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

Thursday 09 January 2020, 13:00-15:00,
Blackpool Central Library, Queen Street, Blackpool, FY1 1PX

AGENDA

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

Time	Item	Description	Owner	Action	Format
Standing Items					
13:00	1.	Welcome and apologies	Chair	Information	Verbal
	2.	Declarations of interests	Chair	Information	Attached
	3.	Notes of the meeting held on 05 September 2019	Chair	Approval	Attached
	4.	Items for any other business	Chair	Information	Verbal
Improving Population Health					
	5.	Individual Patient Activity (IPA)	J Hawker	Approval	Attached
	6.	Regulated Care Sector Residential and Nursing Care Service Specification	S Thompson	Endorse	Attached
	7.	Commissioning Policies • Policy for Low Intensity Pulsed Ultrasound for the Management of Non-Union Fractures	E Johnstone	Approval	Attached
	8.	Lancashire & South Cumbria medicines management group	B Horrell	Information	Attached
	9.	Commissioning Reform – Lancashire and South Cumbria	A Bennett	Endorse	Attached
Any Other Business					
14:55	10.	Any other business	Chair	Information	Verbal

Date and time of next meeting: Thursday 05 March 2020, 13:00-15:00, **Venue to be confirmed**

Dates of future meetings 2020:
07 May 2020
02 July 2020
03 September 2020
05 November 2020

Declaration of Interests for members of the Joint Committee of CCGs

Introduction

Managing conflicts of interest appropriately is essential for protecting the integrity of the NHS commissioning system and to protect NHS England, Clinical Commissioning Groups, GP practices together with other providers from any perceptions of wrongdoing.

It is therefore essential that declarations of interest and actions arising from declarations are recorded formally in the minutes of the Joint Committee

Process

At the beginning of each meeting, the Independent Chair will ask colleagues to indicate if they have any interests to declare.

Members are asked to indicate the type of interest they wish to declare, making reference to the table below:

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and

Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defense organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE);
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend;

After a declaration of interest is made, the Chair will make a determination as to how the individual members should continue to participate in the meeting. This will be on a case by case basis and the decision will be explained to the committee.

There are a number of options for actions that the Chair may take depending upon the particular interest identified:

- Member leaves the room for that agenda item
- Members stays in the room, can participate in the discussion and make comments but cannot vote on any decision
- Member stays in the room, can participate in discussion and can vote on the decision
- Item is deferred –agenda amended to reflect this

If the Chair is conflicted, the Deputy Chair will take the Chair's role for discussions and decision-making of the relevant part of the meeting and may use the above options for action.

The following information will be recorded in the minutes of the meeting:

- Individual declaring the interest
- At what point the interest was declared
- The nature of the interest
- The Chair's decision and resulting action taken.

In addition, any individuals retiring from and returning to meetings should be formally record in the minutes.

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

Present		
Phil Watson	Independent Chair	JCCCGs
Dr Richard Robinson	Clinical Chair	East Lancashire CCG
Geoffrey O'Donoghue	Lay Member	Chorley and South Ribble CCG
Dr Geoff Jolliffe	GP and Clinical Chair	Morecambe Bay CCG
Doug Soper	Lay Member	West Lancashire CCG
Dr Gora Bangi	Chair	Chorley South Ribble CCG
Jerry Hawker	Chief Officer	Morecambe Bay CCG
Roy Fisher	Chair	Blackpool CCG
Paul Kingan	Chief Finance Officer	West Lancashire CCG
Dr Adam Janjua	GP and Acting Chair	Fylde and Wyre CCG
In Attendance		
Peter Tinson	Chief Operating Officer	Fylde Coast CCGs
Andrew Bennett	Executive Lead Commissioning	Lancashire and South Cumbria ICS
Kirsty Hollis	Deputy Chief Officer	East Lancashire CCG
Paul Hinnigan	Lay Member, Governance	Blackburn with Darwen CCG
Tim Almond	Senior System Manager – Urgent Care	Morecambe Bay CCG
Andrew Harrison	Chief Finance Officer	Fylde Coast CCGs (attended for Item 8)
Cathy Gardener		East Lancashire CCG(attended for Item 8)
Donna Parker	Service Redesign Support Manager	East Lancashire CCG and Blackburn with Darwen CCG (attended for Item 8)
Elaine Johnstone	Chair, Commissioning Policy Development and Implementation Group (CPDIG)	Midlands and Lancashire Commissioning Support Unit (attended for Items 6)
Roger Parr	Chief Finance Officer	East Lancashire and Blackburn with Darwen CCGs
Denis Gizzi	Chief Officer	Chorley & South Ribble CCG and Greater Preston CCG
Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Jane Cass	Locality Director	Lancashire and South Cumbria ICS
Edward Fletcher	Commissioning Manager	Cumbria County Council
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Gaynor Jones	Executive Assistant	Lancashire and South Cumbia ICS
Apologies		
David Bonson	Chief Operating Officer	Blackpool CCG
Graham Burgess	Chair	Blackburn with Darwen CCG
Louise Taylor	Executive Director for Adult	Lancashire County Council

