  (No accompanying document)

- *Haemophilus type b and Meningococcal group C conjugate vaccine – Community Supply to Adults with Respiratory Conditions.*
  Menitorix NMR JCCCGs.docx

- *Melatonin prolonged release tablets (Circadin®) for the treatment of Rapid Eye Movement (REM) Sleep Behaviour Disorder (RBD) in Parkinson's Disease and Lewy Body Dementia*
  Melatonin in RBD New Medicine Assessment JCCCGs.docx

- *Prescribing of Pregabalin for the treatment of Generalised Anxiety Disorder (GAD).*
  Pregabalin position statement JCCCGs.docx

- *Oscillating Positive Expiratory Pressure Devices for Non – Cystic Fibrosis Bronchiectasis*
  Oscillating PEP devices for Non-Cystic Fibrosis Bronchiectasis JCCCGs.docx

- *NICE Technology Appraisals (February to September 2020).*
  Available at https://www.nice.org.uk/guidance/published?type=ta

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

VACOcast Diabetic Boot for the management of foot ulcers in the diabetic population

3.1 VACOcast Diabetic Boot for the management of foot ulcers in the diabetic population was prioritised for review following identification via the horizon scanning process.

3.2 The LSCMMG agreed a Red RAG rating (to be supplied by hospital/specialist service for the duration of the treatment) as hospital/specialist services were judged to be the most appropriate route of supply for the treatment.

3.3 No financial risks have been identified as VACOcast is expected to be cost saving compared to standard treatments.

Over the Counter Items that Should not be Routinely Prescribed in Primary Care Policy (July 2020 update)

3.4 The "Over the Counter Items that Should not be Routinely Prescribed in Primary Care" policy was updated to include vaginal moisturisers following a request from Blackburn with Darwen CCG. Also, Sterimar nasal spray was added to the list of example products that could be restricted, following a request from Greater Preston and Chorley and South Ribble CCGs to review Sterimar use.

3.5 The updated wording included in the document was added following consultation with the Equality and Inclusion Team of the MLSCU. The Equality Impact and Risk Assessment for the policy has also been updated to reflect considerations taken into account during the update of the policy. Due to the minor nature of the amendments to the policy and advice received from the Equality and Inclusion Team, clinical consultation was not sought for the policy update.

3.6 The updates to the policy are expected to be cost saving. Savings delivered will continue to be monitored closely by the MLCSU post ratification.

Haemophilus type b and Meningococcal group C conjugate vaccine – Community Supply to Adults with Respiratory Conditions

3.7 A request to review community supply of Haemophilus type b and Meningococcal group C conjugate vaccine in adults with respiratory conditions was received from East Lancashire CCG as their GPs had received requests from respiratory consultants to provide the vaccine to patients with respiratory conditions.

3.8 The LSCMMG agreed a Black RAG rating (supply not recommended in Lancashire and South Cumbria) as there is no robust clinical evidence to support this type of immunisation in adults with severe recurrent COPD exacerbations.

3.9 The Black RAG recommendation is not anticipated to cause any financial, equality or service impact issues.

Oscillating Positive Expiratory Pressure Devices for Non – Cystic Fibrosis Bronchiectasis.

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

3.11 After consultation with respiratory teams across the Lancashire and South Cumbria health economy, the LSCMMG agreed Oscillating Positive Pressure Devices should be supplied only by the specialist respiratory services (Red RAG rating).

3.12 As the cost of the device is covered by tariff, supply of the device is not anticipated to create a cost pressure for CCGs.

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

Rifaximin as second line antibacterial treatment for the treatment of Small Intestinal Bacterial Overgrowth.

4.1 Rifaximin as second line antibacterial treatment for the treatment of Small Intestinal Bacterial Overgrowth was prioritised for review following a request from a Consultant Gastroenterologist at East Lancashire Hospitals Trust.

4.2 The LSCMMG agreed a Red RAG rating (to be supplied by hospital/specialist service for the duration of the treatment) for rifaximin as a second line antibacterial treatment.

4.3 The additional cost of a course of rifaximin in place of alternative antibiotic regimens is approximately £95. The number of patients requiring rifaximin treatment and the number of treatment courses necessary annually is unclear but likely to be small as rifaximin would be used according to clinician judgement later in the treatment pathway.

4.4 The LSCMMG agreed that if there is a desire to review the RAG position of rifaximin in future, an audit would be undertaken to understand where rifaximin is being used and if an amended RAG status is appropriate.

Psoriasis: LSCMMG Biologic and High Cost Drug Commissioning Pathway (July 2020 update)

4.5 The proposed update to the Psoriasis High Cost Drug Commissioning Pathway was initiated following discussions with the Dermatology Department of Salford Royal NHS Foundation Trust and also was initiated in response to a Regional Medicines Optimisation Committee Advisory Statement on the sequential use of biologic medicines.

4.6 The policy underwent clinical engagement across stakeholder organisations, including input from Salford Royal NHS Foundation Trust. LSCMMG did not recommend any amendments to the proposed pathway.

4.7 The implementation of the Psoriasis High Cost Drug pathway is anticipated to have a minimal cost impact. The costs of the pathway will continue to be monitored closely by the Midlands and Lancashire Commissioning Support Unit (MLCSU) post ratification.

Dibotermin alfa for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation AND use outside of the licensed indication for the treatment of non-union long bone fractures.

4.8 A request to review Dibotermin alfa (InductOs®) for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation (licensed indication) AND use outside of the licensed indication for the treatment of non-union long bone fractures was received from East Lancashire CCG following a request to fund the drug from Salford Royal NHS Trust Hospital.

4.9 The LSCMMG agreed:

- A Red RAG rating (to be supplied by hospital/specialist service for the duration of the treatment) for the treatment of acute tibia grade IIIB fractures in adults (as

assessed on the Gustilo-Anderson scale), as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation.
- A Black RAG rating (not to be supplied in Lancashire and South Cumbria) for use outside of the licensed indication for the treatment of non-union long bone fractures**.**

4.10 There are an estimated 24 patients per annum with grade IIIB fractures requiring dibotermin alfa leading to a cost of **£48,500**.

