Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs)

Thursday 01 November 2018, 13:00-15:00

NHS Morecambe Bay CCG (Lecture Theatre)

Moor Lane Mills, Moor Lane, Lancaster, LA1 1QD

Agenda

Time	Item	Item	Owner	Action	Format
Standing Items					
13:00	1.	Welcome and introductions	Chair	Information	Verbal
	2.	Apologies	Chair	Information	Verbal
	3.	Declarations of interests	Chair	Information	Verbal
	4.	Minutes of the meeting held on the 04 October 2018	Chair	Approval	Attached
	5.	Action matrix	Chair	Information	Attached
	6.	Items for any other business	Chair	Information	Verbal
Improving Population Health					
13:15	7.	Commissioning policies: a) Policy for spinal injections and radio frequency denervation for low back pain b) Policy for Assisted Conception Services	E Johnstone	Approval	To follow
14:00	8.	Stroke update	G Stanion C Kindness-Cartwright	Information	Attached
Developing a Joined-up Health and Care System					
14:10	9.	Special Educational Needs and Disabilities (SEND) partnership work	M Youlton	Information	Attached
14:20	10.	Commissioning Development	A Bennett	Information	Attached
14:40	11.	Any other business	Chair	Information	Verbal
Date and time of next meeting: 06 December 2018 (workshop), 13:00-15:00, Preston Business Centre (Room 231), PR2 8DY					

Please send apologies to Gaynor Jones gaynor.jones8@nhs.net

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

Joint Committee of the Clinical Commissioning Groups (JCCCGs)

DRAFT notes of the Joint Committee of Clinical Commissioning Groups (JCCCGs)
Thursday 04 October 2018 13:00-16:00
South Ribble Borough Council, Civic Centre, West Paddock, Leyland, Lancashire, PR25 1DH

Phil Watson (Chair)	Independent Chair	JCCCGs	Attended
Voting Members (one vote per CCG)			
Penny Morris	Chief Clinical Officer	Blackburn with Darwen CCG	Attended
Graham Burgess	Chair	Blackburn with Darwen CCG	Attended
David Bonson	Chief Operating Officer	Blackpool CCG	Attended
Roy Fisher	Chair	Blackpool CCG	Attended
Dr Richard Robinson	Chair	East Lancashire CCG	Attended
Geoffrey O'Donoghue	Lay Member	Chorley South Ribble CCG	Attended
Gora Bangi	Chair	Chorley South Ribble CCG	Attended
Mark Youlton	Chief Officer	East Lancashire CCG	Attended
Jerry Hawker	Chief Officer	Morecambe Bay CCG	Attended
Dr Adam Janjua	GP and Vice Chair	Fylde and Wyre CCG	Attended
Mary Dowling	Chair	Fylde and Wyre CCG	Attended
Debbie Corcoran	Lay Member	Greater Preston CCG	Attended
Sumantra Mukerji	Chair	Greater Preston CCG	Attended
Clive Unitt	Lay Member	Morecambe Bay CCG	Attended
Doug Soper	Lay Member	West Lancashire CCG	Attended
In attendance			
Andrew Bennett	Executive Lead Commissioning (ICS)	Healthier Lancashire and South Cumbria	Attended
Denis Gizzi	Chief Officer	Chorley and South Ribble and Greater Preston CCG	Attended
Lawrence Conway	Chief Executive	South Lakeland District Council representing also Barrow and Lancaster City Councils	Attended
Elaine Johnstone (Item 6)	Chair, Commissioning Policy and Implementation Group	Midlands and Lancashire Commissioning Support Unit (M&L CSU)	Attended
Rebecca Higgs (Item 6)	IFR Policy Development Manager	Midlands and Lancashire Commissioning Support Unit	Attended
Harry Catherall	Chief Executive	Blackburn with Darwen Borough Council	Attended
Marcus Safadi	Staff and Engagement Lead	Healthier Lancashire and South Cumbria	Attended
Amanda Doyle	Chief Officer	Healthier Lancashire and South Cumbria	Attended
Andy Curran	Medical Director	Healthier Lancashire and South Cumbria	Attended
Carl Ashworth	Strategy and Policy Director	Healthier Lancashire and South Cumbria	Attended
Gary Raphael	Finance Director	Healthier Lancashire and South Cumbria	Attended
Mitchell Gadd	Freshwater	Healthier Lancashire and South Cumbria	Attended
Neil Greaves	Communications and Engagement Lead	Healthier Lancashire and South Cumbria	Attended
Gaynor Jones	Executive Assistant	Healthier Lancashire and South Cumbria	Attended
Apologies			
Jane Cass	Locality Director	Healthier Lancashire and South Cumbria	
Paul Kingan	Chief Finance Officer	West Lancashire CCG	
Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG	
Katherine Fairclough	Chief Executive	Cumbria County Council	
Sir Bill Taylor	Chair	Healthwatch Blackburn with Darwen	
Dean Langton	Chief Executive	Pendle Borough Council	
Allan Oldfield	Chief Executive	Fylde Borough Council	
Angie Ridgwell	Interim Chief Executive	Lancashire County Council	
Louise Taylor	Executive Director of Transformation	Lancashire County Council	

A.	Standing Items	Action
1	**Welcome and Introductions** The Chair explained the new meeting arrangements that had been put in place following comments from the last meeting. The Chair stated that this is a joint business meeting of the Clinical Commissioning Groups (CCGs) held in public. The Chair confirmed that together with Andrew Bennett, a pre-meeting had taken place with members of the public to introduce the agenda and to take questions about this. The Chair informed members that a question and answer session would also take place at the end of the meeting relating to the items on the agenda only. Any questions raised that cannot be dealt with in the time available, would be responded to outside of the meeting. The Chair welcomed members to the meeting and introductions were made.	
2	**Apologies** Apologies were noted and listed above. The Chair informed the committee that the meeting was being recorded and would be available on YouTube after the meeting.	
3	**Declarations of Interest** The Chair reminded members present that if during the course of the meeting a conflict of interest subsequently became apparent, it should be declared at that point. Gora Bangi declared an interest as a GP provider. G O'Donoghue subsequently declared an interest in Item 6e, policy on commissioning for glucose monitoring.	
4	**Minutes from previous meetings for ratification** 4a Minutes of the public meeting held on 05 July 2018. The minutes were agreed as an accurate record. The Chair thanked Mary Dowling and A Bennett for their input in reviewing the minutes. 4b Minutes of the public meeting held on 07 June 2018. The minutes required a minor amendment. Dr Tony Naughton was in attendance and had not sent apologies. **RESOLVED**: The Committee agreed the minutes subject to the minor amendment to the June minutes.	
5	**Action Matrix review** The item on mental health prevention was to be discussed at a later date.	
B.	**Improving Population Health**	
6	**Commissioning Policies** Elaine Johnstone introduced the item and explained the context on the work of the Commissioning Policy Development and Implementation Group (CPDIG). The Group was established to enable the eight CCGs to address areas where commissioning policies were required to ensure the most evidence-based and effective use of NHS resource equitably across the whole of Lancashire and South Cumbria (L&SC). A briefing paper outlined the process used by the CPDIG to develop and review policies including comprehensive and robust evidence reviews, clinical involvement, public engagement and equality and impact assessments. The outcomes of this process were reviewed by the CPDIG in order to make recommendations on each of the policies. E Johnstone stated that the first page of each policy noted the changes made and informed members that all the policies had the ability for an individual case to be considered as an exception to a policy, through the individual funding request process. **a)** ***Policy for photorefractive surgery for the correction of refractive error*** The CPDIG had reviewed the clinical evidence for any changes. The CPDIG concluded that this is not an intervention that is an appropriate use of NHS resources and the rationale for this was explained. E Johnstone asked the	

Committee if they were willing to ratify the policy.

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

S Mukerji requested clarity on the process of the public and patient engagement.
E Johnstone informed members that a tiered approach to public engagement had taken place on the basis of whether it was a new or existing policy with proposed changes. This engagement was carried out through CCGs' websites and online surveys. E Johnstone pointed out that this was an existing policy with no substantive changes made to it.

RESOLVED: that the Committee agreed the policy.

b) ***Excision of Uterus for the management of heavy menstrual bleeding***
E Johnstone advised that this policy had existed in individual CCGs, was consistent in approach and had now reached its review date.
E Johnstone added that the updated National Institute for Health and Care Excellence (NICE) clinical guidelines had been published during the lifetime of this policy and those guidelines had been applied in the policy review. Neither consultation with clinicians or the public nor the equality impact assessment had led to any proposals to change the policy. E Johnstone asked if the Committee was willing to ratify the policy.

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

Dr A Janjua informed members that he would have liked to have seen alternative medical treatments being attempted first. E Johnstone accepted Dr Janjua's comment and advised members that legal advice had been taken regarding this issue and the advice was that the wording was not to differ from the extant NICE Guidelines.

P Morris questioned the reason why the review date had not been included on the policies. R Higgs informed members that the review date would be inserted post ratification of all the policies. If new NICE Guidance was issued during the period or if there was a major piece of clinical evidence on effectiveness or safety of any of the intervention, this would prompt an earlier review.

RESOLVED that the Committee agreed the policy.

c) ***Policy for managing lower back pain – spinal injections and radiofrequency denervation***
E Johnstone informed members that this policy had begun life in Pennine Lancashire (East Lancashire and Blackburn with Darwen CCGs). Once Lancashire-wide arrangements had been established this was recognised as an area which would benefit from a Lancashire-wide policy. Managing back pain is a common issue across the whole of L&SC and while there were policies in existence elsewhere, they varied in scope and access criteria.

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

J Hawker, S Mukerji and M Dowling sought clarity about aspects of the policy.

A Bennett stated that in light of these comments it would be appropriate to make further clarifications and bring the document back for ratification at the November meeting. The Committee agreed to this.

Action: E Johnstone/R Higgs

RESOLVED: that the Committee was to receive the re-drafted policy in November.

d) ***Policy for the management of otitis media with effusion (OME) using grommets***

E Johnstone explained that existing CCG policies were in force which had reached their review dates and they were consistent across Lancashire. An evidence review had again been undertaken followed by clinical and public consultation and an equality impact assessment none of which led to proposals to change the access criteria in the policy. Therefore the policy was unchanged and in line with extant NICE guidelines.

RESOLVED: that the Committee agreed the policy.

e) ***Policy for the provision of Insulin Pump Devices***
E Johnstone informed members that this policy had been the subject of a mandatory piece of NICE Guidance called 'Technology Appraisal 151' originally published in 2008. E Johnstone informed members that the policy was entirely in line with the conditions in the NICE guidance.

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

M Dowling commented that section 1.1 seemed to be out of place in the document
R Higgs informed members that section 1.1 was meant to be read in conjunction with section 1.2.

RESOLVED: that the Committee agreed the policy.

f) Policy for the provision of Continuous Glucose Monitoring (CGM) and Flash Glucose Monitoring devices
G O'Donoghue declared a personal interest in this item. The Chair agreed that G O'Donoghue could remain in the room but could not take part in the discussions.

E Johnstone informed members that the context of this policy was more complex than the others presented. The overall intent of the policy was to give a single clear position on access to both types of glucose monitoring device to address existing variation in patient access to CGM devices across L&SC and enable the provision of access to new technology - Flash Glucose Monitoring devices for the first time. The recommendation in the draft policy was aimed at allowing those patients who are most likely to benefit, based on the current evidence, to access a device and to be consistent about all the devices across L&SC.

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

Dr A Janjua thought that the policy could have cost ramifications for the health economy and raised concerns about the clinical response to patients with a fear of hyperglycaemia. E Johnstone provided assurance that the expectation of the policy was that these devices would be initiated and continuously managed through Specialist Services and one route as a GP would be to request Specialist Services to review the specific needs of an individual patient.

J Hawker requested that a review of patient outcomes and financial implications of the policy should take place much earlier than the three-year life of the policy.
E Johnstone confirmed to members that the CPDIG will monitor the policy impact.

G Bangi requested clarification if the clinical scrutiny was in line with best practice and NICE Guidance. E Johnstone informed members that continuous glucose monitoring was aligned to NICE clinical guidelines. Flash glucose monitoring did not have NICE clinical guidelines at the present time.

RESOLVED: that the Committee agreed the policy

Dr A Doyle added that it was vital to standardise some of the policies as new products are constantly being provided that can benefit patients and therefore worthy of investment. Dr Doyle informed members that there is work going on nationally around the clinical effectiveness of interventions and we may find that we need to

	bring policies back for review to align with the national standards and some policies are going to be affected by ongoing consultation. E Johnstone confirmed that the current national proposals in the consultation were in line with our policies. A Bennett thanked E Johnstone and R Higgs for their detailed work and reiterated the five ratified policies: • Commissioning photorefractive surgery for the correction of refractive error • Excision of the Uterus for the management of heavy menstrual bleeding • The management of otitis media with effusion (OME) using grommets • The supply and funding of Insulin Pumps for patients with diabetes mellitus • The provision of continuous glucose monitoring and flash glucose monitoring to patients with diabetes mellitus It was agreed that one policy (*policy for managing lower back pain - spinal injections and radiofrequency denervation*) was to come back to the November meeting following further drafting and clarification.	
7	**Consultation Framework** G Raphael presented the final draft of the Engagement and Consultation Framework which had been created to support the effective coordination of major service changes across L&SC and ensure that the legal responsibilities of CCGs were fully addressed. G Raphael confirmed that the framework also gives the public and other stakeholders a clear view on how the NHS in L&SC is expecting to undertake these activities. The intention is for any engagement involvement, pre-consultation and formal consultation for large service change within L&SC should be subject to the framework. To clarify what is being asked of the Committee G Raphael stated that the framework is a mixture of legal and other mandatory requirements together with aspirational aspects relating to best practice. The Committee was asked to adopt the document as their framework. L Conway responded by saying it was an excellent document and commended the hard work from a local authority perspective. Not only did the local authority welcome the consultation and engagement but also their involvement in the process. L Conway requested rewording on page 18, fourth paragraph, second sentence to read: “local campaign groups sometimes seek Judicial Review of the public decisions”. This change was agreed. G Bangi noted that Lancashire Care Foundation Trust was reported as an overarching organisation but it is also a local organisation to some areas as a provider of community services. M Dowling stressed the importance of all levels of service being involved in major changes to avoid the framework becoming too centralised. A Bennett emphasised that the framework helps the JCCCGs to discharge its duties for communication and engagement more effectively in the public domain to be credible, coherent, evidence-based and honest. **RESOLVED**: that the Board agreed the document as the policy for consultation, subject to the suggested improvements being made.	
8	**Overview: Our Health Our Care (OHOC)** The Chair noted that this item was being presented for information. It was understood that any consultation arising from the OHOC programme in Central Lancashire will be carried out by Greater Preston CCG and Chorley and South Ribble CCG.	

	D Gizzi explained the purpose of the overview and noted two very specific objectives: • to provide an executive overview of the work of the Central Lancashire Integrated Care Partnership (ICP) to transform the whole of the care system; • to provide an update on the acute sustainability element of the programme. D Gizzi presented the triple aims of the Central Lancashire ICP, which are to improve population health outcomes, the quality of care and that other service received provides best value to the public. D Gizzi outlined the seven strategic platforms and areas for development under the OHOC programme. He informed members that the public and patients are included in every part of the consultation process and public engagement was to continue. A timeline was put forward for pre-consultation and engagement with the local population. Following the local election period in 2019, it was expected to move to a formal consultation with the public. D Gizzi requested that the Committee accepts the update and confirmation of the processes as described to manage the acute sustainability, including the pre and post-election engagement consultation processes. The Chair thanked D Gizzi for the presentation and asked for any questions or comments. From a question raised by D Soper whether specialised services was part of the remit, A Bennett informed members that as this process develops, if there are any potential impacts on some specialised services, the Committee needed to clearly understand those from a whole L&SC perspective. **RESOLVED:** that the JCCCGs accepted the update and confirmation of the processes to manage the acute sustainability.	
9	**Any other business** None reported.	
10.	**Date and time of next meeting:** 01 November, Morecambe Bay CCG, Moor Lane Mills, Lancaster at 13:00 with a pre-meet with the public at 12:30.	