	Services and Health and Wellbeing	
Steve Thompson	Director of Resources	Blackpool Borough Council
Debbie Corcoran	Lay Member for Public and Patient Involvement	Greater Preston CCG
Katherine Fairclough	Chief Executive	Cumbria County Council
Dr Sumantra Mukerji	Chair	Greater Preston CCG
Lawrence Conway		
Gary Raphael	Executive Lead - Finance	Lancashire and South Cumbria ICS
Julie Higgins	Chief Officer	East Lancashire and Blackburn with Darwen CCGs
Andrew Bibby	Assistant Regional Director of Specialised Commissioning (North)	NHS England/NHS Improvement
Gary Hall	Chief Executive	Chorley Borough Council
Neil Jack	Chief Executive	Blackpool Borough Council
Sakthi Karunanithi	Director of Public Health and Wellbeing SLT Support	Lancashire County Council
Simon Burnett	Deputy Director of Leisure and Wellbeing	West Lancashire Borough Council
Kevin Toole	Lay Member	Fylde and Wyre CCG

A.	**Standing items**
1.	**Welcome and Introductions** The Chair welcomed members to the regular business meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs) held in public. The Chair, E Johnstone and A Bennett held a 30 minute pre-meeting with a member of the public to enable questions to be raised on the agenda. Members were reminded that the business today was being live-streamed and recorded so that decisions are accessible and available to members of the public following the meeting, on the Lancashire and South Cumbria (L&SC) YouTube channel.
2.	**Declaration of Interests** None reported.
3.	**Notes of the meeting held on 02 May 2019** Following a minor amendment on page 4, Item 7, third paragraph 'assessments' amended to 'reassessments', the notes were agreed as a correct record.
4.	**Items of any other business** None reported.
5.	**Lancashire and South Cumbria Urgent and Emergency Care Strategy (L&SC UEC)** Tim Almond, Senior System Manager, Urgent Care, attended the meeting on behalf of the Urgent Care Network to provide an update on the refreshed UEC transformation work programme in Lancashire and South Cumbria. T Almond demonstrated the purpose of the report, the aims, the local priorities, key achievements and deliverables in line with the requirements of the national NHS Long Term Plan.