4.11 As some Lancashire and South Cumbria patients may be treated by nonunion specialists in Greater Manchester trauma centres, there may be a risk of inequity as the Greater Manchester health economy commissions dibotermin alfa outside of the licensed indication for the treatment of non-union long bone fractures**.**

Melatonin prolonged release tablets (Circadin®) for the treatment of Rapid Eye Movement (REM) Sleep Behaviour Disorder (RBD) in Parkinson's Disease and Lewy Body Dementia

4.12 Melatonin for the treatment of RBD in Parkinson's Disease was prioritised for review by the Lancashire and South Cumbria Medicines Management Group (LSCMMG) following a request by the Fylde Coast CCGs.

4.13 The LSCMMG agreed an Amber0 RAG rating (supplied in primary care following recommendation or initiation by a specialist) for melatonin in RBD in both Parkinson's disease and Lewy Body Dementia.

4.14 There are an estimated 120 RBD patients across the Lancashire and South Cumbria health economy who may benefit from melatonin treatment. Depending on the dose of melatonin used, and if all these patient were treated with melatonin, this would lead to an annual cost burden of £33,242 to £132,960.

Request to change RAG status of Linezolid 600mg tablets for up to 14-day treatment of pneumonia and complicated skin and soft tissue infections on the recommendation of a microbiologist.

4.15 A request for a change in the RAG status of oral linezolid from Red (to be supplied by hospital/specialist service for the duration of the treatment) to Amber0 (supplied in primary care following recommendation or initiation by a specialist) for the treatment of pneumonia and complicated skin and soft tissue infections for up to 14 days was submitted for consideration by an Antimicrobial Pharmacist from Lancashire Teaching Hospitals.

4.16 The LSCMMG requested that the monitoring and referral arrangements should be clarified with microbiologists prior to confirming a RAG recommendation. Further consultation was sought with the Consortium of Lancashire and Cumbria Local Medical Committees (LMCs) to assess the potential service impact of supplying linezolid in primary care.

4.17 Following receipt of the advice from microbiologists regarding monitoring and referral and from the LMCs regarding service impact, the LSCMMG agreed an Amber0 RAG rating but requested that a prescriber information sheet should be published to clarify the monitoring and referral requirements for linezolid tablets.

4.18 The number of patients expected to receive linezolid in primary care is small and not expected to present a significant cost burden, however weekly blood monitoring is necessary for patients receiving linezolid and may impact on practice workloads.

Prescribing of Pregabalin for the treatment of Generalised Anxiety Disorder (GAD).

4.19 Pregabalin for the treatment of Generalised Anxiety Disorder was prioritised for review following a request from Lancashire and South Cumbria NHS Foundation Trust.

4.20 The LSCMMG agreed an Amber0 RAG rating (supplied in primary care following recommendation or initiation by a specialist) for pregabalin in GAD as a third line agent. This was conditional on the MLCSU supplementing the recommendation with a prescribing information sheet, definition of the drug's place in therapy and indication of the treatment pathway.

4.21 Due to the 3rd line position of pregabalin in the treatment pathway and the relatively similar cost of pregabalin when compared to standard care (antidepressants drugs), no financial risk was identified.

4.22 It was acknowledged by the LSCMMG that General Practitioners will be expected to use this familiar drug in a new clinical setting. The accompanying prescribing information sheet will support General Practitioners with supply.

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

NICE Technology Appraisals (TA) (February to September 2020)

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

5.2 Five CCG commissioned NICE TAs were identified:

- Sotagliflozin with insulin for treating type 1 diabetes in adults (TA622).
- Avatrombopag for treating thrombocytopenia in people with chronic liver disease needing a planned invasive procedure (TA626).
- Ustekinumab for treating moderately to severely active ulcerative colitis (TA633)
- Patiromer for treating hyperkalaemia in adults (TA623).
- Fremanezumab for preventing migraine (TA631)

5.3 NICE expects the TA guidance for sotagliflozin, avatrombopag and ustekinumab (TA622, TA626 and TA633 respectively) to be either cost saving or to have a minimal impact on resources.

5.4 The guidance in the NICE TAs for patiromer (TA623) and fremanezumab (TA631) is expected to have a significant impact on resources, as both treatments are more costly than the current standard treatments.

5.5 According to NICE costing assumptions to 2023/24, TA guidance for patiromer (TA623) is expected to create a cost burden for CCGs as follows:

Year	Resource impact
2019/20	£16,149
2020/21	£102,742
2021/22	£179,790
2022/23	£288,144
2023/24	£303,310

5.6 Implementing NICE TA631 guidance for the use of fremanezumab in the prevention of migraine is anticipated to result in an annual cost burden of £638,780 to the Lancashire and South Cumbria health economy.

6. Conclusion

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

- *VACOcast Diabetic Boot for the management of foot ulcers in the diabetic population.*
- *Psoriasis: LSCMMG Biologic and High Cost Drug Commissioning Pathway (July 2020 update).*
- *Over the Counter Items that Should not be Routinely Prescribed in Primary Care Policy (July 2020 update).*
- *Rifaximin as second line antibacterial treatment for the treatment of Small Intestinal Bacterial Overgrowth.*
- *Dibotermin alfa for the treatment of acute tibia fractures in adults, as an adjunct to standard care using open fracture reduction and intramedullary unreamed nail fixation AND use outside of the licensed indication for the treatment of non-union long bone fractures.*
- *Request to change RAG status of Linezolid 600mg tablets for up to 14-day treatment of pneumonia and complicated skin and soft tissue infections on the recommendation of a microbiologist.*
- *Haemophilus type b and Meningococcal group C conjugate vaccine – Community Supply to Adults with Respiratory Conditions.*
- *Melatonin prolonged release tablets (Circadin®) for the treatment of Rapid Eye Movement (REM) Sleep Behaviour Disorder (RBD) in Parkinson's Disease and Lewy Body Dementia.*
- *Prescribing of Pregabalin for the treatment of Generalised Anxiety Disorder (GAD).*
- *Oscillating Positive Expiratory Pressure Devices for Non – Cystic Fibrosis Bronchiectasis.*
- *NICE Technology Appraisals (February to September 2020).*