Questions from the public

The Chair asked if members of the public wished to raise questions in relation to any items on the agenda.

Q: Acute mental health care and the impact of a reduction in-patient beds. If there was any reasoning behind the decision and if there is support to alleviate the reduction in in-patient beds, as it falls on families if they can't get an in-patient bed and there is stress within community mental health teams to find beds. Was there any provision where that risk can be reduced or catered for or if there is any support for families in those situations?

A: A Bennett provided a response: There are pressures in the mental health system particularly with acute illness that needs in-patient treatment. CCGs in Lancashire are working with the Lancashire Care Trust to identify a range of actions, some long and some short term, as to how we try to reduce some of the pressures. One of the very specific actions we have begun is a piece of work with another mental health Trust Northumberland Tyne and Wear (NTW) who are undertaking a peer review of services in Lancashire and looking at pressure in demand, flow patient experience and staff experience. This began in September and the results are expected in November. This is an example of how commissioners and providers are trying to work together. If there is anything more specific at the end of the meeting we can try to get a more precise answer to that question.

Q: on behalf of M Morgan was relayed to members:
'*re engagement, excellent start to develop the necessary level of public participation but it is clear that at the highest level i.e. the Board there is none, yet the Board leads on definition and more so what is eligible consultation. Repeatedly the document reinforces the need for public engagement, especially*

from representative bodies: MPs. Councillors trade unions, councils, community campaigns. Could it not be considered to have engagement at every level? There is a distinct lack of adequate representation at every level of decision making and none with lay members and public bodies in our experience. I am a member of Chorley A&E campaign and we did publicise the OHOC meeting which meant we had a better turn out'.

Q: Would the lay person for the (Chorley and South Ribble) CCG attend some of the meetings to keep us informed. He must be very well informed on what is going on and we would like to perhaps see him at some of our meetings.

A: G O'Donoghue welcomed the publicity from the Chorley A&E Group and responded by saying that from a CCG's point of view we constantly ask after our events how we can do things better. There is a clear issue that we could do better and in terms of attendance at a campaign group, the role of a Lay Member is to ensure that processes are accurate.

Q: Do you have a budget for public engagement as this was not seen in newspapers or leaflets. The public get text messages all the time about flu jabs but could we not have a text from GP surgeries in the same way to announce these meetings to get the public engaged at a higher level.

A: G Raphael informed members and members of the public that money has been put aside to develop ICS (L&SC) communications and engagement teams. We are also looking at linking with local engagement teams and between a central and local team to do a better job than at present. Within the budget we have identified up to £1m to be able to do this better than in the past. Part of that money is being used this year to supplement resources and the CCGs in Central Lancashire are devoted to this project. Freshwater specialises in supporting public bodies to use the most modern techniques to consult the public and that is something that we want to fund to make sure we do it properly. We are making sure that a good level of consultation is achieved and that resources have been devoted to doing that. It was recorded that the use of NHS acronyms was a problem for some members of the public.

A: A Doyle picked up the question regarding decision making and lay involvement and informed that there is at least seven or eight members of the JCCCGs who are here to bring lay perspectives to decision making to ensure we understand this. Some of our lay members have local responsibilities within CCGs around public engagement. There are different ways of communicating, all of which have pros and cons. Very few people read local newspapers but there are those that do just that and do not look at social media so we have to cover all angles, and we also have to look at resources as it costs thousands of pounds to put information in local papers. We do talk to the local press but we do not want to spend thousands on adverts if there are other ways to get the messages out, as you equally would not want us using NHS and local authority resource not in the most effective way.

A: A Janjua picked up the specific text messaging question. As a GP and a GP partner regarding sending text messages for public meetings; when people sign up for text messaging services with their general practice it is only for information directly relating to their care. General Data Protection Regulations (GDPR) that came into force on 24 April 2018 means that GPs have to be very careful how they use that data. If GPs are found to be in breach by sending text messages soliciting attendance at various public events as important as that may be, patients may object so that would never be an option for GPs to do unfortunately.

Q: regarding policies and commissioning and accountability when that decision on whether the findings is going to be given to any one in particular patient for surgeries, or treatments, who is going to be responsible if it goes wrong? Is it the financial body, or is it the GP?

A: Dr A Doyle responded to the question and stated that the accountability for the commissioning decision on what is funded and commissioned is the Commissioning Body, usually the CCG. Accountability for individual clinical care is the individual clinician who gave that clinical care. If the issue that is raised was due to a commissioning decision then the accountability lies with the commissioning body, which is the CCG.

The Chair thanked the Committee members and members of the public for their attendance and closed the meeting at 15:15.

ACTION MATRIX - JCCCGS

Agenda item no. 5

Log No	Meeting Date	Action	Action By	Date By	RAG	Assign to	COMMENTARY
JCCCGs/002	04.10.18	Commissioning policy - *for spinal injections and radio frequency denervation for low back pain* - to come back to the November JCCCGs for ratification	EJ/RH	01.11.18	A		On agenda (Item 7a)

KEY:		
	R	Outstanding
	A	Work in progress
	G	Complete
		Assigned to XXXX
	No	Not due

Agenda Item no. 7

Joint Committee of Clinical Commissioning Groups

Title of Paper	Clinical Commissioning Policy Development: A briefing paper for the Healthier Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	01.11.2018	Agenda Item	Item 7

Lead Author:	Rebecca Higgs, IFR Policy Development Manager, NHS Midlands and Lancashire CSU	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed a review of two intervention specific commissioning policies. Revised and updated policies have been prepared for adoption across Lancashire and South Cumbria.	
Recommendations	That the JCCCGs ratify Lancashire and South Cumbria policies on the following interventions: - *spinal injections and radiofrequency denervation* - *assisted conception services*	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	Yes	
Financial Implications	Yes	
Risk Identified	Yes	
If Yes: Risk	The ability to accurately forecast the financial impact of the changes to the assisted conception policy were limited by stringent intelligence restrictions. The expenditure will be monitored closely by CPDIG post ratification.	
Report Authorised by:	Andrew Bennett	

Clinical Commissioning Policies:

Policy for commissioning spinal injections and radiofrequency denervation for low back pain & Policy for assisted conception services.

1. Introduction

1.1 The purpose of this paper is to apprise the JCCCGs of the work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) to develop commissioning policies on the following interventions:

- *spinal injections and radiofrequency denervation for low back pain.*
- *assisted conception services.*

2. Development process

2.1 Policy development has been completed in accordance with the process approved by the CPDIG, which has been shared with the JCCCGs previously. The development of *the policy for commissioning spinal injections and radiofrequency denervation, (*including the evidence review and criteria setting) commenced under the predecessor Lancashire Commissioning Policies Group (CPG).

2.2 The review process included the following key steps:
- an evidence review by an allocated policy lead;
- clinical stakeholder engagement;
- public and patient engagement;
- notification of local Health, Overview and Scrutiny Committees;
- consideration of any financial implications
- an Equality Impact Risk (EIA) Assessment;
- consultation with Healthier Lancashire and South Cumbria Care Professionals Board (CPB) for clinical assurance purposes.

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

Policy for Commissioning Spinal Injections and Radiofrequency Denervation for Low Back Pain
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/ESlK-N6n9EBFnHuMn0gbwLoBrOlhYLwI-cNTY4JI7GGjLg?e=j2w66Z

Policy for Assisted Conception Services
https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EZlAMs6wMjlFsyhL0CIFnD8BoseUOOJCtmEyKom3lBaLXQ?e=6nvuYa

3. Policy for Commissioning Spinal Injections and Radiofrequency Denervation for Low Back Pain

3.1 This policy was originally developed by the Pennine Lancashire CCGs as they recognised back pain injections were an area of high activity and expenditure for them. It was subsequently identified that this position was common across the whole

of Lancashire and South Cumbria. The predecessor group, the CPG, therefore agreed that consideration should be given to collaborative implementation of this policy.

3.2 The policy underwent extensive clinical engagement, including a review by the North West Coast Strategic Clinical Network. A number of changes were made to the policy to aid understanding and clarify the scope; however, the core eligibility criteria remain unchanged from those in the existing Pennine Lancashire policy.

3.3 The CPB supported the development of the policy, pending the outcome of public engagement.

3.4 As there is variation in both the presence of commissioning policies and the scope of existing policies the effect of the proposed policy differs across the geography. For three areas (Chorley and South Ribble, Greater Preston and West Lancashire), who do not have an existing policy in place, this amounts to the introduction of a new commissioning policy which will introduce a limit on the number of spinal injections that will be commissioned and introduces criteria for access to radiofrequency denervation. For two areas, (Fylde and Wyre and Morecambe Bay), the scope of the policy has been widened to address the use of these interventions in additional types of low back pain that were not previously covered by a commissioning policy. This includes the introduction of a restriction on the number of injections that will be commissioned in those indications, and of criteria for access to radiofrequency denervation. In Blackpool, the policy has been aligned with updated NICE guidance, amending the types of low back pain spinal injections will be commissioned for, introducing consistency in the number of injections commissioned and updating the criteria related to radiofrequency denervation. For the two Pennine CCGs who developed the policy, the criteria remain unchanged from their existing policy.

3.5 The policy is expected to ensure clinical practice is aligned with the prevailing national guidance on the management of low back pain. This will include criteria which will aid the identification of patients who will benefit from radiofrequency denervation, which offers the potential for prolonged benefit.

3.6 The introduction of a consistent policy is expected to have a positive impact on expenditure and reduce overall spending on back pain injections across all areas except Pennine Lancashire. A financial impact analysis was therefore undertaken, which demonstrated that a cost reduction of approximately £315,000 could be expected across Lancashire and South Cumbria. The analysis was presented to Healthier Lancashire and South Cumbria's Finance Investment Group (FIG) on 13.07.2018 when the group supported the ongoing development of the policy and acknowledged the anticipated cost reduction.

3.7 Neither the public engagement, nor the final stage two EIA[1] identified any changes required to the policy when they were presented to the CPDIG on 16.08.2018. As a result, the group agreed the policy should proceed to ratification.

3.8 The policy was presented to the JCCCGs for ratification in October 2018. On that occasion the board asked that the policy be reviewed to aid clarity and ease of understanding. An updated version of the policy has been produced, however the

policy criteria remain unchanged. The committee is asked to ratify the revised version of the *Policy for Managing Low Back Pain- Spinal Injections and Radiofrequency Denervation for Low Back Pain.*

4. Policy for Assisted Conception Services

4.1 This policy has been developed as the existing CCG policies have reached their review dates.

4.2 The review aimed to:

- Align the policy, where possible, with the existing evidence base and best practise;
- Introduce harmonised eligibility criteria, addressing the existing variation in access criteria across Lancashire and South Cumbria;
- Provide clear statements on common areas not currently addressed within existing policies, or where existing policies are ambiguous; and
- Ensure provision remains affordable to CCGs, contributing to the effective use of NHS resource.

4.3 The policy underwent extensive clinical engagement across stakeholder organisations, including secondary care and tertiary service providers. The policy was shared with CPB who supported the development of the policy.

Treatment unit definition

4.4 During the review of this policy it was identified that, in the absence of a clear definition of what constitutes a unit of treatment in many of the existing CCG policies, there is variation in both the treatment supplied to patients, and the cost and charging methods used by providers for a unit of treatment. This in turn has led to inconsistencies in the number of embryo transfers currently offered to patients, and the cost incurred by CCGs for each unit of treatment, depending on which provider patients are treated by.

4.5 The proposed policy therefore stipulates that a treatment unit must include the transfer of **all** embryos created from an episode of ovarian stimulation, until either a pregnancy leading to a live birth is achieved, or no embryos remain.

4.6 The variation in cost and charging methods identified in section 4.4 is recognised as a national issue. Work is ongoing to develop a set of benchmarked prices for assisted conception technologies at a national level which is expected to address this. This work is expected to be published for use in 2019-2020.

4.7 The access criteria in existing CCG assisted conception policies across Lancashire and South Cumbria vary in relation to characteristics including female age thresholds, the existence of children from previous relationships and whether provision for same sex couples and single women is included. Due to the variation in current criteria the effect the key changes in the proposed policy will have differs in each CCG area.

4.8 Several of the changes within the revised policy extend the service to allow access to wider patient groups than before and will therefore create additional costs. The CPDIG agreed this can only be achieved if the service provision is maintained within

a financial envelope that the CCGs can afford. Therefore, under the revised policy, the number of units offered has been reduced from 2 to 1 unit to create the resources required to implement the changes. However, it should be noted that the potential number of embryo transfers included in the treatment unit has been increased, as described in section 4.5 above.

Outcomes of public engagement

4.9 The CPDIG were presented with the outcome of the 12-week public engagement period on 17.05.2018. Changes were made to the policy in response to feedback received, including rewording to improve clarity in some areas, and widening the scope of the policy to include the provision of gamete cryopreservation to a wider cohort of patients than was originally proposed.

4.10 In light of the changes made, the policy was shared again with CPB for further assurance. The board supported the updated version.

Summary of changes

4.11 In summary the key changes proposed include:

- An increased upper age limit for several CCGs, in line with the guidance in the National Institute for Health and Care Excellence (NICE) Clinical Guideline (CG)156.

  Patients in 6 areas will benefit from increased access to treatment (Blackburn with Darwen, Chorley and South Ribble, East Lancashire, Fylde and Wyre, Greater Preston and West Lancashire). For the remaining 2 areas there will be no impact on access. **(**Blackpool and Morecambe Bay)

- The application of a consistent lower age limit to remove existing variation.

  Patients in 4 areas will therefore benefit from increased access. (Blackpool, Chorley and South Ribble, Greater Preston and West Lancashire) In the remaining 4 areas no significant impact is expected. (Blackburn with Darwen, East Lancashire, Fylde and Wyre and Morecambe Bay)

- Standardised eligibility criteria regarding the provision of treatment where living children exist.

  Patients in 2 CCG areas will therefore experience decreased access. (Fylde and Wyre and Morecambe Bay) In the remaining 6 areas there is no change. (Blackburn with Darwen, Blackpool, Chorley and South Ribble, East Lancashire, Greater Preston and West Lancashire)

- Standardised eligibility criteria for same sex couples and single women, to address gaps and inconsistencies in equality and inclusion considerations within legacy policies.

  Patients in 3 areas will experience increased access. (Blackburn with Darwen, East Lancashire and Fylde and Wyre) Patients in 3 areas will experience a higher threshold for access. (Chorley and South Ribble, Greater Preston and West Lancashire) In the remaining 2 areas there is no change. (Blackpool and Morecambe Bay)

- Defined access criteria and storage periods for gamete cryopreservation to provide clarity on an area where existing policies are lacking.

  Patients in all 8 areas will experience increased access.

- A clear definition of the procedures incorporated within a treatment unit to provide clarity on an existing area where policies are lacking.

  Patients in all 8 CCG areas will benefit from equitable access to treatment, regardless of where they access treatment.

- A reduction in the number of units of treatment offered from two units within current policies, to one unit in the proposed policy.

  In all 8 areas, where the female partner is under the age of 40 years of age, patients will experience a reduction in access to treatment.

Financial impact

4.12 Annual expenditure on assisted conception services from the main providers of all 8 CCGs is in the region of £2.5 million.

4.13 Attempts to model the financial impact of the proposed changes have been limited by the stringent intelligence restrictions surrounding data on current CCG expenditure, which are in place to ensure patient confidentiality.