	The content of the report provided a clearer indication on local drivers and the need for change within the Integrated Care System (ICS) footprint. It also provided information on the national work surrounding clinical access, targets and access standards. The core of the document described all elements of the health and social care economy and the innovation to drive the improvement narrative throughout the strategy. Feedback on the intentions had been received along with clarity around performance figures at an ICS level. T Almond welcomed any questions, comments and thoughts. P Tinson welcomed a review of urgent treatment centre provision and requested the inclusion of different models of primary care, extended access in different ICPs and shared learning around increasing utilisation of appointments logged. D Soper agreed with the direction of the strategy but questioned the quality and reliability of the data in relation to monitoring emergency admissions and improving same day discharge. T Almond informed the Joint Committee that standardisation of data is being considered. A Bennett questioned predicting patterns of demand for urgent care and asked when the national review of access to national standards will be concluded. T Almond informed the Joint Committee that work is ongoing within NHS Improvement in predicting activity and factoring in soft metrics to improve accuracy. The Joint Committee was asked to note the content of the refreshed UEC Strategy and locally agreed priorities. **RESOLVED**: **that the Joint Committee noted the content of the report.**
Improving Population Health	
6.	**Commissioning Policies** Elaine Johnstone attended the meeting to provide the Joint Committee with a review of seven intervention-specific commissioning policies by the Commissioning Policy Development and Implementation Working Group (CPDIG), responsible for the oversight of the process submitted to the Joint Committee for approval and ongoing programme of policy review. E Johnstone described the changes made to each individual policy, mainly around the clarity of wording. The policies had been drafted to align current policy criteria with NHS England's Evidence Base Intervention (EBI) Guidance. It was recommended that the Joint Committee ratify the following collaborative commissioning policies that will replace any existing CCG policies once approved: a) Tonsillectomy b) Surgical release of trigger finger c) Surgical management of gynaecomastia d) Management of otitis media with effusion using grommets e) Surgical Treatment of carpal tunnel syndrome f) Breast reduction surgery g) Removal of benign skin lesions The Chair asked for questions and comments. G Jolliffe asked if the policy for the removal of benign skin lesions was consistent with the application of the policy for general practice and if it could be flagged to general

	practice. E Johnstone informed the Joint committee that it is the expectation that a policy that is ratified by the Joint Committee applies to all clinicians across the whole of L&SC. From a question raised on when a policy becomes effective, E Johnstone informed the Joint Committee that the date at which a patient is referred is the date at which to consult a policy. The Policy Development Group will discuss this subject further in due course. E Johnstone noted a request for annual feedback on the extent of compliance for the Joint Committee to assess. **RESOLVED**: **that the Joint Committee ratified the seven intervention-specific commissioning policies that will now proceed to implementation.**
7.	**Individual Patient Activity (IPA) programme** J Hawker provided an update on the progress of the current IPA activity across L&SC to support a case for change that builds on previous information presented to the Joint Committee in May 2019. The approach to IPA across L&SC was evident in terms of the scale of challenge presented. Two primary objectives were noted: to improve the current performance of the existing IPA services and for the IPA Programme Board to bring forward proposals around the future commissioning and operation of IPA services and Continuing Health Care (CHC). A formal paper will be brought to the Joint Committee by the end of the calendar year, regarding long-term proposals for the management of IPA services. Work is continuing to build on extensive programmes of work around best practice across the north of England looking at CHC systems. Progress has been made over the last few months in terms of improving the education, training and understanding of the CHC process. The current position on Personal Health Budgets (PHBs) was provided. Support from the Joint Committee was sought to recommend that current funding is extended to year-end. The Joint Committee approved the proposed Joint Disputes Resolution Protocol and agreed that delegated authority is to be given to the IPA Board for final ratification. J Hawker thanked the teams involved on developing the financial intelligence and bringing together clear plans on how to improve the experience of people accessing the IPA services and in ensuring collectively, the eight CCGs are compliant with the national expectations in terms of the NHS Continuing Health Framework and quality standards for IPA services. The Chair asked if there were any questions or comments. G Jolliffe raised a question on levelling variation of spend within CCGs. The Joint Committee was informed of three levels of spend. National evidence shows a complex mix of areas and profiles of people accessing CHC services. P Tinson observed that local authority costs had not been included and asked if local authority partners had agreed to provide information to give a more holistic picture. J Hawker informed the Joint Committee that local authorities have been active in their work with the IPA Board.