Brent Horrell, Head of Medicines Commissioning,

NHS Midlands and Lancashire CSU

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Title of Paper	JCCCGs LSC Temporary Service Change Assurance Process Briefing		
Date of Meeting	5th November 2020	Agenda Item	8

Lead Author	Emily Kruger			
Contributors				
Purpose of the Report	Please tick as appropriate			
	For Information	X		
	For Discussion			
	For Decision			
Executive Summary	The Joint Committee of CCG members were presented an introduction to the system wide assurance process around temporary service changes that was in development to provide oversight, and escalation across significant temporary service changes made during the continuing covid-19 pandemic.			
Recommendations	The Joint Committee is asked to: • Note the position of the temporary service changes and the processes that are being applied as part of the assurance, and support or restoration.			
Next Steps	• An update on affected temporary service changes will be provided during February 2021			
Is this a level 1 or Level 2 decision?	Level 1		Level 2	
Equality Impact & Risk Assessment Completed	Yes	<u>No</u>	Not Applicable	
Patient and Public Engagement Completed	Yes	<u>No</u>	Not Applicable	
Financial Implications	<u>Yes</u>	No	Not Applicable	
Risk Identified			<u>No</u>	
If Yes : Risk				
Report Authorised by:				

Healthier Lancashire & South Cumbria

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Introduction

During September, the Joint Committee of CCG members were presented an introduction to the system wide assurance process in development around temporary service changes implemented since the start of the covid-19 pandemic. The process has been developed and in operation since May 2020, to provide oversight, assurance, and a point of escalation across the significant temporary service changes on behalf of partners within Lancashire & South Cumbria.

The briefing contains a progress update on the process, the service changes in scope, and further developments. The briefing is provided to offer confidence to members that a robust process is being co-ordinated and applied to temporary service changes, both locally and at a system-wide level, as partners and organisations continue to respond to the ongoing pandemic.

Service Changes In Scope

Current Significant Temporary Service Changes

As at 29th October the services in scope of the system wide assurance process are as follows:

Area	Significant Temporary Service Changes
Bay Health Partnership	UHMB: Temporary closure of Langdale Ward (Step up/down Community ward at WGH, Kendal)
	UHMB: Royal Lancaster Infirmary – Oncology transferred to Westmorland General Hospital.
Central Lancashire	Lancashire Teaching Hospitals – Chorley & South Ribble Hospital A&E Critical Care - transferred to Royal Preston Hospital
LSCFT	Mental Health Urgent Assessment Centre supporting each ED across LSC
	Kentmere Inpatient Unit Closure
Pennine	ELHT has relocated Paediatric outpatient care to Burnley General from Royal Blackburn. Children's outpatients at Royal Blackburn Hospital (RBH) is being utilised as a covid emergency assessment unit. Royal Blackburn children's minor injuries unit remains closed.
West Lancashire	S&O: Ormskirk site – Paediatric A&E overnight closure

Restored Service Changes

Since the introduction to this work, which was presented to the JCCCG in September, it has been possible to restore a number of services which are no longer in scope of the system wide process, and are listed below;

- University Hospitals of Morecambe Bay midwife led births and home birthing services are now restored at the Helm Chase Birthing Centre, Kendal.
- Blackpool Urgent Treatment Centre is now re-located back at Blackpool Victoria Hospital
- LSCFT Electro Convulsive Therapy service provision has been restored to its maximum capacity within the anaesthetic infection prevention control guidelines. This is now considered an operational issue and full-service restoration is being monitored through the phase 3 operational planning, and elective restoration work as agreed with NHSEI.
- Accrington Victoria Hospital - Minor Injuries Unit and Radiology Department are now transferred back from Blackburn Hospital and the service is restored.

Assurance Update

Impact assessments, in addition to local quality and equality impact assessments, are scheduled as a minimum of quarterly for each of the service changes as part of the system wide assurance process. The impact assessments reflect an updated position for the impact that the change has brought about on patients and the public as well as other key aspects including staffing, interdependent services, and finances. Evidence is also required to support the rationale for ongoing changes as well as determine the considerations for restoration, and any associated plans. To date all services have been compliant with the process and impact assessments have been submitted and approved by the Lancashire & South Cumbria Joint-cell members. The next set of impact assessments are due for all temporary service changes by the 20th November 2020, with the exception of the Langdale Ward, that had completed an impact assessment more recently, and was approved on 26th October 2020.

In addition, fortnightly assurance continues with updates provided by each organisation responsible for the service changes. Updates are reviewed and approved by the Lancashire & South Cumbria Cell Executive Leads prior to submission to NHSEI.

Nominated ICP service change leads, who are also supporting the system wide process, are actively monitoring service changes for their area and continue to meet monthly as part of the review processes and ensure that any interdependencies are being managed effectively.

Process

A Standard Operating Procedure (SOP) has been drafted to detail the processes, roles and responsibilities involved with the assurance of the temporary service changes, both at a Lancashire & South Cumbria wide level, as well as outlining how each Integrated Care Partnership are monitoring and reviewing service changes.

The SOP also describes the process for any potential new temporary service change requests, where such requests are escalated and assessed from a system level perspective with regards to any wider implications prior to being approved and operationalised. This is to ensure that mutual aid efforts have been maximised to maintain service continuity for patients and our population.

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Next Steps

- The SOP is due for completion and approval via the Lancashire & South Cumbria Joint-cell and NHSEI during November 2020. A copy will be provided in the next scheduled JCCCG update in February 2021.
- Assurance processes with current, and any new temporary service changes, will continue.
- An update on the system temporary service change process will be provided to the JCCCG during February 2021.