4.14 Those data restrictions meant it was not possible to accurately estimate the financial impact of the changes to the policy. However, the reduction in the number of units of treatment offered by the policy is expected to release some resource, which will be utilised to implement the changes made to the policy which widen access for certain groups or individuals.

4.15 Based on the data available, the CPDIG is reasonably confident that the new policy will meet its aims to improve equity of access to treatment whilst remaining affordable for CCGs. The actual impact of the policy will be monitored closely by CPDIG post ratification, as part of the standard implementation process for all policies.

4.16 A stage two EIA[2] has been undertaken. All equality queries identified during the development of the policy have been addressed by the amendments made to the eligibility criteria referred to above.

5. Conclusion

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

- *Policy for Commissioning Spinal Injections and Radiofrequency Denervation for Low Back Pain*
- *Policy for Assisted Conception Services*

Elaine Johnstone, Chair of the CPDIG
24.10.2018

References

1. Equality Impact and Risk Assessment Stage 2 for Policies, Policy for Commissioning Spinal Injections and Radiofrequency Denervation for Low Back Pain, 07.08.2018 https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EYRWYbISLL9Huv4b-6zq9EcBrxaZqSJeKP_YelHLslhU9Q?e=pHxvil

2. Equality Impact and Risk Assessment Stage 2 for Policies, Assisted Conception Services, 09.10.2018. https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EQQ5ahMAZ4dLjEI4yCthPiEBfz1U1Ygawo7THfD6vVNatA?e=QzjXRc

Policy for commissioning spinal injections and radiofrequency denervation for low back pain.		
	Version Number:	**Changes Made:**
Version of: October 2018	V0.5	Policy revised to clarify scope and aid understanding following feedback from the October meeting of the Joint Committee of Clinical Commissioning Groups including: - Deletion of the reference to neck pain to align with the previous scope clarification. - A simplified title. - Clarity that injection therapy should only be undertaken prior to consultant referral where there is community provision commissioned by Clinical Commissioning Groups (CCGs)
Version of: August 2018	V0.4	- Policy title amended to include the word “low” to add clarity following patient engagement. - OPCS/ ICD codes added
Version of: April 2018	V 0.3	Scope of the policy clarified, including the removal of pathway diagrams, and policy content and title refined to reflect the policy is limited to the use of non-surgical invasive treatments for the management of low back pain.
Version of: February 2018	V0.2	The following changes were made following consideration of the stage 3 feedback: - Scope clarified to make it explicit it applies to patients over 16 years only. - 8.2.1- wording regarding the number of injections commissioned altered to align with the wording at 8.2.3.
Original Draft: November 2017	V0.1	Initial draft prepared in line with the Pennine policy and a meeting with Anne Greenwood, Pennine policy lead.

Lancashire and South Cumbria Clinical Commissioning Groups (CCGs)

Policies for the Commissioning of Healthcare

Policy for Commissioning Spinal Injections and Radiofrequency Denervation for Low Back Pain

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right, but will be applied with reference to other policies in that suite.
1.2	This policy is based on the CCGs' Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Policy**
2.1	Invasive, non-surgical interventions and treatments for low back pain and sciatica must be considered in line with NICE NG59.
2.2	**Spinal Injections- Non-specific low back pain (NSLBP)** The CCG considers that, in line with NICE Guidance NG59, spinal injections for managing NSLBP do not accord with the Principle of Effectiveness, therefore the CCG will not routinely commission this intervention.
2.3	**Spinal Injections- Radicular pain**
2.3.1	An initial assessment should be undertaken in line with NICE guidance, NG59.
2.3.2	The use of non-pharmacological & pharmacological interventions, including self-management, should be **optimised prior to injection therapy.** **Eligibility criteria:**
2.3.3	The CCG will commission spinal facet joint and epidural injections for the management of radicular pain when the following criteria are satisfied:
2.3.3.1 **2.3.3.2**	- The patient has **acute and severe sciatica and** - The injections are part of a multimodal, multidisciplinary management plan (injection + medications + physiotherapy +/- CBT)
2.3.4	Where there is an existing community service commissioned by the CCG, a maximum of two spinal injections will be funded prior to Consultant referral for further management, provided the eligibility criteria at section 2.3.3 are met.
2.3.5	Following referral to a Consultant:

2.3.5.1 **2.3.5.2**	- Selective nerve root blocks or DRG block can be used for diagnostic purposes, provided the eligibility criteria at section 2.3.3 are met. - A maximum of two therapeutic spinal injections will be funded within any individual treatment cycle prior to patient discharge or surgical referral, provided the eligibility criteria at section 2.3.3 are met.
2.4	**Spinal Injections- Specific low back pain**
2.4.1	An initial assessment should be undertaken in line with NICE guidance, NG59.
2.4.2	The use of non-pharmacological & pharmacological interventions, including self-management, should be **optimised prior to injection therapy.**
2.4.3	**Eligibility criteria:** The CCG will commission spinal injections for the management of specific low back pain when the following criteria is satisfied:
2.4.3.1	- Patient assessment & injection is performed by a clinician trained in back pain assessment, diagnosis and management as part of a full MDT management plan approach.
2.4.4	Where there is an existing community service commissioned by the CCG, a maximum of two spinal injections will be funded prior to Consultant referral for further management, provided the eligibility criteria above are met.
2.4.5	Following referral to a Consultant a maximum of two further therapeutic spinal injections will be funded within any individual treatment cycle prior to patient discharge or surgical referral.
2.5	**Radiofrequency denervation**
2.5.1	The CCG will commission radiofrequency denervation in the following circumstances:
2.5.1.1	- In people with chronic low back pain (rated as 5 or more on a visual analogue scale, or equivalent) following a positive response to a diagnostic medial branch block
2.5.1.2	- The CCG will commission repeat radiofrequency denervation after a period of 6 months, provided the discharge criteria set out in section 8.3.3 below are met.
2.5.2	The following patient discharge criteria must be adhered to by all clinicians following radiofrequency denervation treatment:
2.5.2.1	- Patients must be discharged from the service post denervation if pain relief is >50% for a period of >4 months.
2.5.2.2	- Should a new referral be required, this must be accompanied by completion of a new assessment within primary care.

3	**Scope and definitions**
3.1	The scope of this policy includes the use of spinal injections and radiofrequency denervation for the management of low back pain in patients over the age of 16 years.
3.2	The scope of this policy does not include the specific management of back pain related to related to the following conditions: - Infection - Trauma (e.g. fractured spine which may need vertebroplasty or kyphoplasty as approved by NICE) - Inflammatory disease such as spondyloarthritis - The evaluation of people with sciatica with progressive neurological deficit or cauda equina - Scoliosis - Spinal injury - Metastatic spinal cord compression - Suspected cancer If serious underlying pathology is suspected refer to the relevant NICE guidance.
3.3	The CCG recognises that a patient may have certain features, such as - having back pain, - wishing to have a service provided for back pain, - being advised that they are clinically suitable for spinal injections, and - being distressed by their back pain, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
3.4	There are three groupings of pathologies that commonly affect the lumbar spine and cause back pain for which injections have been considered. These groups however, are very different in their response to injection therapy. Before treatment, patients need adequate assessment within a multi-disciplinary team and management approach to make a diagnosis or diagnoses. Injections could be part of the diagnosis process (diagnostic block). For the purpose of this policy the CCG defines the groups as follows: **A) Radicular pain** - Patients with nerve root compression irritation and/or inflammation. Patients typically present with predominantly leg pain or sciatica. The two most common causes of radicular pain are prolapsed (herniated) intervertebral disc and spinal canal stenosis. Patients should be managed on an explicit care pathway with explicit review and decision points. Injection therapy for radicular pain in a carefully selected patient is an appropriate procedure and is therefore funded in certain circumstances. See

	section 2.3 for eligibility criteria. **B) Non-specific low back pain (NSLBP)** – is low back pain not attributable to a specific pathology or cause. It is not associated with potentially serious causes (e.g. infection, tumour, fracture, structural deformity, inflammatory disorder, radicular syndrome, or cauda equina syndrome). The management of non-specific low back pain represents a challenge in health care provision. NSLBP is also known as low back pain, mechanical, musculoskeletal or simple low back pain (NG59) Injection therapy is not an appropriate procedure for NSLBP, as advised by NICE NG59, and is therefore not funded. **(C) Specific low back pain** - is back pain attributed to a specific pathology or cause. Specific back pain can have multiple causes including: Myofascial pain, specific disc bulge, failed back surgery, fracture vertebra, inflammation /stress of sacroiliac or facet joints (after positive diagnostic block) or lumbar sympathetic nerves pathology. Injection therapy for specific low back pain in carefully selected patients within a multi-disciplinary team management approach is an appropriate procedure and is therefore funded in certain circumstances. See section 2.4 for eligibility criteria.
3.5	Relevant evidence and guidelines have been reviewed including the recommendations of: • NICE quality standard published 27July 2017 https://nice.org.uk/guidance/qs155 • NICE guidance published 30th November 2016 https://www.nice.org.uk/guidance/ng59 • NHSE National Pathway of Care for Low Back Pain & Radicular Pain December 2014 http://rcc-uk.org/wp-content/uploads/2015/01/Pathfinder-Low-back-and-Radicular-Pain.pdf • Royal College of Surgeons Commissioning Guide: Low back pain 2013 and NHSE Guide to Commissioners of Spinal Services January 2013 • NHS RightCare https://www.england.nhs.uk/rightcare/
4	**Appropriate Healthcare**
4.1	Spinal facet joint and epidural injections are invasive treatments that are used in two ways: - First (**Diagnostic**): Selective nerve root block can be used to diagnose the source of radicular back pain. Medial branch block is recognised as a diagnostic tool to diagnose the source of facet joints pain. - Second (**Therapeutic**): spinal facet joint injections and epidural injections are used as a treatment to relieve both radicular and specific pain low back pain.

4.2	The CCG regards the achievement of this purpose as according with the Principle of Appropriateness. Therefore, this policy does not rely on the principle of appropriateness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question before confirming a decision to provide funding.
5	**Effective Healthcare**
5.1	The following policy criteria rely on the principle of effectiveness: - The criterion at section 2.2 relating to NSLBP; NICE NG59 states there was no consistent good quality evidence to recommend the use of spinal injections for the management of non-specific low back pain. There was minimal evidence of benefit from injections, and reason to believe that there was a risk of harm, even if rare.
6	**Cost Effectiveness**
6.1	The CCG does not call into question the cost-effectiveness of spinal facet joint and caudal injections and therefore this policy does not rely on the Principle of Cost-Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be cost-effective in this patient before confirming a decision to provide funding.
7	**Ethics**
7.1	The CCG does not call into question the ethics of spinal facet joint and caudal injections and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
8	**Affordability**
8.1	The CCG does not call into question the affordability of spinal facet joint and caudal injections and therefore this policy does not rely on the Principle of Affordability. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient before confirming a decision to provide funding.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
9.2	In the event of inconsistency, this policy will take precedence over any non-

	mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
10	**Force**
10.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
10.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: - If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. - If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
11	**References**
	NHS England (2013) Guide to the Commissioners of Spinal Services http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf Royal College of Surgeons Commissioning Guide: Low back pain 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-paincommissioning-guide NHS Guidelines CG 88 (May 2009) Low Back Pain in Adults: Early Management https://www.nice.org.uk/Guidance/CG88 NHS England National Pathfinder Projects (December 2014) National Pathway of Care for Low Back and Radicular Pain *(Report of the Clinical Group)* http://www.rcseng.ac.uk/healthcare-bodies/docs/pathfinder-low-back-and-radicular-pain NHS Wiltshire CCG "Managing Back Pain - Spinal Facet Joint and Epidural Injections Policy" (July 2014) http://www.wiltshireccg.nhs.uk/wp-content/uploads/2013/12/Managing-Back-Pain-Spinal-Facet-Joint-and-Epidural-Injections-Policy-AMENDED.pdf NHS Shropshire CCG "PROCEDURES OF LIMITED CLINICAL VALUE POLICY" (September 2015) http://www.shropshireccg.nhs.uk/download.cfm?doc=docm93jijm4n2001.pdf&ver=12190 NHS Guidelines NG59 (November 2016) Low back pain and sciatica in over 16s assessment and management

	https://www.nice.org.uk/guidance/ng59/resources/low-back-pain-and-sciatica-in-over-16sassessment-and-management-1837521693637

Appendix 1: Associated OPCS codes

The codes applicable to this policy are:

OPCS codes
A521, A522, A528, A529, A573, A574, A575, A577, V485, V486, V487, V488, V544, W903, X375, X382

Date of adoption
Date for review

Policy for Assisted Conception Services		
	Version Number:	**Changes Made:**
Version of: October 2018	V0.9	Insertion of “leading to a live birth” in the definition of a treatment unit (section 1.2.2.2) following further review by the Care Professionals Board to provide clarity. Amendment of the definition of a treatment unit to include 12 cycles of IUI rather than 6 to improve alignment with NICE.
Version of: September 2018	V0.8	Deletion of the term “eligible family structure” and reference restricted to the requirement for there to be no children from the current or previous relationships to account for discussions at the September CPDIG.
Version of: September 2018	V0.7	The following changes were made: - Amendment to section 1.1.3 to account for the use of IUI to demonstrate clinical infertility. - Layout of the criteria for donor eggs/sperm simplified. - Clinical infertility definition amended in line with legal advice. - Statement related to protected characteristics at 2.7 added to align with other relevant policies. - Wording around fertility preservation for cancer patients clarified.
Version of: May 2018	V 0.6	The following changes were made following patient engagement: - Criteria regarding same sex couples clarified to confirm only one partner must demonstrate sub-fertility. - Storage of gametes for transgender patients included in the commissioned procedures. - Definition of female partner clarified. The policy criteria were also moved to the beginning of the policy, in line with the agreed format.
Version of: January 2018	V0.5	Changes to wording at sections 1.2.2 and 1.4.1 to provide clarity following feedback at CPB.
Version of November 17	V0.4	Changes made in response to feedback received from stage 3 stakeholders. Changes were ratified and added to at the November CPDIG
Version of: 25.09.17	V0.3	Wording at section 1.4.7 relating to transgender males amended to reflect the requirement to meet the criteria that relate to females in section 1.1.
Version of:	V0.2	1. Lower age limit added

August 2017		2. Criteria regarding surgical sperm retrieval removed 3. Amendment to the proposed storage period for embryos produced as part of an assisted conception treatment unit 4. Inclusion of funding for storage for those who have had gametes stored as part of NHS pathway. 5. Adjustment to wording surrounding storage for patients with cancer once the assisted conception pathway has commenced. 6. Amendment to wording around single women. 7. Amendment to wording around IUI funding. A number of grammatical/structural corrections have also been made to aid understanding. (Changes agreed by the August CPDIG on 17.08.17)
Original Draft, 13.07.17	V0.1	Policy drafted in line with directions of the CPDIG meeting, 18.04.2017

Placename CCG

Policies for the Commissioning of Healthcare

Policy for Assisted Conception Services

	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
1	**Policy Criteria**
1.1	The CCG will commission one treatment unit of assisted conception (as defined in section 1.2) provided **all** of the following criteria are satisfied at the date on which the treatment unit commences:
1.1.1	• Clinical infertility, as described in 1.3, has been demonstrated;
1.1.2	• The patient/s have no living biological or adopted children from the current or any previous relationship;
1.1.3	• Neither partner has previously had a treatment unit or part of a treatment unit of assisted conception irrespective of the source of funding of that treatment unit, unless it can be clearly demonstrated that:
1.1.3.1	• The unit of treatment was undertaken in line with section 1.3 to demonstrate the presence of clinical infertility OR
1.1.3.2	• The unit of treatment was in a different relationship AND EITHER
1.1.3.3	• The cause of the infertility was attributable predominantly to the other partner in that relationship OR;
1.1.3.4	• The treatment was not related to clinical infertility;
1.1.4	• The female partner is between 18 years and 42 years of age. Treatment must commence before the female partners 43rd birthday;
1.1.5	• Additionally, if the funding package includes harvesting of eggs from a donor, then the donor has not yet reached the age of 40 years and has no evidence of infertility;
1.1.6	• Neither partner has been previously sterilised;
1.1.7	• The female partner seeking to become pregnant has a body mass index in the range 19-30;
1.1.8	• The female partner is a non-smoker, and commits to remain so throughout the treatment unit and until the completion of any resulting pregnancy; For the purposes of this policy the use of an e-cigarette is considered equivalent to non-smoking status.
1.1.9	• The other partner (when applicable), is a non-smoker, and commits to remain so throughout the treatment unit; for the purposes of this policy the use of an e-cigarette is considered equivalent to non-smoking status.