	D Soper asked for thoughts on capping individual high cost packages of care in excess of £1.5m per annum for people in their own homes. J Hawker drew attention to the NHS long term commitment to the personalisation agenda in providing care with the best use of resources. It was reported that there is clear evidence in using PHB to improve the experience of the patient. The Chair asked the Joint Committee to vote on the following recommendations: • Note the ongoing performance position and current level of improvement action and ensure individual CCG Governing Bodies are full sighted on the current risks associated, including potential additional investment requirements to address (appendices A-E) • Note progress and actions to develop proposals on both new commissioning and operational delivery models for IPA services due to be presented before end of the year (appendices A-E) • Endorse the recommendation of the IPA Programme Board to continue and increase the level of non-recurrent funding to ensure CCGs continue to comply with the duties to promote and provide PHBs. Note: The decision whether to extend the PHB investment remains under the statutory duty of individual CCGs (appendix F) • Approve the proposed Joint Disputes Resolution Protocol set-out in appendix G and delegate authority to the IPA Programme Board to sign-off any minor non-material amendments at the September board meeting. This is to allow parallel approval processes with the Local Authorities. **RESOLVED: that the Joint Committee endorsed the recommendations.**
8.	**Ophthalmology Project Initiation Document (PID)** A Harrison, Chief Finance Officer for Blackpool and Fylde and Wyre CCGs attended the meeting in his capacity as the executive lead for planned care commissioning across the ICS. A Harrison introduced colleagues, K Gardner and D Parker, leads on the process for the PID for Ophthalmology planned eye care. The Joint Committee is asked to approve the PID that had been constructed by the CCG's Commissioning Support Unit and ICS colleagues in support of harmonising standards, measures and outcomes for eye care pathways, in particular, age related macular degeneration, glaucoma and cataracts; the PID includes a series of touch points and governance steps to the goal of common standards, metrics and outcomes. The next step is to facilitate both clinical and pubic engagement in the process which, if approved, will be undertaken by the group made up of CCG led lead commissioners supported by ICS and Integrated Care Partnership (ICP) programme colleagues. The Chair asked if there were any questions or comments. Dr Bangi asked if there was a solution to the Avastin debate. A Harrison informed the Joint Committee that at this stage the PID is looking to seek to generate those standards, outcomes and measures of which the treatment of either Avastin or other drugs will be taken as an option and to determine the best approach. A Curran informed the Joint Committee that the Pharmacy Medicines Optimisation Programme is currently looking at this area. D Soper noted the omission of data for Morecambe Bay and West Lancashire. A Harrison advised that the intention is to collect all data. Colleagues from Morecambe Bay are involved and West Lancashire are involved less so, in the process. G Jolliffe asked what the ambition is for achieving consensus amongst practicing

	ophthalmologists across ICS and highlighted potential challenges with clinicians regarding single use drugs. A Harrison advised that this will be further discussed at the upcoming clinical engagement event to seek the best possible solution. G Jolliffe asked for firm direction for providers across the system. The Chair asked the Joint Committee to agree the following recommendation: • To approve the PID to support the ICS-wide creation of standards, measures and outcomes for ophthalmology care pathways across the Clinical Commissioning Groups. **RESOLVED: that the Joint Committee approved the ophthalmology PID.**
9.	**Terms of Reference (TOR) Review** J Hawker provided two visions of the TOR to consider (Section 2, Version 1 and Section 3, Version 2) taking into account the legal duties of individual statutory bodies and the Joint Committee and taking significant steps forward to recognising the move to system working and our future as set out in the NHS Long Term Plan. J Hawker highlighted the need for the Joint Committee and the individual eight CCGs to be explicitly clear around delegated authority to the Joint Committee and the extent this applies to the Work Programme; subject to the TOR being agreed, J Hawker recognised that the Joint Committee Work Programme needs to be refreshed. The recommendation is for the Joint Committee to adopt Version 2 to go forward to the eight CCGs for final sign-off. The Chair asked if there were any questions or comments. D Soper requested an amendment to Version 2 paragraph 3.2; the CCGs named in paragraph 5 are not named in paragraph 1.5. Also, 'STP' Board to be amended to 'ICS' Board. G Jolliffe motioned to adopt the progressive nature of Version 2. A Doyle commended the amount of work that has gone into the review and supported endorsing Version 2. **RESOLVED: that the Joint Committee accepted and recommended Version 2 to be adopted by the eight CCGs.**
10.	**Any other business** None reported. The Chair declared the formal meeting closed.
11.	**Questions from the public** Mr J Clayton, Chorley Hospital Campaign Group member, asked for clarity on the longevity of Personal Health Budget funding. A Doyle informed Mr Clayton that there is not a shortfall in funding for individually assessed self-care needs.
Date and time of next meeting: 07 November 2019, 13:00-15:00, Morecambe Bay CCG, Lancaster. 02 January 2020, 13:00-15:00 05 March 2020, 13:00-15:00	