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Title of Paper	JCCCGs Work Programme Update		
Date of Meeting	5th November 2020	Agenda Item	9

Lead Author	Emily Kruger	
Contributors	Andrew Bennett, Executive sponsors	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	x
	For Decision	x
Executive Summary	The Joint Committee agreed a final version of the work programme for 2020/21 at its meeting in March 2020. Each CCG Governing Body subsequently approved the delegations requested for joint decision-making in the JCCCGs. Clearly since that time, the Covid pandemic has caused significant disruption to the activity planned in the majority of the work programmes. Work in some areas has continued albeit with a revised scope, responding to the outcome of formal inspections or linked to restoration activity. In recent weeks, executive sponsors have been asked to reconsider their programmes of work, with a specific request to identify if they require decisions to be made by the Joint Committee of CCGs during the remainder of the financial year. The outcome of this review is attached. Members will therefore note that: • There are no changes to areas 1 and 2 and remain as per the original workplan. • Several areas of work remain effectively paused with no major decisions required of the JCCCGs in 2020/21. • Some programmes have a revised scope and are indicating they will require decisions from the Joint Committee. • One new programme (Health Infrastructure Plan (HIP2) has moved forwards and identified that it wishes to begin formal engagement with the JCCCGs. This is because there is an expectation of a public consultation across Lancashire and South Cumbria to take place in the autumn of 2021. •	
Recommendations	The Joint Committee is asked to: • Note that a review of the work programme for delegated decision-making has now taken place • Comment on the updated programme • Request each CCG's Governing Body to endorse the revised work programme to take effect for the remainder of 2020/21.	
Next Steps	Accountable Officers will be asked to present a revised work programme to each Governing Body before the end of December	

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

	2020.			
Is this a level 1 or Level 2 decision?	Level 1		Level 2	x
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable	
Patient and Public Engagement Completed	Yes	No	Not Applicable	
Financial Implications	Yes	No	Not Applicable	
Risk Identified			No	
If Yes : Risk				
Report Authorised by:	Andrew Bennett			

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

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

Joint Committee of the Lancashire & South Cumbria Clinical Commissioning Groups

2020/21 Work Programme – Revision November 2020 – March 2021

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

Area 2: Commissioning Policies and Standards across Lancashire & South Cumbria				
Service/ Subject	**Executive Sponsor**	**Original Description**	**Key Output**	**Level of Decision making**
Commissioning Policies	Andrew Bennett	Agree updated commissioning policies developed collectively for all CCGs	Policy Documents	Level 1
Medicines Management Policies	Andy Curran	Agree updated medicines management policies developed collectively for all CCGs	Commissioning Policies Commissioning Pathways Ratification of NICE Technology Appraisals	Level 1
Commissioning Standards	Sponsors of specific workstreams recommending standards	Agree key clinical standards to be consistently met across Lancashire & South Cumbria, so that all people receive the highest possible care and best outcomes.	Standards Documentation	Level 1

Area 3: Lancashire & South Cumbria ICS Priority Programmes of work							
Service/ Subject	**Executive Sponsor**	**Original Description**	**Key Output**	**Level of Decision making**	**Update**	**Revised Description**	**Rationale**
SEND	Julie Higgins	Agree partnership improvement programmes linked to SEND inspections. This may involve collaborative work between CCGs and local authorities, including specific delivery of a commissioning plan, evaluation and monitoring system, implementation of the neuro developmental pathway, therapy service review and transition to adult services.	2020/21 Lancashire SEND partnership improvement programmes	Level 2	**No Change**	N/A	
Advancing Integration	Jerry Hawker	Collaborative work between CCGs and Local Authorities in Lancashire and South Cumbria to agree a commissioning strategy and financial strategy for Intermediate Care Services.	Commissioning strategy Finance strategy	Level 2	**Revised 20/21 Workplan**		Executive Sponsorship has been transferred from Julie Higgins to Jerry Hawker and any revisions will be reflected in the workplan once the scope of this work has been agreed
Stroke	Aaron Cummins/ Talib Yaseen	Review and approve Outline Business Case for the optimum configuration of Hyperacute Stroke Units (HASUs)	Outline Business Case Pre-Consultation Business Case	Level 1	**Revised 20/21 Workplan**	Review and approval of the Stroke ambulatory model and associated funding	The programme has been scaled back during 20/21 due to Covid. The programme is currently awaiting prioritisation discussions to take place and therefore

	Commissioner sponsor TBA	Review and approve Pre-consultation Business Case (PCBC) Decide on requirement and readiness to consult with the public on options for HASU configuration Review outcomes of HASU public consultation (if required) Approve full business case Approve commissioning approach and delivery plan	Full Business Case Delivery Plan				decisions for HASU - are postponed to 21/22 More imminently there is approval required of Ambulatory model funding which could potentially be expected during 20/21 and so has been included in the revised description.
Vascular	Karen Partington/ Talib Yaseen Commissioner sponsor TBA	Review and approve Pre-consultation Business Case. Decide on requirement and readiness to consult with the public on options for operating model. Review outcomes of public consultation (if required) Approve full business case Approve commissioning approach and delivery plan	Pre-Consultation Business Case Full Business Case Delivery Plan	Level 1	**Postponed to 21/22**	N/A	The programme has been paused due to the impact of covid therefore postponing any required decisions. Any revisions will be scoped and reflected in the 21/22 workplan

Head & Neck/Oral Maxillo-facial services	Aaron Cummins/ Talib Yaseen Commissioner sponsor TBA	Review and approve Pre-consultation Business Case (PCBC) Decide on requirement and readiness to consult with the public on options for operating model. Approve full business case Approve commissioning approach and delivery plan	Pre-Consultation Business Case Full business case Delivery Plan	Level 1	**Postponed to 21/22**	N/A	The programme has been paused due to the impact of covid therefore postponing any required decisions. Since this time the programme has been transferred under the responsibility of the Cancer Alliance and plans are under review. Any revisions will be scoped and reflected in the 21/22 workplan
Diagnostics – Interventional Radiology, Endoscopy and Endoscopic Ultrasound	Kevin McGee/ Talib Yaseen	Approve case for change to the operating model for interventional radiology services across Lancashire and South Cumbria Review options appraisal for the operating model for interventional radiology services across Lancashire and South Cumbria Approve case for change to the operating model for endoscopic ultrasound (EUS) services across Lancashire and South Cumbria Review options appraisal for the operating model for endoscopic	Case for Change Options appraisal Case for Change Options appraisal Case for change Options appraisal	Level 1	**Postponed to 21/22**	N/A	The programme has been delayed due to the impact of covid therefore postponing any required decisions to 21/22. Since this time the Endoscopy element of the programme has been transferred under the responsibility of the Cancer Alliance and plans are under review. Any revisions will be scoped and reflected in the 21/22 workplan through the Cancer Alliance updates

		ultrasound (EUS) services across Lancashire and South Cumbria Approve case for change to the operating model for endoscopy services across Lancashire and South Cumbria Review options appraisal for the operating model for endoscopy services across Lancashire and South Cumbria					
Adult Mental Health	Peter Tinson	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in March 2020 for implementation from April 2020. Model will describe governance arrangements, including JCCCG responsibilities. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process.	Operating Model and Financial Framework Operational Plan	Level 1	**Revised Workplan for 20/21**	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in March 2020 for implementation from April 2020. Model will describe governance arrangements, including JCCCG responsibilities. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process.	The schedule has been updated to reflect any updates being presented to the JCCCG up to March 21. Any confirmed updates are provided within the schedule section of the report.