1.1.10 **1.1.11** **1.1.11.1**	• If the female partner is aged 40-42, a treatment unit will be offered provided the following two additional criteria are fulfilled (NICE CG 156, {1.11.1.4}): • There is no evidence of low ovarian reserve (see Appendix 1 for definition); • There has been a discussion of the additional implications of pregnancy and IVF at this age.
1.2	**Treatment Unit**
1.2.1 **1.2.2** **1.2.2.1** **1.2.2.2**	A treatment unit is the currency used to describe the amount of assisted conception treatment to which a patient is eligible. A treatment unit is defined as EITHER: A - Up to 12 separate attempts at IUI, each in a different menstrual cycle; **OR** B - One programme of IVF treatment comprising: • Ovarian Stimulation; • Induction of ovulation; • Harvesting of resultant eggs; • Harvesting of semen; • Fertilisation; • Storage of eggs/ semen/ embryos in accordance with section 1.5; Transfer of any resultant fresh and frozen embryo(s) on as many separate occasions as required until either, a pregnancy leading to a live birth is achieved or there are no embryos remaining.
1.2.3	The CCG will define a unit as cancelled if it fails to reach the stage of an attempt to harvest eggs. For the purposes of this policy a unit will be counted as cancelled on only one occasion in the lifetime of a woman. Otherwise if a unit has been partially completed it will count as a whole unit for the purposes of calculating future eligibility for assisted conception services. If a unit is cancelled due to low ovarian reserve this should be taken into account when considering suitability for further IVF treatment.
1.2.4	In the event of a treatment unit failing as a result of an error within the service provider the CCG expects the service provider to offer a repeat treatment unit. The failed treatment unit will not count towards the woman's lifetime allowance as such a failed unit does not give any indication of the probability of future success.

1.2.5	IUI is likely to be offered using the partners' own gametes only when either; it is impossible for them to have sexual intercourse, or when the sperm has been frozen in accordance with the criteria in this policy and the couple are now eligible for assisted conception services.
1.3	**Clinical Infertility**
1.3.1 **1.3.1.1** **1.3.1.2** **1.3.1.3** **1.3.1.4**	For the purposes of this policy, a person/couple are considered to be clinically infertile where they are of reproductive age and either: • There is a diagnosed condition or congenital abnormality that would make natural conception impossible; **or** • There is a known cause of infertility, following assessment and investigation in the circumstances set out in 1.3.2; **or** • There is no known cause of infertility and the criteria outlined at 1.3.3 are met; **or** • There is an inability to have sexual intercourse and the criteria outlined at 1.3.4 are met.
1.3.2 **1.3.2.1** **1.3.2.2** **1.3.2.3**	A person/couple should be offered further clinical assessment and investigation if they are of reproductive age and have not conceived after: • 1 year of regular (i.e. 2-3 times per week) unprotected vaginal sexual intercourse with the same partner; **or** • 6 cycles of artificial insemination (with partner or donor sperm). Where conception is attempted via vaginal sexual intercourse or artificial insemination with partner sperm, the partner should also be offered assessment and investigation.
1.3.3 **1.3.3.1** **1.3.3.2** **1.3.3.2.1** **1.3.3.2.2**	Where there is no known cause of infertility to fulfil the criteria at section 1.3.1.3 a person/couple must have: • undergone assessment and investigation in the circumstances set out in 1.3.2; and • failed to conceive after a total of either: - 2 years of regular (i.e. 2 – 3 times per week) unprotected vaginal sexual intercourse with the same partner; **or** - 12 cycles of self-funded artificial insemination (with either partner or donor sperm), at least 6 of which are by intrauterine insemination undertaken at a Human Fertilisation and Embryology Authority (HFEA) registered clinic.
1.3.4 **1.3.4.1**	The CCG will regard an inability to have sexual intercourse as being equivalent to clinical infertility, and will commission one treatment unit (as defined in section 1.2), under any of the following circumstances: **EITHER**

1.3.4.2 **1.3.4.2.1** **1.3.4.3** **1.3.4.3.1** **1.3.4.3.2**	• There is a structural abnormality of the genital organs such that sexual intercourse would be impossible; **OR** • There is a serious psychosexual problem. The patient has seen a senior clinical psychologist who advises that the problem is pathological and cannot be reversed and supports the use of IUI; **AND** • The psychosexual problem leads to a physical obstacle to sexual intercourse, e.g. erectile or ejaculatory failure or vaginismus. **OR** • There is a physical disability that would make sexual intercourse impossible or extremely painful, or which would risk causing significant injury to one of the partners; **AND** • The gynaecologist responsible for delivering the IUI advises that the feature making sexual intercourse impossible, extremely painful, or which would risk causing significant injury to one of the partners would not mean that pregnancy or delivery would be clinically inadvisable, for either the mother or the child; **OR** • There is irreversible erectile dysfunction associated with a clinical condition reasonably assumed to be causal (e.g. diabetes, multiple sclerosis, spinal cord dysfunction).
1.4	**Sperm and Egg Donation**
1.4.1 **1.4.1.1** **1.4.1.2** **1.4.1.3** **1.4.1.4**	Sperm and egg donation will be funded if: • it is required as part of an approved treatment unit **and** • the eligibility criteria at section 1 of the policy are fulfilled **and** • the patient, or for couples one of the partners, is able to make a contribution to the child's genome. Assisted conception to create an embryo entirely from third party gametes will not be funded.
1.4.2	Where there is a lack of donor eggs available patients who are eligible for treatment with donor eggs, in line with NICE recommendations, will be placed on a hospital waiting list, where these exist. Patients will be placed on the waiting list for an initial period of 3 years, after which they will be reviewed to assess whether the fertility policy eligibility criteria are still met. Funding is dependent on the patient fulfilling the eligibility criteria at section 1 of the policy at the time treatment commences.
1.5	**Embryo, Egg and Sperm Storage**

1.5.1	**The storage of gametes or embryos when assisted conception procedures produce more gametes or embryos than can be used immediately**
1.5.1.1	The CCG **will** fund the freezing and storage of surplus eggs or embryos where assisted conception treatments have produced more eggs or embryos than can be used for immediate transfer to the uterus. However, eligibility for funding for ongoing storage will only be provided in line with section 1.5 of this policy.
1.5.1.2	The CCG will not provide funding for the storage of surplus sperm / semen except in accordance with sections 1.5.2 below.
1.5.2	**The storage of gametes or embryos for the purposes of fertility preservation**
1.5.2.1	The CCG **will** commission the harvesting and storage of gametes for patients who are on the cancer pathway, such that clinical advice is that treatment is required immediately, that will remove or irreversibly damage the gonads or may prevent the production of gametes.
1.5.2.2	The CCG will commission the storage of gametes when they have been retrieved for the purposes of fertility preservation as part of an established NHS pathway of care.
1.5.2.3	The CCG will commission the harvesting and storage of gametes for patients who have been diagnosed with gender dysphoria, are under the care of a Specialist Gender Identity Centre (GIC) and are likely to develop infertility as an unwanted consequence of the treatment required to address their condition.
1.5.2.4	In circumstances described in 1.5.2.1, 1.5.2.2 and 1.5.2.3 the CCG will not apply the eligibility criteria described in 1.1, with the exception of the upper age limit restriction for female partners, in line with the principle of effectiveness. However, by funding the storage of gametes the CCG is NOT agreeing to fund further, future assisted conception services. If gametes are stored for the purpose of fertility preservation and assisted conception treatment is required, in order to be eligible for assisted conception treatment the patient will need to demonstrate eligibility in line with the criteria at section 1.1 of this policy, or any relevant policy in force at the time.
1.5.2.5	The CCG will not commission the harvesting and storage of gametes for patients with a level of risk of future infertility in accordance with the Principle of Appropriateness.

1.5.2.6	The CCG will not commission the harvesting and storage of eggs for women with low ovarian reserve in accordance with the Principle of Effectiveness.
1.5.3	**Duration of embryo or gamete storage**
1.5.3.1	Funding for storage of gametes or embryos will continue until one of the following occurs:
1.5.3.1.1 **1.5.3.1.2** **1.5.3.1.3** **1.5.3.1.4**	• The gamete or embryo has been in storage for two years; • In cases where the storage has occurred in line with section 1.5.2.1-1.5.2.3 above, embryo or gamete preservation should be offered for an initial period of ten years in line with NICE CG 156 guidance, rather than the two years stipulated at 1.5.3.1.1. However, the criteria at 1.5.3.1.1 will apply once the patient has commenced treatment on the assisted conception pathway; • The patient / couple have had a live birth and now have a living child who has reached the age of one year. (see section 1.5.3.3) • The female partner dies.
1.5.3.2	The CCG expects the service provider to give the patient at least six months' notice that NHS funding for the storage will cease, and this will be built into the service agreement. The CCG expects the Trust to give the patients the option of continuing to fund the storage beyond the point at which CCG funding ceases. No embryos or gametes stored under funding by the CCG should be destroyed without giving the patients the opportunity to consider private funding or donation.
1.5.3.3	The purpose of funding storage for gametes or embryos after a live birth is only to enable the patient to decide what to do with them, and does not imply that funding will be offered for the use of those gametes or embryos to attempt to achieve a pregnancy.
1.6	**Surrogacy**
1.6.1	The CCG will not commission any form of assisted conception services or treatment leading to surrogacy for those in surrogacy arrangements. (i.e. the use of a third party to bear a child for another couple). This is because of the numerous legal and ethical issues involved. See also sections 3.5 and 6.4.
1.7	**Treatment following Reversal of Sterilisation**
1.7.1 **1.7.2**	Assisted conception services will not be provided where this is required due to a previous sterilisation procedure or a reversal of sterilisation procedure in either partner in accordance with the Principle of Appropriateness. The CCG will commission assisted conception services for the management of azoospermia, provided the cause of the azoospermia is unrelated to a previous vasectomy.

1.8	**Uterine Transplantation**
1.8.1	The CCG will not commission uterine transplantation, and neither will it commission assisted conception services when the intention is that the pregnancy will be carried in a transplanted uterus in accordance with the Principle of Cost Effectiveness.
1.9	**Where responsibility lies with more than one CCG**
1.9.1	When assisted conception services involve biological participants who are the responsibility of more than one CCG, this CCG will follow any mandatory requirement in terms of the split of funding. In the absence of a mandatory requirement, the CCG expects that the funding responsibility will be shared equally between the CCGs responsible for the female partner and the other partner who seek to benefit from the service.
1.10	**NICE Guidance**
1.10.1 **1.10.1.1** **1.10.1.2**	Except where indicated otherwise in this policy: • The CCG expects to commission assisted conception services in accordance with NICE technology appraisal guidance or NICE clinical guidance that may be in force at the time, and; • The CCG expects its service providers to deliver assisted conception services in accordance with NICE technology appraisal guidance or NICE clinical guidance that may be in force at the time.
1.11	**Service Providers**
1.11.1	The CCG will commission services that fall within the scope of this policy only when they are offered by service providers within its portfolio of service agreements or are available on the Free Choice Network in line with the General Policy for IFR Decision Making.
1.12	• In all respects the CCG will comply with legal requirements which take precedence over other provisions of this policy.
2	**Scope and Definitions**
2.1	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2.2	Assisted Conception is a group of clinical procedures intended to achieve a healthy pregnancy and involving the temporary removal of gametes (eggs and / or sperm) from the human body.
2.3	• The scope of this policy is limited to the commissioning of tertiary fertility services and includes intra-uterine insemination (IUI), intracytoplasmic sperm injection (ICSI) and in vitro fertilisation (IVF). This may also include

	the provision of donor sperm and donor eggs and the storage of gametes and embryos. The groups included are limited to:
2.3.1. **2.3.2** **2.3.2.1** **2.3.2.2** **2.3.2.3** **2.3.2.4** **2.3.2.5**	• People who have vaginal intercourse; • Specific patient subgroups (as listed in NICE CG 156 guideline scope): o Women in same-sex relationships who have unexplained infertility after donor insemination; o Single women who have unexplained infertility after donor insemination; o People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psychological problem; o People with conditions or disabilities that require specific consideration in relation to methods of conception; o People who are preparing for cancer treatment who may wish to preserve their fertility.
2.3.3 **2.3.3.1** **2.3.3.2** **2.3.3.1**	The scope of this policy also includes requests for assisted conception for: • Those who have undergone a sterilisation procedure or a reversal of sterilisation procedure; • Those who wish to use surrogacy arrangements; • Those who wish to consider uterine transplantation.
2.4 **2.4.1** **2.4.2** **2.4.3** **2.4.4** **2.4.5** **2.4.6**	The following are not within the scope of this policy: • Investigations to ascertain the cause of infertility; • The prescribing or administration of medicines to improve fertility by Increasing the probability of natural conception; • Pre-implantation genetic diagnosis (except that a policy for PIGD may make reference to aspects of this policy); • Services to address recurrent miscarriage; • Reversal of sterilisation as a service for the purpose of alleviating post-vasectomy pain. • Surgical sperm retrieval (this intervention is the commissioning responsibility of NHS England via the Highly Specialised Adult Urology services.)
2.5 **2.5.1** **2.5.2** **2.5.3** **2.5.4** **2.5.5** **2.5.6** **2.5.7** **2.5.8**	The CCG recognises that a patient may have certain features, such as: • No children; • Difficulty in conceiving; • A diagnosis that implies that it may be difficult to conceive; • A risk of becoming unable to conceive in future; • Gametes or embryos in storage; • A blood-borne or sexually transmissible infection; • Previous failed attempts at assisted conception (including attempts that resulted in a conclusion that future attempts would be done differently); • A wish to use services within the scope of this policy.

2.5.6	Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.6	Appendix 1 defines and explains certain terms and abbreviations that are used in this policy.
2.7	The CCG is committed to eliminating discrimination and promoting equality in its own policies, practices, and procedures. While no protected characteristic under the Equality Act is automatically a matter for exceptionality under this policy, the CCG is committed to treating everyone equally and with the same attention, courtesy and respect regardless of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.
3	**Appropriate Healthcare**
3.1	The purpose of assisted conception services is to enable people who are otherwise clinically unable to do so, to achieve a pregnancy leading to a live birth. The CCG considers that assisted conception to achieve this purpose will accord with the Principle of Appropriateness.
3.2	The CCG is aware that most children are conceived as a result of a natural process that takes place without any clinical intervention. The CCG recognises the need to ensure that any active intervention it makes in relation to this natural process should comply with the provisions of the Equality Act (2010).
3.3 **3.3.1** **3.3.2** **3.3.3**	The CCG considers that other services competing for the same CCG resource more clearly have a purpose of preserving life or of preventing grave health consequences. Therefore, the CCG has committed only a limited budget to assisted conception services and sets the following policy criteria which rely on the Principle of Appropriateness: • The criteria requiring a health problem to be demonstrated, thus confirming that conception will not occur without an assisted conception intervention; • The criteria relating to previous children • The criteria relating to reversal of sterilisation, recognising that sterilisation is usually carried out as a matter of choice and not as a matter of clinical need.
3.4	Most requests for consideration under this policy will be from heterosexual couples who request assisted conception services using their own gametes to conceive a pregnancy in the female partner. There may be other circumstances in which the request for funding comes from an individual or individuals who are not in a heterosexual relationship, or in which the circumstances of the couple mean that assisted conception would need to involve a third party. Decisions in such cases will rely on the Principle of Appropriateness and also on the CCG's position in relation to third party involvement which is within scope of the Principle of Ethics.

3.5	The CCG considers that its portfolio of service agreements contains a range of services that will address the needs of the majority of patients with clinical infertility who request assisted conception services. The CCG considers it appropriate to focus its resources on that range of services. Therefore, the CCG will not normally commission services of an unusual, innovative or highly specialised nature, and this relies partly or wholly on the Principle of Appropriateness. An example of this is the policy statements in respect of services not offered by service providers within its portfolio of service agreements, and also to services such as surrogacy and uterine transplantation.
3.6	The CCG intends that the benefit of assisted conception to the patient is from achieving parental status in respect of a child to whom the patient has made a genetic contribution. The experience of pregnancy, breast feeding, or associated bonding, is not the primary purpose of the service. Therefore, if it is not possible for the patient (either or both partners) to make a contribution to the child's genome, then assisted conception to create an embryo entirely from third party gametes is not appropriate. Some patients in this situation may seek adoption or fostering. Assisted conception is not appropriate for the purpose of rectifying a deficit in the availability of children for adoption or fostering, and therefore unavailability of children will not normally provide grounds for exceptionality in this respect.
3.7	Although the age limit for treatment relies mainly on the Principle of Effectiveness, the purpose of this policy is to restore fertility to people who, without their medical conditions would have good fertility. The lower chance of natural conception in a population of normal older women (compared with a population of normal younger women) is itself a reason why this policy does not offer assisted conception services (irrespective of whether they use their own or donated eggs) to women older than the levels set in NICE guidance (CG156). Therefore, the age criteria, and the application of the age criteria to the recipient as well as the donor in the case of donated eggs, rely in part on the Principle of Appropriateness.
4	**Effective Healthcare**
4.1	The CCG recognises in general terms that IVF, IUI, ICSI and sperm washing techniques can be effective in achieving their respective purposes in selected patient groups.
4.2 **4.2.1** **4.2.2**	The CCG considers that some groups of patients are more likely to have successful outcomes than others. Therefore, the CCG sets the following policy criteria which rely on the Principle of Effectiveness: • The criteria relating to the age of the woman and of any egg donor (See also section 1.1;) • The criteria relating to the number of treatment units to which a patient is eligible (patients are most likely to succeed in their first attempt at

4.2.3 **4.2.4**	IVF. Patients entering their second or subsequent treatment units are all ones who have failed in earlier treatment units and are less likely to be able to conceive through IVF); • The requirement to consider all previous treatment irrespective of the funding source of that treatment, when assessing the patient's eligibility to further treatment units; • The Body Mass Index Criteria, which is gender specific, and is based on evidence that this factor affects the success of IVF.
4.3	The distress caused by the failure to meet expectations when an offer of assisted conception funding is made in circumstances in which it is unlikely to succeed, also relates to the Principle of Effectiveness. The CCG considers that distress and anxiety caused by healthcare are dis-benefits that need to be taken into account when considering effectiveness, and this consideration therefore contributes to eligibility criteria including numbers of units.
5	**Cost Effectiveness**
5.1	The measure of cost effectiveness used by NICE and referenced in other CCG policies, is the quality adjusted life year (QALY). However, NICE acknowledges that it is likely that assisted conception is offered on the NHS for reasons other than QALY maximisation. For this reason few criteria in this policy rely solely on the Principle of Cost Effectiveness.
5.2	Uterine transplantation is a new technique for which some successes have been reported, but, it is too early to determine the overall success rate of the procedure, or to determine the rate of side effects and complications for the donor, the recipient and the baby. Therefore, the CCG considers that assisted conception is likely to be less cost effective when a transplanted uterus is used, than otherwise, and it seeks to make best use of the budget available for assisted conception services. Policy in relation to the use of a transplanted uterus is therefore based on the Principle of Cost-Effectiveness.
6	**Ethics**
6.1 **6.1.1** **6.1.2**	The CCG recognises possible ethical issues in relation to assisted conception, including issues in terms of: • the distress caused by the failure to meet expectations when an offer of assisted conception funding is made in circumstances in which it is unlikely to succeed. The CCG expects all patients to give fully informed consent, but is still concerned that it does not wish to commission services that are likely to do more harm than good. This consideration therefore contributes to eligibility criteria (including numbers of units); • the need to make sure that resources are distributed fairly and equitably, which is the reason why the policy includes eligibility criteria relating to cost effectiveness and to prioritising a suitable range of standard services. Eligibility criteria relating explicitly or implicitly to these issues therefore rely on the Principle of Ethics.

6.2 **6.2.1** **6.2.2**	The CCG considers that it would be inequitable to enable certain patients to bypass certain eligibility criteria by taking an alternative pathway to that taken by the majority of assisted conception patients. For these reasons the following aspects of this policy rely on the Principle of Ethics: • the application of effectiveness criteria to all treatment modalities within the scope of this policy, and not only to the treatment modality to which the evidence base refers. (For example age criteria apply to all recipients of assisted conception services, and not only to women using their own eggs for the purposes of IVF); • an intention to carry out future treatment units differently is not a matter of exceptionality if a patient is requesting more treatment units than the usual entitlement.
6.3 **6.3.1** **6.3.2** **6.3.3**	The CCG is required to comply with legislation including the Human Fertilisation and Embryology (HFE) Act 2008 and the Equality Act 2010 and any primary or secondary legislation that amends or supersedes those Acts. The following aspects of this policy rely wholly or partly on those Acts: • sections relating to the duration of storage of gametes (HFE Act); • sections relating to the duration of storage of embryos (HFE Act); • sections relating generally to compliance with legislation.
6.4	The CCG recognises that surrogacy and gamete donation may give rise to a number of ethical and legal considerations. Those concerns are within the scope of the Principle of Ethics.
7	**Affordability**
7.1	The CCG has a limited budget and must make difficult choices. Many of the restrictions in this policy relate to one or more of the Principles of Appropriateness, Effectiveness, Cost-Effectiveness or Ethics. However, the need to manage resources within budget, and therefore the Principle of Affordability is also a basis for making restrictions to the commissioning of assisted conception services, and assisted conception services that are not normally commissioned in accordance with this policy are unlikely to accord with the Principle of Affordability (as well as possibly failing to accord with other Principles).
7.2	For reasons of affordability, the CCG cannot offer unlimited treatments, for example in terms of the number of treatment units or the duration of storage of gametes or embryos.
8	**Exceptions**
8.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.

8.2	It is acknowledged that there are continual developments in the technology available to assist conception. However an intention to carry out future treatment units differently does not amount to exceptionality if a patient is requesting treatment units beyond the number normally offered in accordance with this policy.
8.3	Claims that assisted conception has been delayed beyond the upper age limit, for example because of hospital delays, waiting lists or the requirement to undergo medical treatment, do not amount to exceptionality. The CCG considers that it is irrational to set an age limit which is based on the chance of success (effectiveness), but to make exceptions to it when the reason for exceptionality does not mean that the chance of success is higher in the exceptional patient than in other patients to whom the criterion applies. However, a delay as a result of a hospital failure may need to be rectified by the hospital.
8.4	Claims related to the age or level of contact between a patient/s and a living child do not amount to exceptionality.
8.5	In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
9	**Force**
9.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
9.2 **9.2.1** **9.2.2**	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory; • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
10	**References** Equality Act (2010), Information and guidance on the Equality Act 2010, including age discrimination and public sector Equality Duty (https://www.gov.uk/guidance/equality-act-2010-guidance) Fertility Fairness, Infographic and Information for Commissioners (http://www.fertilityfairness.co.uk/for-commissioners/)

	Human Embryo and Fertilisation Authority, UK Government's independent regulator overseeing fertility treatment and research. Provision of clear and impartial information to all affected by fertility treatment. (https://www.hfea.gov.uk/) Human Fertilisation and Embryology (HFE) Act 2008 (http://www.legislation.gov.uk/ukpga/2008/22/pdfs/ukpga_20080022_en.pdf) NICE Clinical Guideline. (2013), Fertility: assessment and treatment for people with fertility problems. Published by the Royal College of Obstetricians and Gynaecologists. February 2013 (https://www.nice.org.uk/guidance/cg156/resources/cg156-fertility-full-guideline3) NICE Clinical Guideline CG156 (2013 updated August 2016) Fertility Problems: Assessment and Treatment. National Institute for health and care excellence (https://www.nice.org.uk/guidance/CG156)

Date of adoption
Date for review

Appendix 1: Definitions and abbreviations

Anti-Müllerian Hormone (AMH)	A substance produced by small developing follicles, which is therefore an indicator of the number of follicles that start to develop at the beginning of each menstrual cycle. In women with a good ovarian reserve a large number of follicles start to develop and therefore the level is high. The converse is true. A low AMH level is an indicator of a high risk of a personal early menopause. A low AMH also indicates that IVF is less likely to succeed as it is more difficult to stimulate the ovaries.
Assisted Conception	A group of clinical processes intended to achieve a pregnancy, involving the temporary removal of gametes (eggs and / or sperm) from the human body. Assisted conception includes IUI and IVF.
Biological child	For the purposes of this policy, a biological child of an individual is either a genetic child of that individual (see separate definition), or a child that was conceived as part of a relationship including that individual, but with the use of a donated gamete instead of the gamete of that individual. Care needs to be taken to interpret the definitions of a biological child and a genetic child correctly.
Conception	The start of a pregnancy.
Embryo	A new organism in the earliest stage of development. In humans this is defined as the developing organism from the fourth day after fertilisation to the end of the eighth week
Embryo Transfer	See transfer.
Female Partner	Any reference to a female partner/ could relate to any of the following: • The female partner in a heterosexual relationship • The partner in a female same sex relationship wishing to undergo assisted conception treatment with the intention of becoming pregnant. • A single female • A female to male transgender patient, who has retained female reproductive organs and wishes to undergo assisted conception treatment with the intention of becoming pregnant.
Fertilise/ Fertilisation	The entry of a sperm into an egg to produce an embryo. (See separate definition for fertility and its derivatives).

Fertility	Technically fertility is a history of having produced children and fecundity is the (current) ability to produce children. However, the terms often have different meanings in common usage and for the purposes of this document fertility is used to mean the ability to produce children, and the word fecundity is not used. Derivatives including fertile, infertility and infertile accord with this definition. However, fertilise and fertilisation are defined separately.
Gametes	Eggs and / or sperm. Such cells contain half of the genetic material of the person who produced it and they can combine with gametes from the opposite gender to conceive a genetic child of that person.
Genetic Child	For the purposes of this policy, a genetic child of an individual is a child that was conceived using the gametes (eggs or sperm) of that individual. Such a child has half of the genetic material of that individual (and half from its other parent). Care needs to be taken to interpret the definitions of a biological child and a genetic child correctly.
Gonads	The sex glands. The gonads are the ovaries in the female, that produce eggs (ova) and the testicles in the male that produce sperm (spermatozoa). Both also produce sex hormones.
In vitro Fertilisation (IVF)	A type of assisted conception which includes medical stimulation of the ovaries to develop follicles and to induce ovulation; surgical harvesting of those eggs; harvesting of semen; using those eggs and that semen to achieve fertilisation in a laboratory setting; and transferring of a resulting embryo or embryos to the uterus. An extension of the process may include the frozen storage and transfer of surplus embryos.
Intra-cytoplasmic sperm injection (ICSI)	A type of in vitro fertilisation in which fertilisation is achieved by injecting sperm into the cytoplasm of the egg, rather than simply mixing the egg with the sperm. Sometimes abbreviated to ICSI. This is often used for male factor infertility. Within this policy, unless indicated otherwise, ICSI is regarded as a type of IVF, and the term IVF should therefore be regarded as including ICSI.
Intra-uterine Insemination (IUI)	A type of assisted conception preferred for some types of infertility, whereby semen is obtained from the male partner / donor and clinically inserted into the uterus of the female partner. Medication may be used for ovarian stimulation, but eggs are not removed from the body of the female partner. A similar process is intra vaginal insemination, in which the semen is inserted in the vagina. For the purpose of this policy, the term intra-uterine insemination also includes intra-vaginal insemination and the two processes are regarded as equivalent. Sometimes abbreviated to IU.
Menstrual Cycle	A physiological process in a woman, whereby an egg develops and is released from the ovary, and the uterus is prepared for the implantation of any embryo produced by the fertilisation of that egg. The term menstrual cycle should not be confused with the term Treatment Cycle.
Natural Conception	Achievement of a pregnancy without the temporary removal of gametes (eggs and / or sperm) from the human body.
Ovarian Reserve	A measure of the number of Oocytes (potential eggs) remaining in the ovary. The number declines with age, and by the time of the menopause no oocytes remain. An adequate ovarian reserve is defined by NICE CG156 para 1.3.3.2 as: a total antral follicle count of more than 4, OR an anti-müllerian hormone level of more than 5.4 pmol/l, OR a (day 3) follicle-stimulating hormone level of less than 8.9 IU/l
Patient	See female partner above.
Pre-implantation genetic diagnosis (PIGD)	A clinical process using IVF technology whereby embryos are created, but before transfer to the uterus they are checked to ensure that they do not have a particular genetic condition present in (or carried by) the parents. Only embryos without that condition are transferred. Sometimes abbreviated to PIGD.
Programme of IVF treatment	A Programme of IVF treatment is defined and described as part of the definition of a treatment unit.
Single	For the purposes of this policy a single person is regarded as a person who is not in a current relationship with a partner. It does not relate to the marital status of that person. A person may be single, or may not be single in accordance with this definition, irrespective of their marital status.
Surgical Fertility Services	Surgical procedures designed to correct a structural abnormality that is preventing pregnancy. The definition includes only the specific list of services defined in the scope of this policy (paragraph 2.3).

Transfer	When an embryo is produced as part of an IVF treatment unit it is then placed in the woman's uterus at the appropriate point in the menstrual unit in the hope that it will implant and a pregnancy will result. The terminology used is that the embryo is transferred to the uterus. A transfer usually places one embryo, but for the purpose of this policy the simultaneous placement of two or more embryos into the uterus is regarded as one transfer.

Appendix 2: Associated OPCS

The codes applicable to this policy are:

OPCS codes
Q131, Q132, Q133, Q134, Q135, Q136, Q137, Q138, Q139, Q218, Q219, Y961, Y962, Y963, Y964, Y965, Y966, Y968, Y969.

Agenda Item no. 8

Joint Committee of CCGs
UPDATE REPORT

Work Programme: Stroke Programme	**Programme Director:** Gemma Stanion **Programme Team:** Elaine Day, Claire Kindness-Cartwright, Kate Turner **Clinical Lead:** Mark O'Donnell
PERIOD OF REPORT	October 2018

FOR INFORMATION

1. Introduction

This report provides a high-level overview of the whole Stroke Programme in Lancashire and South Cumbria (LSC), focussing on the different phases of the end to end stroke pathway including stroke prevention, hospital-based treatment, integrated community stroke rehabilitation and life after stroke.

It gives an update on the current position within Lancashire and South Cumbria and outlines, at a high level, the work which is being progressed and the key decisions which will need to be made during the coming months of the programme.