						To receive updates against the approved winter pressures bid.	
Children's Mental Health	Peter Tinson	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in April 2020 for implementation from May 2020. Model will describe governance arrangements, including JCCCG responsibilities. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process. Approve the annual refresh of the CYPEWMH Local Transformation Plan Approve the end of year position for 2019/20 and the financial allocations for 2020/21 as detailed within the annual CYPEWMH Business Plan Approve the Clinical model for CYP Mental Health services across Lancashire and South Cumbria	Operating Model and Financial Framework Operational Plan Transformation Plan 2020/21 Business Plan 2020/21 Clinical Model Transition and Implementation Plan Financial Modelling Template	Level 1	**Revised Workplan for 20/21**	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in April 2020 for implementation from May 2020. Model will describe governance arrangements, including JCCCG responsibilities. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process. Review and approve the National KLOE responses. Approve the end of year position for 2019/20 and the financial allocations for 2020/21 as detailed within the annual CYPEWMH Business Plan Approve the Clinical model for CYP Mental Health services	All decisions and updates relating to the original workplan description are required with the exception of the annual transformation plan which has been replaced by National KLOEs. This has been updated within the revised workplan and will be reported on in the new year if deemed appropriate

		Approve transition and implementation plan for the Clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve the Financial Modelling Template to underpin the Clinical model for CYP Mental Health services across Lancashire and South Cumbria				across Lancashire and South Cumbria Approve transition and implementation plan for the Clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve the Financial Modelling Template to underpin the Clinical model for CYP Mental Health services across Lancashire and South Cumbria	
Learning Disabilities and Autism	Peter Tinson	Responsibility for all commissioning functions in accordance with the agreed operating model and financial framework. Model and framework to be agreed in May 2020 for implementation from June 2020. Model will describe governance arrangements, including JCCCG commissioning. Responsibility for agreement of annual operational plan (including finance), typically in January/February each year as part of a wider collaborative commissioning planning process.	Operating Model and Financial Framework Operational Plan	Level 1	**No Change**	N/A	N/A
Ambulance Commissioning – Paramedic	David Bonson	Responsibility for all commissioning functions in accordance with the agreed	Operating Model, Finance	Level 1	**Revised Workplan for 20/21**	Responsibility for all commissioning functions in accordance with the agreed	The approval of the future operating model across 999, NHS 111 and PTS services which will

emergency service (PES). NHS 111 and Patient Transport Services (PTS)		North West Collaborative Governance Arrangements. Approve integrated future operating model across 999, NHS 111 and PTS services which will include a collective financial and contractual framework for Lancashire and South Cumbria (to be mobilised by April 2021) Agree strategic direction for Patient Transport Services across Lancashire and South Cumbria	and Contractual Framework Strategic Plan Procurement Plan			North West Collaborative Governance Arrangements. Agree strategic direction for Patient Transport Services across Lancashire and South Cumbria	include a collective financial and contractual framework for Lancashire and South Cumbria has been delayed due to covid pressures and the implementation of 111 first. This is now expected by September 21 and will form part of the 21/22 workplan.
Cancer	Denis Gizzi	Agree recommendations for commissioners which arise from the Cancer Transformation Programme.	Report and Recommendations	Level 1	**Postponed to 21/22**	N/A	Due to the impact of covid the Cancer transformation programme has paused in order to prioritise Cancer activity and restoration work. The Cancer Transformation programme and the Target Operating Model proposed (shared and agreed at JCCCG) is a significant undertaking, requiring collaboration between providers and clinical teams. The work will resume as soon as pandemic crisis dissipates and risk is deemed to be at a manageable level.

Planned Care	Andrew Harrison	Agree prioritised list of pathways and timeline for development of outcome based consistent clinical pathways across Lancashire & South Cumbria	Clinical Pathways	Level 1	**No Change**	N/A	The planned care work is deemed a priority to support Covid restoration work and compliments the Elective Care Recovery Group that has recently been established. An update report will be provided regarding any specific pathways .
Falls Lifting Service	Louise Taylor (Executive Director – LCC)	Receive recommendations for further opportunities for joint commissioning of this service.	Report and recommendations	Level 2	**Postponed to 21/22**		Existing contracts have been extended due to Covid. The earliest to restart this is April 2021
Telecare	Louise Taylor (Executive Director – LCC)	Review recommendations for further opportunities for joint commissioning of these services.	Report and recommendations	Level 2	**Postponed to 21/22**		Existing contracts have been extended due to Covid. The earliest to restart this is April 2021
Health Infrastructure Plan (HIP2)	Talib Yaseen Rebecca Malin	Receive reports and recommendations for commissioners arising from the planning process to respond to this national initiative	Report and recommendations	Level 1	**Revised Workplan for 20/21**	Receive reports and recommendations for commissioners arising from the planning process to respond to this national initiative To discuss and agree the arrangements for consultation, which is planned to commence in Oct 21. Including where responsibility for leading the work is held, and how this is undertaken.	As timelines are starting to be confirmed, as part of the planning work, there is a clear ask to support and organise the consultation relating to HIP2 which has been included as part of the revised workplan.