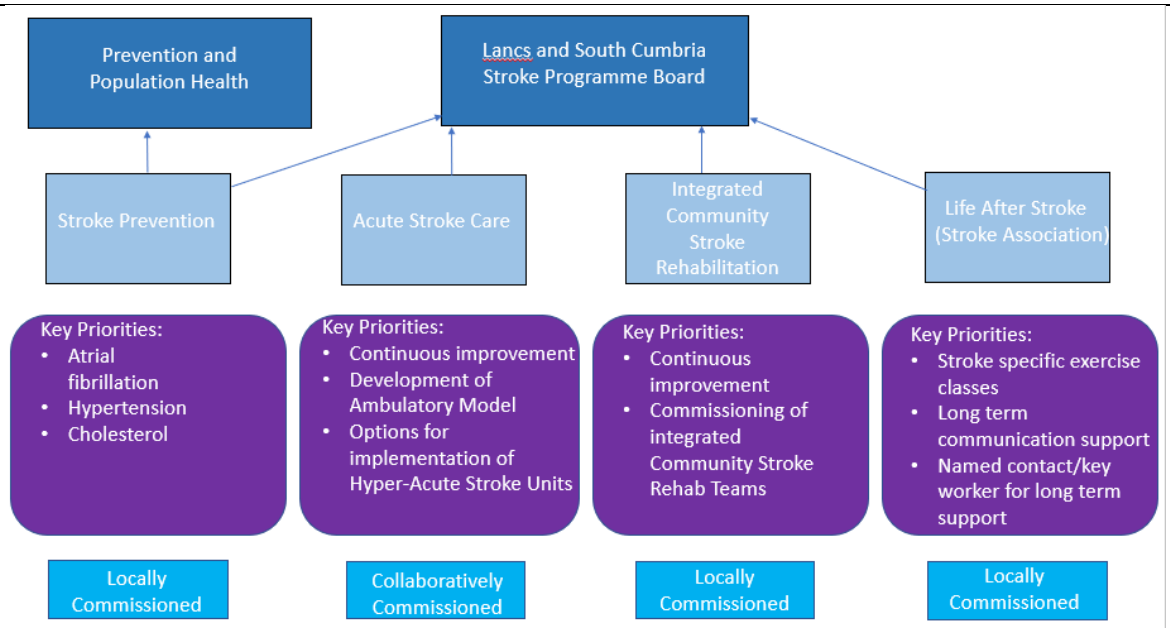
The Joint Committee of CCGs is requested to:

- **Note the content of this report.**
- **Note the significant progress made to date and the focus of continuous improvement in Stroke Services across Lancashire and South Cumbria.**
- **Note that investment decisions will need to be taken by commissioners before the end of March 2019 to support community-based rehabilitation services in order to secure the successful implementation of the proposed ambulatory care model for Stroke.**
- **Note the decisions to be made about the Stroke programme by commissioners and providers in the next few months.**
- **Endorse the programme and work going forward.**

2. Programme Overview – End to End Pathway

The end to end stroke pathway service specification for Lancashire & South Cumbria was agreed by the Lancashire and South Cumbria CCGs in 2015. It describes what patients within our region should expect in terms of care to prevent a stroke as well as treatment, rehabilitation and longer-term support after a stroke.

This has led to the creation of a Stroke programme across the Lancashire and South Cumbria ICS. The diagram below provides a high-level overview of the programme and sub-groups, key priorities, reporting and commissioning arrangements for each. There are key interdependencies with other ICP work programmes where these are also in place.



3. Stroke Prevention

The ICS-wide Stroke Prevention Alliance (partnership of ICS Stroke Prevention workstream with key stakeholders including the Advancing Quality Alliance, RightCare, Innovation Agency) is currently finalising its revised strategy and has identified the effective management of Atrial Fibrillation (AF), Hypertension and elevated Cholesterol as the three key risk factors to focus on over the next 3-5 years.

Current Position:

PHE has recently published data[i] indicating that for Lancashire & South Cumbria:

a) Atrial Fibrillation: There are 46,700 residents estimated to have AF with approximately 33,200 recorded on GP registers leaving 13,500 undiagnosed (observed to expected ratio approx. 71.1%). Of those with diagnosed AF there are 7,200 high risk AF patients not being appropriately anticoagulated
b) Hypertension: there are 433,900 residents estimated to have hypertension with approx. 258,000 recorded on GP registers leaving 175,900 undiagnosed (observed to expected ratio approx. 59.4%). Of those with diagnosed hypertension there are 50,800 patients not being appropriately treated to the Quality and Outcomes Framework (QOF) target though the number not being treated to NICE's clinical target is likely to be considerably higher
c) Cholesterol: For patients newly diagnosed with hypertension (age 30-74) with a cardiovascular disease (CVD) risk assessment >=20% only 64.2% are treated with statins. it is important to emphasise that for the wider cohort of all patients with a CVD risk assessment >-20% effectively treated with statins, it is estimated nationally that this figure is likely to be in the range of only 35-40%

More recent information from our established national data sets (GRASP-AF Quality Improvement tool and QOF) quote figures of approximately 5,900 high risk AF patients not being appropriately anticoagulated and 50,500 patients with hypertension not being appropriately treated in Lancashire and South Cumbria. This demonstrates there is still significant progress to be made in both these areas. Recent audit data has also highlighted significant concerns regarding the management of AF within hospital settings.

There has been a significant amount of work progressed within this area, however frustrations exist relating to the challenge of implementing a consistent prevention agenda across Lancashire and South Cumbria, linked to population health.

Improvement actions being taken now

- Working with the National CVD Prevention Board and local Clinical Leads to devise 1, 3 and 5-year ambitions in respect of these risk factors
- Integrated approach with ICS Primary Care Workstream to ensure these levels of ambition are reflected in ICS-wide standards for primary care currently being developed
- Engaged Stroke Prevention Clinical Leads to undertake a series of ICP based clinical engagement visits which will support both the launch of the Stroke Prevention Strategy as well as the development of associated ICP Plans

- Coordinating the delivery of support to individual ICPs in conjunction with RightCare, AQuA, Innovation Agency and other partners

Future Decisions

Commissioners in the ICS will have to decide before the end of March 2019 whether to:

- Mandate targets recommended by our Stroke Prevention clinical leads across the ICS to be delivered through a range of prevention and primary care actions.
- Target the use of financial resources in local GP quality contracts which support improved case management of patients with risk of cardiovascular disease.

4. Hospital-based Treatment

a. Continuous Improvement

All trusts have been making huge efforts to continuously improve their acute stroke services within the context of significant challenges in most clinical pathways and areas, the biggest of which is the workforce. When the Lancashire & South Cumbria Stroke Programme started in January 2014 SSNAP performance was a “sea of red”. The standard of Acute Stroke Services across LSC remain inconsistent, with unwarranted variation in access, timely treatment and access to rehabilitation services, and consequently outcomes, depending on where you live.

Current position

The table below shows performance at an overall level (aggregated score of detailed domains) against the National Stroke Sentinel National Audit Programme (SSNAP) measures. Progress has been greater in some areas than others however the challenges faced in all areas have been significant.

Overall Levels

Lancashire & South Cumbria

Site	Jul-Sep 15	Oct-Dec 15	Jan-Mar 16	Apr-Jul 16	Aug-Nov 16	Dec 16 -Mar 17	Apr 17 - Jul 17	Aug 17 - Nov 17	Dec 17 - Mar 18	Apr 18 - Jun 18
National	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Blackpool Victoria Hospital	E	E	E	E	D	E	E	C	C	D
Royal Blackburn Hospital	E	E	D	D	D	C	C	B	A	A
Royal Preston Hospital	D	C	C	D	D	D	C	B	B	B
Furness General Hospital	C	D	D	D	D	C	C	C	C	D
Chorley and South Ribble Hospital	B	C	B	C	C	D	D	B	B	B
Pendle Community Hospital - Marsden Stroke Unit	No Data	No Data	No Data	D	D	C	D	B	B	C
Royal Lancaster Infirmary	D	D	D	D	D	D	D	D	D	C

Improvement actions being taken now

- A single continuous improvement plan for Lancashire and South Cumbria is being developed based on the current improvement plan template/process in place at Blackburn. This will also link to a therapy dashboard which has been developed
- A number of Trusts are preparing to undertake short pilots of different ways of working including alternative ambulatory clinics, ring-fencing stroke beds and relocating Transient Ischaemic Attack (TIA) clinics to the stroke ward to assess the impact of these initiatives and support future improvement work

Future Decisions

Before the end of the 2018/19 financial year, commissioners in the ICS will need to agree:

- Investment plans for the whole stroke pathway including specialist rehabilitation at all sites, nurse consultants, psychology, pharmacy etc.
- The realistic ambition for delivering improved quality and safety and reducing unwarranted variation in acute stroke care between sites
- The value of a collaborative approach to recruiting key clinical professionals into an ICS-wide stroke service rather than individual hospital and community organisations (which may mitigate risks to recruitment challenges at certain sites)

b. Development of a sustainable Acute Model of Care

This revised programme of work commenced with mapping the acute phases of the stroke pathway, focussing in particular on the options for implementing hyper-acute stroke units (HASUs) to deliver the first 72 hours of specialist care across Lancashire & South Cumbria.

Given our current population, high incidence of stroke mimics, and challenges around workforce availability, the detailed hyper-acute options appraisal and modelling work (available on request) identified that predominantly focussing on implementation of hyper-acute stroke units was not practicable at this stage, and not appropriate for patients who live in geographically remote areas. Additionally, the significant unwarranted variation in access to acute stroke services across Lancashire & South Cumbria needed to be addressed first, therefore an alternative ambulatory care model is being developed and modelled.

A group of stroke clinicians and clinical commissioners have been researching and developing an **ambulatory care model a**s a more sustainable model of hospital care which is appropriate for the population and geography of Lancashire and South Cumbria. The ambulatory care model is based on national best practice, and recommendations from the national Getting It Right First Time (GIRFT) team and is seen as a more appropriate model because it:

- Prevents patients from being admitted unnecessarily
- Provides access to quicker assessment, diagnosis, appropriate treatment and rapid rehabilitation
- Refers patients on to more appropriate pathways, if needed e.g. TIA clinics, migraine etc.

Improvement actions being taken now

- Following agreement by clinicians and clinical commissioners, the model is being discussed with therapy providers (to note that the ambulatory model has greater impact on acute therapy team workload and numbers of staff required)
- To undertake more detailed impact analysis of the model, including on ambulance services, hospital estates, diagnostics, workforce and the requirements for a triage, treat and transfer pathway
- Finance modelling and exploring options around alternative funding mechanisms as the traditional “payment by results” tariff is not the preferred option

Future Decisions

Before the end of the 2018/19 financial year, commissioners in the ICS will need to agree:

- The ambulatory care model as a more sustainable model of hospital care now being recommended by our clinical leaders
- Amendments to the service specification which document the alternative ambulatory model
- Realistic implementation plans with providers, asking hospitals to work more closely together to mitigate the risk of limited numbers of staff.

c. Options for Implementation of Hyper-Acute Stroke Units (HASU)

Subject to a collective agreement to the ambulatory model as the most appropriate clinical model for hospital-based stroke care in Lancashire and South Cumbria, the ICS will then need to ensure that all patients have access to hyper acute stroke care in the early stages of a moderate to severe stroke. A timeline for this process still needs to be agreed to ensure any unintended consequences are mitigated, including unexpected financial impacts or changes in patient flows. These may need to be re-modelled if the ambulatory model is agreed to be taken forward to implementation.

The National Stroke Peer Review team has visited all the acute stroke sites across LSC in the past 18 months. The ICS can expect to receive further recommendations from the National Team in terms of optimum locations for HASUs based on SSNAP performance, population sizes and co-dependent clinical services.

Future Decisions

Before the end of the 2018/19 financial year, commissioners in the ICS will need to:

- Make decisions based on recommendations from the National Team regarding optimum locations for HASUs
- Decide whether or not the location of HASUs leads to significant service change. If so, this will need further consideration of the need for full public consultation

5. Integrated Community Stroke Rehabilitation

The National Stroke Plan due out in November 2018 mandates that every acute stroke unit should have access to an integrated community specialist rehabilitation team that provides early intensive rehabilitation and ongoing therapy for

up to 6 months, which is based on need and <u>not</u> criteria or discharge destination. Nationally and locally it is realised that this service needs to be put into place as part of continuous improvement and is an essential part of an effective stroke pathway.

At this point in time it is understood that the Lancashire & South Cumbria stroke pathway service specification aligns with the expected priorities in the national plan. Integrated Community Stroke Teams (ICSTs) will be endorsed as a key part of the pathway.

<u>Current position</u>

The table below demonstrates the current Lancashire & South Cumbria services benchmarked against the seventeen key elements of the integrated stroke service specification. This highlights significant variation between localities and compared to the specification. Patients are not being given the opportunities they should to maximise their functional recovery and reduce disability, resulting in increased costs across the system in Health *and* Social Care.

SECTION A: Team information		Blackpool	Fylde and Wyre	Morecambe Bay CCG			Blackburn With Darwen CCG	East Lancs CCG	Southport and Formby CCG	West Lancs CCG	Greater Preston CCG	Chorley and South Ribble CCG
	Team name	ESD Team		LNESDT	MBESDT	SLL&M	BWD CST	EL CST	N Sefton CNRT	West lancs CNRT	CNRT	
SECTION B. Compli												
1	All core professionals in team	N		N	N	N	N	N	N	N	N	
2	Staffing levels met	N		N	N	N	N	N	N	N	N	
3	Service provided for 6 days a week	N		N	N	N	N	N	N	N	N	
4	Service provided for up to 6 months	N		N	N	N	Y	N	Y	Y	Y	
5	Pathway 1.Therapy at home with ICST support	Y		Y	Y	N	Y	Y	Y	Y	Y	
6	Pathway 2.Therapy at home with joint ICST & re-ablement	Y		Y	N	N	N	Y	Y	Y	N	
7	Pathway 3. Intermediate care	N		N	N	N	Y	Y	Y	N	N	
8	Pathway 4.Residential/nursing home patients	Y		Y	N	N	Y	Y	Y	Y	Y	
9	Service accepts 40% ESD cohort	Y		Y	Y	N	Y	Y	Y	Y	Y	
10	Service accepts 60% non ESD cohort	N		Y	N	N	Y	Y	Y	Y	Y	
11	Assessment within 72 hours	N		Y	Y	N	N	N	Y	N	N	
12	Wait of 7 days or less from assessment to treatment	Y		Y	Y	N	N	N	N	N	N	
13	In reach into acute setting	N		Y	Y	N	N	Y	N	N	N	
14	Self referral permitted	N		N	N	N	Y	Y	Y	Y	Y	
15	Life after stroke services available	Y		Y	Y	N	Y	Y	Y	Y	Y	
16	6 month review for all residents	Y		N	N	N	Y	Y	N	N	N	
17	Inputting into SSNAP in timely way	Y		N	Y	N	Y	Y	Y	N	Y	
	Total (out of 17 elements)	8		9	7	0	10	11	11	8	8	
	% compliance with model	53		60	47	0	67	73	73	53	53	

ESD – Early Supported Discharge CST – Community Stroke Team CNRT – Community Neuro-Rehab Team

Improvement actions being taken now

- CCGs and Providers have worked together to review/scope/map current services and identify requirements
- All CCGs have actively engaged in the production of plans for the commissioning and implementation of Integrated Community Stroke Rehabilitation Teams, including Early Supported Discharge, within the next 12-18 months
- Continuous improvement work is being progressed both locally and via collaborative Task & Finish Groups where a pan-Lancashire & South Cumbria approach is beneficial

Future Decisions

Before the end of March 2019, commissioners in the ICS will need to:

- Make investment decisions in relation to the commissioning of integrated community stroke rehabilitation services. Without this, the ambulatory model described above will not work effectively
- Consideration needs to be made to the provision of psychological services for patients, and support to families and carers

6. Life After Stroke

The stroke pathway service specification describes three key elements of support that stroke patients should have access to:

- Stroke specific exercise classes
- Long term communication support
- Named contact/key worker for long term support

In addition, engagement with patients and carers highlighted that access to patient information could be improved and would have a positive impact in supporting patients and carers post-stroke.

Current position

The current position is highly variable. CCGs have different arrangements in place to commission a range of services from the Stroke Association, resulting in inequity of access to support for patients and carers post-stroke. In addition, pressures on local authority budgets, where they contribute to some of these services, increases the inequity.

There are opportunities to review life after stroke support and consider, in conjunction with the Stroke Association, how this can be commissioned, at either an ICP or ICS level, to enable more equitable access for patients and their carers.

In relation to improved access to patient information:

- A Directory of (all support) Services was developed by the Stroke Association which is refreshed on a 6-monthly basis and covers Lancashire & South Cumbria
- Patients, carers and staff working within stroke services were engaged and involved in the development of the Lancashire & South Cumbria Stroke Patient Information Guide, developed by the Commissioning Support Unit

Improvement actions being taken now

- Stroke Association has started to provide 6-month reviews in Blackpool
- Stroke Association has secured Sports England money in Central Lancashire to support people in to exercise programmes after stroke
- Work within Morecambe Bay Stroke Pathway Group focussing on how to make access to Stroke Association services more equitable
- Number of Stroke Association Peer Support groups increasing, based more on a voluntary staffing model

Future Decisions

Commissioners in the ICS will need to:

- Decide whether life after stroke support services should be commissioned at an ICP or ICS level

7. Engagement

a. Clinical

Throughout the programme there has been significant clinical engagement in support of developing the end to end

stroke pathway service specification and shaping, developing and modelling options for the ambulatory care model and options for hyper-acute stroke units. All trusts are represented at the Clinical Reference Group as are Clinical Commissioners from each of the CCGs.

Wider staff engagement sessions are planned in November and December 2018 across all acute trust sites to share the update on progress to date and to seek wider staff feedback and input to the development of the ambulatory care model. Invitations are being extended to partner trusts including NWAS and Lancashire Care Foundation Trust.

b. Patients/Carers

Throughout the programme there has been significant patient/carer engagement.

During 2016, patients supported the development of the end to end stroke pathway service specification as part of workstream groups as well as programme team members engaging with a large number of patients/carers at Stroke Association support groups across Lancashire & South Cumbria, to share the specification and seek feedback. In addition, all Stroke Association groups have been re-visited during summer 2018 to provide an update on the work and seek further feedback and input.

Patients, carers and staff were key to the development of the Patient Information Guide which was shaped through a series of workshop sessions and resulted in an interactive tool which is available in a range of formats to suit the needs of stroke patients, carers and clinicians.

The Stroke Programme Board, and (sub-group) Clinical Reference Group membership includes a patient representative who actively contributes to discussion and influences the direction of travel. In addition, further patient engagement is planned during January-March 2019 and, subject to clarification on consultation requirements, more formal pre-consultation engagement and public consultation will be undertaken if required in future.

The Joint Committee of CCGs is requested to:

- **Note the content of this report.**
- **Note the significant progress made to date and the focus of continuous improvement in Stroke Services across Lancashire and South Cumbria.**
- **Note that investment decisions will need to be taken by commissioners before the end of March 2019 to support community-based rehabilitation services in order to secure the successful implementation of the proposed ambulatory care model for Stroke.**
- **Note the decisions to be made about the Stroke programme by commissioners and providers in the next few months.**
- **Endorse the programme and work going forward.**

[i] Size of the Prize: reducing heart attacks and strokes (STP Level), Accessed via http://www.healthcheck.nhs.uk/commissioners_and_providers/data/size_of_the_prize_reducing_heart_attacks_and_strokes Public Health England, 2017

Agenda item no. 9

Joint Committee of Clinical Commissioning Groups

Title of Paper	**Special Educational Needs and Disabilities – Update**		
Date of Meeting	1 November 2018	Agenda Item	9

Lead Author: Hilary Fordham			
Purpose of the Report	For Discussion		
To update the Joint Committee of Clinical Commissioning Groups (JCCCG) on the progress being made following the SEND Inspection in Lancashire and the agreement of the Written Statement of Action (WSOA). To present the high level Neurodevelopmental Pathway and set out the proposed next steps for implementation.	For Information		Yes
	For Approval		
Executive Summary			
Recommendations	CCB is asked to: • Note the update and progress since the WSOA was accepted. • Note the specific work on the neurodevelopmental pathway, its agreement as a high level pathway and agree the next steps for gap analysis and implementation.		
Equality Impact & Risk Assessment Completed	Yes	No	Underway
Patient and Public Engagement Completed	Yes	No	Underway as per report
Financial Implications	Yes	No	Not yet known
Risk Identified	Yes		No
If Yes : Risk	ICPs not able to implement the ASD and Neurodevelopmental pathway.		
Report Authorised by:			

Agenda item no. 9

Special Educational Needs and Disabilities – Update

October 2018

Purpose

To update the Joint Committee of Clinical Commissioning Groups (JCCCG) on the progress being made following the SEND Inspection in Lancashire and the agreement of the Written Statement of Action (WSOA).

To present the high level Neurodevelopmental Pathway and set out the proposed next steps for implementation.

JCCCG is asked to:

- Note the update and progress since the WSOA was accepted.
- Note the specific work on the neurodevelopmental pathway and the agreement as a high level pathway for implementation.

Background

Lancashire County area had its SEND Inspection in November 2017. The Inspection took the form of a whole system inspection with the Local Authority being the lead agency, but all CCGs as commissioners expected to take part and accept the findings and all providers being part of the process.

The report was received in January 2018 and set out some very challenging findings and a Written Statement of Action was requested to address the 12 key actions which were identified. This was agreed by Ofsted in May 2018 and collected the 12 areas in into 5 workstreams:

- Strategy
- Commissioning and Access to Provision
- Engagement
- Identifying and Meeting Need
- Improving Outcomes

A programme of monitoring is in place with the Department of Education Advisor and the NHS England Advisor. These meetings take place quarterly and two have been held so far. The outcomes of these will ultimately influence the advice given to the Minister at the end of the year regarding progress.

Agenda item no. 9

Governance and Support Structures

At the time of the last update significant work had been undertaken to address the governance and partnership issues associated with this agenda which were heavily criticised in the report.

The SEND partnership Board has now been in place for several months and progress is being made to build relationships, set strategy and oversee the implementation of the actions. Regular reporting is now happening to the Health and Well-Being Board and JCCCG.

The Improvement Team remains in place to support the implementation of the WSoA, led through a combination of the Senior Improvement Partner, recruited by LCC and the Senior SEND Lead recruited across the CCGs. The CSU continues to support several of the workstreams.

Progress with Implementation

The workstream groups are now starting to see progress in each of their areas. Detail for each workstream is set out below and then the final section provides specific detail on the development of the ASD / Neurodevelopmental Pathway.

Strategy Group

This group's workstreams include:

- The development of the strategic vision to improve outcomes.
- The development of an accurate understanding of SEND across the local area.

The September SEND Partnership Board received and discussed an overarching vision statement for SEND in Lancashire which has been developed in partnership with young people and families. This was debated and has been slightly revised in readiness for further sharing with young people and families and sign off at the next meeting, the Draft Vision Statement is included at Appendix A for information. A wider strategy is now been developed, again in conjunction with young people and families, for discussion at the next Partnership meeting.

The Designated Clinical Officer (DCO) Function development is being overseen as part of this workstream. All three DCOs are in post, duties have been agreed between them and work is continuing within the team to develop the role and work with other organisations to understand their requirements of the team. Most importantly the DCOs are also working with a number of families and developing an understanding of the issues they face so that as a function they can start to influence commissioning and provision decisions.

The final area of work in this workstream relates to the development of the Joint Strategic Needs Assessment (JSNA). This will be an on-going process and the information required and used will

develop over a significant period of time. However, an initial scoping of the requirements has been undertaken and work is ongoing to meet the timescale set in the WSOA of January 2019.

Commissioning and Access to Provision

This group covers several of the issues which were items of particular concern for CCGs:

- Development of robust joint commissioning arrangements.
- Development of evidence based pathways for Autism across the area
- Improve the transitions processes for services 0 – 25.
- Develop equal access to provision, regardless of location.

This group has six workstreams:

- Joint Commissioning Arrangements – much of this work is being undertaken as part of the ICS Commissioning Framework discussions. The Framework and progress to date was presented to the SEND partnership at its September meeting, and they were updated on a number of areas of work such as CAMHS Re-design which impacts on children and young people with SEND. The Partnership also agreed to progress joint commissioning for speech and language therapy services across the patch building on work that has already been undertaken in the Fylde and Wyre area.
- ASD and Neurodevelopmental Pathway development – detail on this workstream is set out below. The particular issue related to North Lancashire and lack of any pathway has been resolved and a new service is now commencing, with a number of those on the previous waiting lists having now started their assessment processes.
- Transitions – Initial workshops are underway in this workstream to help develop an overall strategy, ensure support at all transition points through schools, in particular in post 16 transitions and working towards independence and employment; readying for life not just addressing the 'transition' issues.
- Access to services for vulnerable children – this group has focused initially on consistency of process and services for Children Looked After. With support from Morecambe Bay CCG and the Commissioning Support Unit, the Designate Nurses and Children Looked after Nurses have undertaken a mapping exercise across the County and identified five areas where the processes are inconsistent. The output is being finalised and next steps to addressing the inconsistencies will be agreed as part of this process.
- Special School Nursing – the LCC Children's Overview and Scrutiny Committee set up a task and finish review of the provision of special school nursing across the county. This report has been delayed but work has commenced on looking at provision across the L&SC area to again identify inconsistencies and work with special schools to identify their needs and how these might be addressed going forward, this work is being supported by Fylde and Wyre CCG.

- Complex Cases Panels – it has become apparent through work in North Lancashire and via the Inspection that the processes surrounding the complex cases panels are not effective. The processes were agreed after the establishment of the CCGs and the issuing of the first guidance on SEND, but now require review and improvement. Agreement has been reached with LCC that initial work will be undertaken on this in North Lancashire and then rolled out to the rest of the county. Initial meetings have been undertaken and the work will continue to report into the Commissioning and Access to Provision workstream.

Engagement

This group is of particular importance given the issues raised in the report and has been recognised by the SEND Partnership Board which now has several Young People's and Families representatives as part of its membership. There has also been a significant programme of engagement events undertaken, which has yielded some helpful comments and suggestions which are now being worked through for each of the workstreams to consider.

One concern is that the Parent Carer forum which should be available to the Partnership to utilise for support, input and guidance has not been running in Lancashire. The Forum should be run independently of the partners and Contact is commissioned to run this. Work continues with DfE support to re-develop this.

The SEND Partnership has agreed not to wait for the Parent Carer Forum but to continue its work on engagement through a variety of means and these include:

- Repeat of the engagement events run in June and July to present back the outputs and how the feedback has been used to influence change.
- Engagement on individual workstreams and projects; all workstreams now have parent care representatives and individual projects are engaging as described with regard to transitions processes and the neuro-developmental pathway development.
- Continued work through POWAR (young people's engagement group) which was praised as part of the inspection.
- Re-development of the Local offer to sit on its own platform outside of LCC's website and with significant engagement of parent carers to influence design and structure.
- Development of the use of technology to provide feedback on specific items for example an App to enable feedback on the EHCP review process.
- Development of a working together strategy.

Identifying and Meeting Need

This group is focused on ensuring that children and young people's needs are appropriately identified and then through either a SEN Support Plan or the development of a formal EHCP support is delivered.

The role of the DCOs is important in this area to ensure that EHCPs are consistent, outcome driven and of appropriate quality. Engagement events have informed the development of quality standards

which will form part of a quality framework used to identify the quality of EHC Plans. Multi-agency workshops are being held to look at how the quality of plans can be improved.

Work is also on-going to ensure that systems are in place to appropriately identify children and young people who require support.

Improving Outcomes

This group is focused on improving the educational attainment of young people and as part of that addressing another of the key features set out in the report to reduce the number of exclusions for those children who have an EHCP. The next steps for this group are as follows:

- Agree targets for improvement in Exclusion rates (reducing) and Attainment rates (increasing).
- Implement a programme of action with schools.
- Target and support those at risk of permanent exclusion.
- Implement training and support for governors on this agenda.

ASD and Neurodevelopmental Pathway

The second main workstream within the Commissioning and Access to Provision workstream is to develop improved pathways for ASD as part of a Neurodevelopmental Pathway. This workstream is being led by Dr Maria Hall, Community Paediatrician from Central Lancashire and Caroline Waddington, Senior Programme Manager, CSU.

Significant progress has been made on this work since it commenced earlier this year taking work from across the Lancashire and South Cumbria area and developing this into a high level agreed pathway at a workshop in September 2018. Appendix B sets out the high level pathway followed by some key notes. The key features are as follows:

- Children and families are at the centre of the model supported by care co-ordination.
- Support at all stages, the idea being that regardless of 'diagnosis' the child and family have a need and therefore require support to address this should be provided.
- A process of ensuring that children and families access the support they need within the pathway by professionals using appropriate consistent tools and skills to develop a support profile with the young person and family to assist them; again regardless of diagnosis outcome.
- The pathway is based on the Thrive Model which is being used in the Emotional Health and Well-Being re-design so that the two pathways can relate together and children and families can move through it to where they need to be rather than having a criteria driven approach.

Significant engagement has been undertaken both prior to development as part of work on the Fylde coast, on-line (500 responses) and as part of the workshops.

The pathway was agreed as a high level working pathway at a workshop on the 14th September.

The next steps are to work with each Integrated Care Partnership to understand the services they have at present, the gaps to delivery of this model and the implementation plan they can put in place to reach a standard delivery of the model. It is appreciated that all areas will have different starting points and a summary of the gap analysis and implement plans will be provided to the Commissioning and Access to Provision Group for oversight.

Recommendations

JCCCG is asked to:

- Note the update and progress since the WSOA was accepted.
- Note the specific work on the neurodevelopmental pathway and the agreement as a high level pathway for implementation.