Digital Health	Gary Raphael	Recommendations which support: a) the commissioning of services from providers who are willing to collaborate towards a single electronic patient record across Lancashire and South Cumbria. b) The commissioning of services from providers who adopt a "digital first" approach to service design and delivery	Report and recommendations	Level 2	**Revised Workplan for 20/21**	Recommendations which support: a) the commissioning of services from providers who are willing to collaborate towards a single electronic patient record across Lancashire and South Cumbria. b) The commissioning of services from providers who adopt a "digital first" approach to service design and delivery c) The commissioning of services from providers who are committed to sharing information to support direct care and population health management.	Leads have included an update in addition to the workplan for 20/21 to receive recommendations to support the commissioning of services from providers who are committed to sharing information to support direct care and population health management.

Area 4: Commissioning Leadership in developing new ways of working as set-out in the NHS Plan							
Service/ Subject	**Executive Sponsor**	**Original Description**	**Key Output**	**Level of Decision making**	**Update**	**Revised Description**	**Rationale**
Commissioning reform	Andrew Bennett	Oversight of Commissioning reform process based on agreed roadmap (via Commissioning Reform Group)	Progress reports Proposed CCG constitution	Level 2	**Revised Workplan for 20/21**	Oversight and progress reports of Commissioning reform process based on agreed roadmap (via Commissioning Reform Group)	Progress reports will continue in 20/21 . A new constitution will not be produced until 21/22
Commissioning reform	Andrew Bennett	Following engagement process with member practices and partner organisations, progress proposals to establish a single CCG and five locality commissioning teams across LSC. This is subject to a vote of member practices to take place in May 2020.	CCG merger submission to NHS England/Improvement Due Diligence Plans required by NHS England and CCGs as part of an agreed transition process.	Level 2	**Revised Workplan for 20/21**	Following engagement process with member practices and partner organisations, progress proposals to establish a single CCG and five locality commissioning teams across LSC. A formal set of recommendations on governance and leadership as per the system reform plan	There have been delays to merger discussions as a result of covid. There is likely to be formal recommendations on governance and leadership to be proposed by 31st March 2021, as per the system reform plan which has been reflected in the revised workplan. A vote for member practices is delayed and due to take place in June 2021.
Transformation Funding	Gary Raphael	Opportunity to develop proposals for risk/gain share arrangements for the use of local transformation funding as part of financial strategy development.	Risk/gain share proposals	Level 2	**No Longer Required**		Actions relating to the transformation funding have been subsumed into the phase 3 planning process for 20/21, and therefore there is no decision required via the JCCCG.

Decision Making Authority Level Definition:

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

JCCCG Revised Workplan Schedule: Nov 20 – Mar 21

The table below presents the planned schedule based upon the areas of the JCCCG workplan confirmed from November 20 to March 2021. Please note that this schedule is subject to change and any updates will be reflected in the relevant months meeting agenda.

Service/ Subject	Executive Sponsor	Product	Month Expected *indicative
Children's Mental Health	Peter Tinson	CAMHS redesign operating model	November 20
Medicines Management	Andy Curran	Medicines Management policy recommendations and update paper	November 20
HIP2	Talib Yaseen / Rebecca Malin	Introductory Presentation	December 20
Mental Health	Peter Tinson	Mental health governance paper proposal Update paper on major service areas required, including rehab and winter pressures bids, national KLOEs.	January 21
Ambulance Commissioning – Paramedic emergency service (PES). NHS 111 and Patient Transport Services (PTS)	David Bonson	Update paper, including 111 first progress report.	January 21
Planned Care	Andrew Harrison	Progress update report on priority pathways	January 21
Digital	Gary Raphael / Declan Hadley	Update paper including and recommendations based upon the JCCCG workplan	February 21
Stroke	Aaron Cummins	Ambulatory model funding proposal	March 21*

Joint Committee of CCGs
5th November 2020

Title of Paper	**Report from the Commissioning Reform Group**		
Date of Meeting	5th November 2020	Agenda Item	10

Lead Author	Dawn Haworth			
Contributors	Andrew Bennett			
Purpose of the Report	Please tick as appropriate			
	For Information	x		
	For Discussion	x		
	For Decision			
Executive Summary	The purpose of this report is to provide the Joint Committee of CCGs with an update of the business discussed by the Commissioning Reform Group during its meetings in September and October 2020.			
Recommendations	The Joint Committee of CCGs is asked to: 1. Note this report from the Commissioning Reform Group 2. Note the further actions which will now be undertaken with oversight from the Commissioning Reform Group			
Next Steps	CRG meets to review progress on the actions set out in this paper on 10th November 2020.			
Is this a level 1 or Level 2 decision?	Level 1		Level 2	x
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable	
Patient and Public Engagement Completed	Yes	No	Not Applicable	
Financial Implications	Yes	No	Not Applicable	
Risk Identified			No	
If Yes : Risk				
Report Authorised by:	Andrew Bennett			

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endorsements and recommendations to the governing bodies of each member CCG, and other decision making bodies.

Joint Committee of CCGs
5th November 2020

Joint Committee of CCGs
Thursday 5th November 2020

Report from the Commissioning Reform Group

Introduction

The purpose of this report is to provide the Joint Committee of CCGs with an update of the business discussed by the Commissioning Reform Group (CRG) during its meetings in September and October 2020. The report follows a previous update on the work of the CRG presented to the Joint Committee in September. This report asks the Joint Committee to note the work of the group and the further actions which will now be undertaken with oversight from the Commissioning Reform Group.

Commissioning Reform Group

The CRG's purpose is to agree and oversee the implementation of a road map for commissioning reform in Lancashire and South Cumbria. The meeting is attended by Executive leads and Clinical/Lay representatives from each CCG, CSU Directors, ICS Leads and the locality Director of NHSEI.

Meetings of the CRG have been held on the 8th September and 13th October. The main areas of business to date are summarised below:

1. Consolidated Quality and Performance Report

Discussions between CCG Executives and CSU Directors, facilitated by the Chief Nurse for NHSEI in Lancashire and South Cumbria, and a subsequent workshop session with relevant system leaders identified opportunities to streamline existing quality and performance reports used by CCGs. This would reduce duplication and release management capacity, particularly in Business Intelligence functions, which could be directed towards new priorities.

CRG agreed that a paper recommending the development of a single consolidated Quality and Performance report for the Lancashire and South Cumbria system should be presented to Joint Committee. This is included as part of the agenda of the Joint Committee.