Hilary Fordham

Chief Operating Officer, MBCCG

Mark Youlton

Chief Officer, ELCCG

October 2018

Agenda item no. 9 - Appendix A

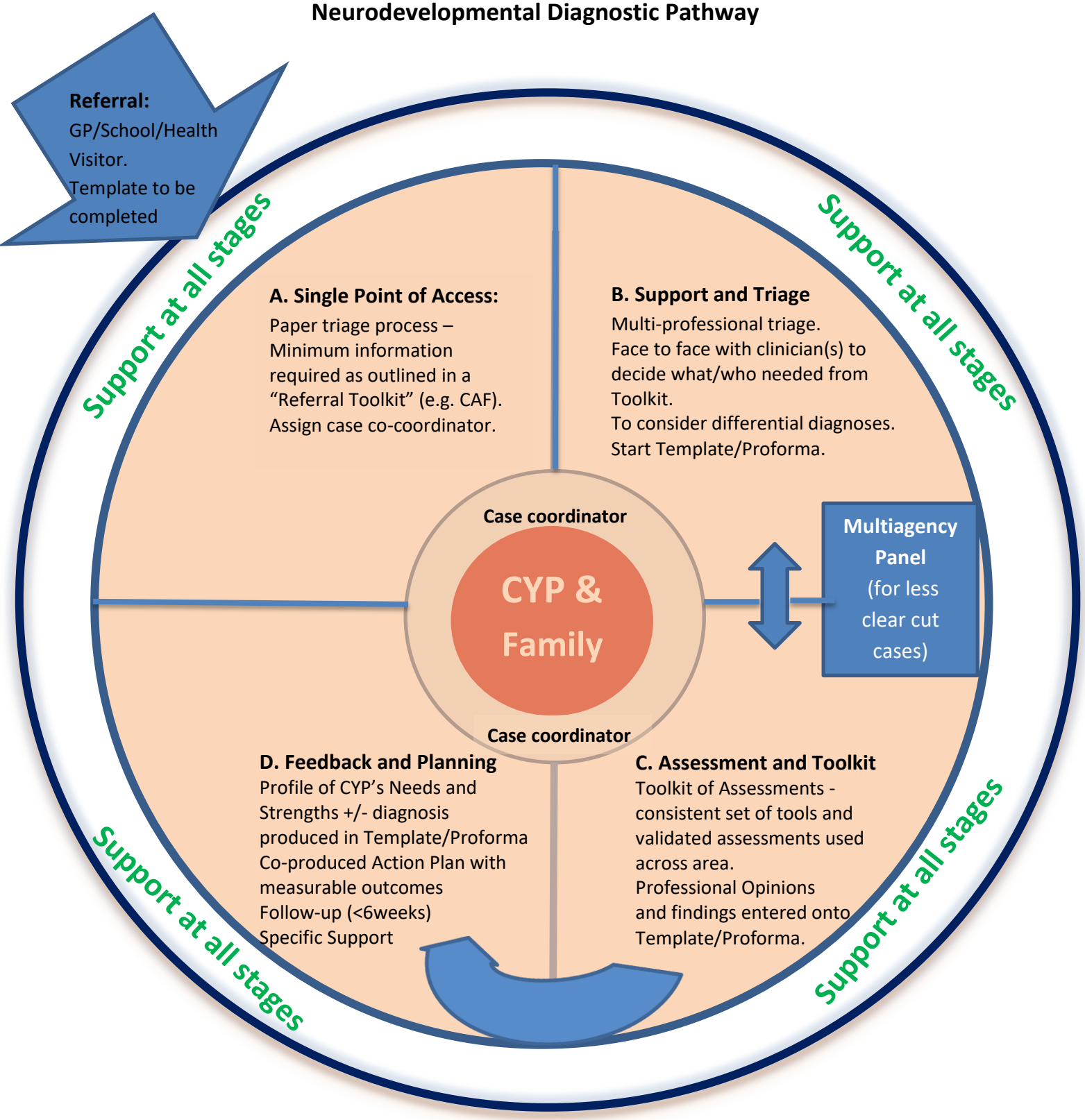
Draft Lancashire Vision Statement

The Lancashire SEND Partnership has a vision for the future; although there is a great deal of work to be done and we know we are not there yet, we have high aspirations and share a commitment to achieve change.

ONE Vision for the future

- We are passionate about planning for and meeting the needs of children and young people with special educational needs and disabilities;
- We work together, as equal partners, who understand and listen to each other;
- Our highly regarded services are child centred, accessible and responsive;
- Our children and young people are supported to achieve their potential and ambitions, as valued members of the community.

Lancashire and South Cumbria – (Draft) High Level Neurodevelopmental Diagnostic Pathway



*There was discussion about the terminology used. For the purposes of getting to this stage of a draft pathway these were not discussed in detail at the workshop. However, it was recognised that some feel that we should call it a Request for Assessment rather than use the word Referral, that we should call this an Assessment Process rather than Diagnostic Process and that Parenting Courses should be renamed. In the interests of clarity, the term referral has been used for now.

Explanatory Notes

The child/young person (CYP) and his/her family are at the centre of the process.

There is a case coordinator (or keyworker or key professional) who will be consistent throughout the process, will ensure information is shared as appropriate, be a link to sources of support and will facilitate movement through the pathway.

Support is available at all stages of the pathway. Families need information and support as early as possible but throughout the assessment process. Families are driven to get a diagnosis as they feel this is the only way they can get support, particularly in education. The case coordinator will be able to advise which local services are available and appropriate.

The pathway is not a linear process. It is possible to move forward and backwards within it.

Entry to the pathway is via a single point of access through a request for assessment (referral*) and will initially be considered in a paper triage process. There has been some discussion as to whether this should/could be centralised for the whole region or should be done locally. This is yet to be decided. There will be clear Referral Criteria that are consistent across the area (e.g. evidence of involvement of Universal Services or a CAF completed) that may be able to meet the needs of some CYP without the need for more specialist assessment. It was discussed that it could be possible for parents to self-refer if the referral criteria were met. If a referral is not felt to be appropriate at the paper triage stage there should be signposting to sources of intervention, support or a more appropriate service. There is recognition that sometimes early support can prevent an escalation of difficulties.

If a referral is felt to be appropriate the next stage should be a face-to-face assessment by at least one professional. The professional(s) need to be able to decide whether further specialised assessment is required, suggest what type of assessment tools and/or opinions may be needed, and able to consider differential diagnoses. For cases in which the presentation is unclear or complex, a multiagency panel should decide how to proceed. CYP with more straightforward presentations would not need to have input from the panel.

It was suggested and agreed that it would be helpful to use a Template or Proforma that could be populated at each stage of the assessment process and held by the young person or the parent/carer. Information would then be shared between professionals and it would avoid the need for the CYP/family to repeatedly give the same information. This could be a paper document or in an online format. There could be a section that was kept separately for confidential information that the CYP or family did not wish to share. The outcomes of assessments and the profile of strengths and needs would be added to the document. It would be created at the initial appointment and added to throughout the process until after completion of the assessment and follow-up.

For those CYP requiring assessment, the most appropriate diagnostic tools and professional opinions should be selected from a defined Toolkit. The Toolkit should be consistent across the region and include validated assessments e.g. ADOS, and should not include tools such as questionnaires if they have not been validated. The Toolkit will also include professional assessments e.g. a mental health assessment, a language assessment etc. Details of the Toolkit have not been decided at this time. The two-way arrow indicates that the assessment will involve further review by a professional to decide if addition information is needed using other tools from the Toolkit.

The pathway will result in a Profile of the child/young person's strengths and needs. This may include a diagnosis if appropriate. The findings will be fed back to the young person or parent/carer at the conclusion of the pathway. A follow-up appointment will be offered within 6 weeks and there will be the opportunity to signpost to more specialised support if appropriate e.g. to an ADHD-focused parenting course, or Cygnet course if ASD has been diagnosed.

Joint Committee of Clinical Commissioning Groups

Title of Paper	Commissioning Development in Lancashire & South Cumbria		
Date of Meeting	1st November 2018	Agenda Item	10

Lead Author	Andrew Bennett, Dawn Haworth	
Purpose of the Report	For Information	
Executive Summary	In June 2018, the Joint Committee of Clinical Commissioning Groups (JCCCGs) received a paper providing an update on the development and implementation of the commissioning development framework since its approval in January 2018. The Joint Committee received a set of recommended commissioning priorities for each workstream set out in a place-based approach. The paper also indicated an intention to apply the framework to planned care services and to progress further discussions around integration/alignment of commissioning activities with Local Authorities. The JCCCGs agreed the recommendations and asked that work to develop operating and support models be progressed. This paper provides an update on progress since June including: 1. Governance and other arrangements established to oversee and support implementation of the Commissioning Framework 2. A summary of progress across workstreams in implementing the Framework. 3. Timeline for implementation, including phasing 4. An update on work to develop and implement the People and Organisational Development Framework	
Recommendations	The JCCCGs is asked to: 1. Note the governance and other arrangements established to oversee and support implementation of the Framework. 2. Note that work is continuing towards implementing the framework, across workstreams. 3. Note the proposed timeline for implementation and phasing. 4. Ask the Executive Lead for Commissioning to bring forward recommendations for the next stage of implementation.	
Equality Impact & Risk Assessment Completed	No	
Patient and Public Engagement Completed	Not Applicable as this work relates to the deployment of management resources linked to commissioning functions.	
Financial	It is proposed that any changes are made within existing resources	

Implications	available to commissioning organisations.
Risk Identified	Yes
If Yes : Risk	Inadequate approach towards the implementation of changes affecting both the statutory duties of individual organisations and the objectives of commissioning employees. Need for effective implementation plans and clear approach to assurance.
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS

Joint Committee of Clinical Commissioning Groups – 1st November 2018

Commissioning Development in Lancashire and South Cumbria

1. Introduction

This report is provided to Lancashire & South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs) as a formal update on work to implement a new place-based commissioning framework for Lancashire and South Cumbria. The JCCCGs is asked to note the current position in relation to implementation of the commissioning framework

In June 2018, the JCCCG received a paper providing an update on the development and implementation of the framework since January, together with a set of recommended commissioning priorities for each workstream set out in a place-based approach. The paper also indicated an intention to apply the framework to planned care services and to progress work around integration/alignment of commissioning activities with Local Authorities.

The JCCCGs, agreed the recommendations and asked that work to develop operating and support models be progressed.

2. Progress with Commissioning Framework Implementation since June

2.1 Strengthened Oversight

Following the JCCCGs decision in June 2018, it was agreed to further formalise the governance and delivery arrangements that had underpinned the development of the framework. The Commissioning Oversight Group (COG) was established to:

- Further choreograph the implementation of the recommendations of the working groups for all the above services
- Define how collective commissioning resources across CCGs, CSU and NHSE would be applied and realigned across the ICS, ICPs and neighbourhoods in line with the agreed models
- Ensure that implementation plans are delivered in line with expectations
- Manage associated risks and issues
- Ensure anticipated benefits from proposed changes are achieved.

COG meets monthly and is chaired by the ICS Executive Lead for Commissioning. It includes executive level representation from across the ICS, ICPs, NHSE and Commissioning Support Unit. Once COG has considered the implementation plans received from each workstream, it will make its recommendations to the JCCCGs.

2.2 Workstream Progress

There are now nine workstreams progressing implementation of the Framework:

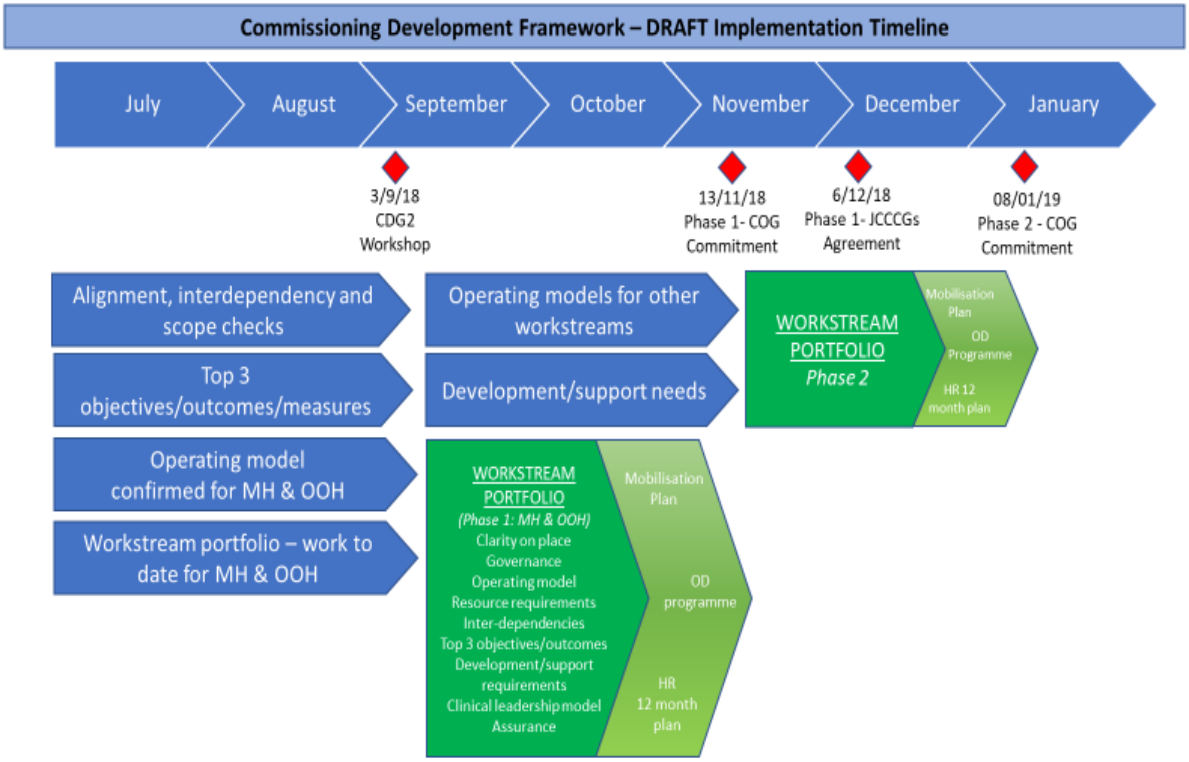
- Out of Hospital
- Adult Mental Health
- Children and Young People's Emotional Wellbeing and Mental Health
- Services for people with Learning Disability and Autism
- Children, Young People and Maternity services
- Services for People with Cancer
- Individual Patient Activity
- Urgent and Emergency care
- Planned Care.

In order to ensure that workstream leads were fully engaged in and adequately supported throughout the work needed to implement the framework, it was agreed to expand the membership of the existing Commissioning Development Group (CDG) to include the workstream leads and for that group to focus on bringing them together to:

- Share learning from the application of the framework to date
- Provide mutual support in ensuring all workstreams are ready to move through the implementation phase
- Develop and test out approaches to the next phase, adapting these to the requirements of the individual workstreams as appropriate
- Resolve issues and tackle obstacles that may arise during implementation
- Drive forward effective implementation across all work streams
- Co-ordinate reporting of progress from the workstreams to COG and ultimately to JCCCGs in December 2018

The group is chaired by the Executive Lead for Commissioning and meets as needed, often utilising a workshop format where leads share their approaches and the challenges that they are facing, working together to problem-solve.

To date, the expanded CDG has developed a timeline for the next phase of implementation together with a portfolio pack of information to be developed by each workstream to progress implementation. The timeline, proposed portfolio content and phasing of workstreams are summarised in the diagram below.



The CDG has collectively peer-reviewed the state of readiness of each workstream to proceed with the next phase of implementation and agreed that Adult Mental Health and Out of Hospital will be the first workstreams to progress development of their portfolio for approval at the JCCCGs in December 2018. The remaining workstreams will benefit from the learning from these two groups and will present their portfolios for approval at the JCCCGs in February 2019.

2.3 People and Organisational Development

The COG has progressed further work on the development of a People and Organisational Development (OD) Framework. The People and OD Framework is an evolving document which will continue to be reviewed and develop throughout the transition process. The Framework outlines the principles applying to the HR and employment processes supporting the alignment of functions, roles and new appointments associated with the development of the ICS and ICPs. It also provides the guiding standards relating to any necessary employee movement from the current commissioning system to the new ICS and ICP arrangement and is intended to ensure consistency in the handling of employee matters going forward.

The People and OD Framework recognises that whilst the new place-based arrangements will require some new skills and competencies it is important that the system retains the wealth of experience, knowledge and skill that already exists, as we move forward. As such the role of Organisational Development is seen as central to the transition and further work is underway with workstreams to identify their OD requirements.

The COG has also drafted a memorandum of understanding (MOU) between the partners within the ICS and ICPs which aims to outline how partner organisations will operate, behave and engage with each other to meet the needs of the system and ultimately the patients and service users whilst ensuring the commissioning system remains sustainable and that staff involved in the reconfiguration of the commissioning system are treated fairly, equitably and consistently. The MOU includes principles, behaviours and a proposed approach to the management of changes and can be used to hold the system to account.

Recommendations

The JCCCGs is asked to:

1. Note the governance and other arrangements established to oversee and support implementation of the Framework.
2. Note that work is continuing towards implementing the framework, across workstreams.
3. Note the proposed timeline for implementation and phasing.
4. Ask the Executive Lead for Commissioning to bring forward recommendations for the next stage of implementation.