2. ICP development in the context of wider system reform

A task and finish group has been established in September to develop an agreed core strategic narrative supporting for the development of ICPs across Lancashire and South Cumbria. The task and finish group is chaired by Dr Geoff Jolliffe, (Chair Morecambe Bay CCG) and contains Executive representatives from across the ICS partners. The group is supporting the work of the ICP Programme Directors to develop a common narrative and timeline for the further development of Integrated Care Partnerships (ICP) across Lancashire and South Cumbria.

The CRG has received updates from ICP Programme Directors at its meetings in September and October. A final version of the narrative and timeline was endorsed by the ICS System Leaders' Executive on 21st October and presented to the ICS Board for endorsement on the 4th November 2020.

Further discussions will now take place with system leaders to agree the development priorities for ICPs which can be progressed jointly between now and the end of March 2021.

3. System Reform

The CRG received the Lancashire and South Cumbria System Reform Plan (SRP) which was submitted to the NHSEI Regional Director on 2nd October. The Plan responds to the national Phase 3 planning guidance published on 31st July 2020 and sets out the next phase of system reform in the Lancashire and South Cumbria Integrated Care System. CRG noted that the Phase 4 guidance is expected to provide additional clarity to a range of issues in the SRP including the role of the Strategic Commissioner.

At the time of writing, feedback on the System Reform Plan is awaited from the Regional Director.

CRG agreed a number of key workstreams and associated Executive Sponsors for commissioning reform. The following actions were also agreed:

- Revise and simplify the previously developed case for change
- Confirm a high-level timeline which identifies the key actions and decision points
- Ensure that involvement of member practices is reflected within the timeline
- Commence discussions relating to a single constitution and governance
- Support further discussions between CCG Chairs and the Regional Director about the process to establish a single Executive team working across the 8 CCGs.
- Develop a Communications and Engagement Plan

4. Primary Care Commissioning

The CRG received a presentation regarding Primary Care Commissioning including decision making, collaborative priorities, COVID operational responses, delegated commissioning and proposed future commissioning arrangements. Further discussions are planned.

Recommendations

The Joint Committee of CCGs is asked to:

1. Note this report from the Commissioning Reform Group

2. Note the further actions which will now be undertaken with oversight from the Commissioning Reform Group

Andrew Bennett **Executive Director of Commissioning**

30th October 2020

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Title of Paper	LSC Single Quality & Performance Report		
Date of Meeting	5 November 2020	Agenda Item	11

Lead Author	Linda Riley			
Contributors	Helen Curtis; Kathryn Lord			
Purpose of the Report	Please tick as appropriate			
	For Information	√		
	For Discussion	√		
	For Decision	√		
Executive Summary	There is a requirement to develop a single, consolidated quality and performance report for Lancashire and South Cumbria. This report outlines progress to date and lists a set of recommendations the JCCCG are asked to consider enabling development of the required report.			
Recommendations	Outlined in section 3 of this report			
Next Steps				
Is this a level 1 or Level 2 decision?	Level 1		Level 2	√
Equality Impact & Risk Assessment Completed	~~Yes~~	~~No~~	Not Applicable	
Patient and Public Engagement Completed	~~Yes~~	~~No~~	Not Applicable	
Financial Implications	~~Yes~~	~~No~~	Not Applicable	
Risk Identified	~~Yes~~		No	
If Yes : Risk				
Report Authorised by:	Commissioning Reform Group			

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Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Proposal to move to a single quality and performance report for LSC

1. Introduction

1.1 LSC CRG requested that the CSU work with key CCG leads and assess how we can support the wider system to provide a consolidated Quality and Performance (Q+P) report to be delivered at ICS level, with the ability to interrogate further at ICP, CCG or PCN levels.

1.2 This approach is supporting the wider commissioning system reform agenda looking to both consolidate systems and processes and deliver business requirements 'at scale' where most appropriate. However, this is likely to progress and encompass wider than just commissioning going forward. It needs to also take account of current system working and how this feeds any future consolidated reporting, e.g. The QSG. To do this requires further work and for this to be phased in coming months as the commissioning reform agenda progresses.

2. Current Status

2.1 To date, there is a suite of system reporting dashboards of key metrics and indicators.

There is consensus that this single Q+P reporting for LSC requires further work to ensure:

- All relevant, detailed understanding is reflected in the accompanying narrative as this is essential and should be included at all levels
- An agreement as to how that narrative is secured and reflected at which levels (ICS/ICP/PCN) and ownership for resolution of issues remains local where needed
- Needs agreement as to how this is best done given the value of including local 'soft intelligence' to inform activities and reporting
- The ability to ensure emerging metrics and requirements employ an agreed systematic and standardised approach
- To develop and implement an agreed robust Standard operating process (SOP) to support this
- There is support and input from both 'lay members' and clinical membership leads from across present CCG community

2.2 The Q+P report is dynamic and the ability to report and drill down at all levels is one important facet However, this is also about ensuring it supports performance and service improvement going forward at all levels, albeit with the added ability of benchmarking and comparative information, eg. across each ICP. As referenced, it also needs further work to understand the system accountability infrastructure and ensure we do not lose the work reported to QSG.

Healthier Lancashire & South Cumbria

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

2.3 There have been several workshops and discussions across the system involving CCG/CSU and NHSEI colleagues with agreement secured to:

- Move at pace to deliver a single Q+P report to JCCCG at ICS level via a standard report
- Ensure this is dynamic and interactive (as well as ability to produce a static report)
- Acknowledge the work done has progressed standardisation of reporting metrics given the significant variation across naming conventions from individual CCG reports.
- Ensure any future ability to provide reports can be done at all levels; ICS, ICP, CCG and PCNs.
- The need to have an agreed Standard operating procedure in place to enable additionality of new, emerging, changing metrics as this is not a static

2.4 Whilst this has had engagement and direct involvement from key system leads, we believe that further work and involvement is needed with our clinical community and to secure lay member input to this process and final outputs.

2.5 However, a key factor in progressing this work, is not to just reduce administration or release resource, it creates a real opportunity to use as an enabler as a system to focus on performance and service improvement leveraging any comparative analysis and activities to focus in key areas and improve care for the benefit of the LSC patient population served.

2.6 There is an established task and finish group due to meet further to undertake the following:

- Review the revised list of o/s metrics and agree final current cohort
- CSU will pull together a Standard Operating Procedure (SOP) to be agreed by the group outlining the process in respect of metric data sourcing, flow and production and share with the group so that everyone is clear how it will work
- The LSC Quality Surveillance Dataset to be shared with the group members to identify any further Quality metrics needed to be brought into the single solution
- To ascertain how the ICS Executive / JCCCG wants to receive and consume the Q+P reporting and from when
- To confirm how CCGs want to receive and consume the Q+P reporting (ie. static or interactive) and from when
- To agree who will add the Subject Matter Expertise narrative - this needs an agreed structure otherwise narrative may be uninformed/contradicted

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

3. **Recommendations**

3.1 The JCCCG are asked to support the following recommendations:

I. to endorse the use of one consolidated Q+P report to the JCCCG covering the whole LSC ICS (all 8 CCGs) with a finalised timeframe to be agreed by 30 November 2020 detailing key milestones

II. To secure a CCG senior lead to work on behalf of the system as key decision maker and work with the CSU to co-produce an implementation plan including involvement of key stakeholders

III. For that CCG senior lead to present the consolidated Q&P report to the JCCCG

IV. To support the ongoing development in a phased and realistic way.

Linda Riley
2/11/20

Item 12

Commissioning Reform Group (CRG)
Tuesday 8 September 2020, 10.00am-12.00noon
MS Teams

MEETING NOTES

Attendees: Roy Fisher (chair), Andrew Bennett, David Bonson, Carl Ashworth, Dawn Haworth, Cath Owen, Clare Thomason, Helen Curtis, Vicki Ellarby, Neil Greaves, Jim Hacking, Jerry Hawker, Jane Cass, Paul Kingan, Linda Riley, Gary Raphael, Claire Richardson, Paul Richardson, Richard Robinson, Sarah Sheppard, Doug Soper.

Apologies: Amanda Doyle, Julie Higgins, Linda Chivers, Graham Burgess.

Item	Notes
1.	**Introduction and apologies** Apologies noted as above D Haworth to add 'Declarations of Interest' to future agendas. Colleagues who stated they are employed by CCGs declared a financial interest in matters discussed at this meeting under item 6.
2.	**Action Notes 11.08.20** **Actions:** • Item 8, paragraph 1 "in the event of organisational changes" to be deleted (D Haworth) Notes agreed as accurate with the above amendment.
3.	**Action Log update** Noted most actions are on today's agenda. Updated the following actions: CRG 7: Clinical Executive Sponsor – A Bennett to ask Geoff Joliffe to undertake this role CRG 9: Primary Care Commissioning Report – A Bennett to ask Peter Tinson to include in his paper where decisions will be made.
4.	**Feedback from ICS Board 02.09.20 and JCCCGs 03.09.20** Noted papers circulated with agenda and that JCCCGs supported the five recommendations about system reform. NHSEI Regional Director has requested an implementation plan for system reform by end September. Agreed the need to • ensure there are sensitive and consistent messages to staff • build on progress made previously, prior to pandemic **Actions:** • Communications to be added as standing item to CRG agenda (D Haworth) • N Greaves to produce messages for staff/system following each CRG meeting, in liaison with ICP communications leads

5.	**Draft System reform timetable to include:** • **Commissioning reform workstreams** • **Updated timeline and stages** Members discussed the draft diagram shared with agenda. Agreed the need to • Confirm timeframe and dependencies between ICP development and move to single CCG • Clarify whether there is a difference between a single CCG and the ICS • Confirm relationship with Cell structure and wider ICS architecture • Reflect Local Government reform • Build on this for NHSEI Region submission at end September • Take final system reform implementation plan through CCG Governing Bodies and Execs • Develop project plans for workstreams underpinned by distributed leadership **Actions:** • ICP Programme Directors to o work up minimum requirements for each of the three phases o consider how to illustrate critical interdependencies between the three elements: commissioning reform, ICP development and provider collaboration o work with A Bennett to support development of strategic narrative and timeline in line with feedback, for submission to NHSEI Region by end September 2020 • A Bennett and A Doyle to discuss with AOs identifying workstream leads for commissioning reform
6.	**Draft HR Guidance** Members discussed the draft guidance circulated with agenda. Recognition of tight timeframe and need to support staff through the process. Agreed the need to • Clarify whether the process is to appoint single AO and Exec team for new single CCG rather than to lead existing eight CCGs • Confirm NHSEI position regarding ringfencing and ensure consistency • Clarify employing authority and liability • Consider implications for direct reports to Exec Team and also wider partners such as CSU and NHSEI • Recognise that challenges for staff of forthcoming of Winter period are likely to be compounded by management of change process • Confirm CCG Governing Bodies are committed to process **Actions:** • J Cass and S Sheppard to discuss and agree arrangements for connection with NHSEI Region Team • S Sheppard to produce a further iteration of the document based on feedback today and following the meeting and circulate by 14.09.20 • CCG AOs to take final paper through Governing Bodies to seek endorsement for process

7.	**Update on progress with ICP development proposals** K Kyle provided an update on the work of the IPC Programme Directors. Next steps, in light of feedback from JCCCGs and ICS Board: • Further work on strategic narrative over next 2 weeks • Establish ICP Development Advisory Group • Work with NHSEI team re development of Partnership Agreement, governance arrangements including LA and VCFSE, place-based distributed leadership model, performance management and assurance, workforce and OD. • All ICP Programme Directors have taken proposals, shared previously at CRG, to respective ICPs and are collating feedback
8.	**Performance and Quality Report Workshop** Noted workshop scheduled for 18th September. Agenda currently being finalised. **Actions:** • Workshop focus to be broadened to include both quality and performance and to include additional invitees including lay members and clinical leads (L Riley)
9.	**Any other business** D Soper asked for clarity regarding where decisions will be made in future, citing the example of Stroke Reconfiguration and asking about the role of the provider collaborative in decision making. **Action:** Examples regarding future decision making to be developed by A Bennett by end October.
Date and time of next meeting: Tuesday 13th October 2020 10am-12noon	