JCCCG Meeting
09 January 2020 13:00 – 15:00

Title of Paper	Individual Patient Activity (IPA) Programme Board - Progress Report		
Date of Meeting	9th January 2020	Agenda Item	05

Lead Author	Jerry Hawker – Chair Lancashire & South Cumbria IPA Programme Board & Chief Officer Morecambe Bay CCG	
Contributors	Margaret Williams, Jackie Hadwen	
Purpose of the Report	Please tick as appropriate	
	For Information	X
	For Discussion	
	For Decision	
Executive Summary	The JCCCG has acknowledged that the current level of Individual Patient Activity (IPA) services provided across Lancashire and South Cumbria (with the exception of Blackpool) is providing standards of care that fall well below an acceptable standard and should be of concern to all CCG Governing Bodies. A Lancashire & South Cumbria IPA Programme Board was established in May 2019 and assumed responsibility for progress two key streams of work • Develop and make formal proposals on the future arrangements for commissioning and operational delivery of IPA services by the end December 2019. • Deliver the explicit ambition to try to stabilise the current system, accelerate improvement in current performance and provide a more stable platform for future transformation. This report provides an update on progress to stabilise and improve the commissioning and operational delivery of IPA services from April 2020. Key messages: • Continued poor performance across all domains of CHC performance (except Blackpool) • Range of improvement initiatives progressing with expected impact in 2020. • Significant work completed on proposed new model of CHC commissioning and operational delivery based on the establishment of a single Lancashire & South Cumbria business unit operating on a hub and spoke model. • Full business case to be presented to the March 2020 Joint Committee	
Recommendations	The Committee is asked to:	

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	1. Note the content of the paper and the intention to present a final business case on the future commissioning and delivery of IPA services in March 2020. 2. Provide comment and support in principle for the proposed new model and highlight any concerns or risks that need to be addressed. 3. Note the continuing poor performance in LSC and the actions taken to improve. 4. Note the need for CCG's to plan to include provisions for investment in IPA services in 2020/21		
Next Steps	Full Business case to be presented in March for endorsement		
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable
Risk Identified	Yes		
If Yes : Risk	Non-compliance with NHS CHC Framework		
Report Authorised by:	Jerry Hawker		

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Future commissioning and operational delivery of Individual Patient Activity (IPA) services

1. Introduction

1.1 The JCCCG has acknowledged that the current level of Individual Patient Activity services provided across Lancashire and South Cumbria (with the exception of Blackpool) is providing standards of care that fall well below an acceptable standard and should be of concern to all CCG Governing Bodies.

1.2 This was articulated through an earlier independent review which highlighted 7 specific thematic areas where sustained improvement was required. The Committee endorsed the establishment of a new IPA program Board to act as a single point of coordination on behalf of the Lancashire & South Cumbria CCGs and Integrated Care System.

1.3 The Program Board was established in May 2019 and assumed responsibility for progressing two key streams of work;

- Develop and make formal proposals on the future arrangements for commissioning and operational delivery of IPA services before the end of 2019/20.
- Deliver the explicit ambition to stabilise the current system, accelerate improvement in current performance and provide a more stable platform for future transformation.

1.4 This report provides an update on progress to stabilise and improve current performance and a more extensive update on the development of formal proposals for the future arrangements for commissioning and operational delivery of IPA services from April 2020.

2. Operational Performance

2.1 Appendix A provides a summary of performance through to the end of October 2019 and highlights the continued varied performance across Lancashire & South Cumbria with East Lancashire and Morecambe Bay consistently being significant outliers both locally in Lancashire & South Cumbria, regionally and nationally. Understandably and with justification this is attracting significant concern from the regulators given the associated poor experience of care these results reflect.

2.2 The overall poor performance does not however reflect some important and positive steps that are being taken and will start to have a positive impact from January 2020. These include:

2.3 Introduction of ‘scheduling’ at MLCSU making the tracking cases through to MDT decision within 28 days more visible in real time. This also applies for reviews at 3 and 12 months.

2.4 Introduction of ‘referral management’ at MLCSU in line with NHSE guidance to digitise CHC. This programme of work should lead to more standardised and better quality of checklist completion. The programme is supported by training for partners.

2.5 A whole system deep dive event has been held in Pennine with support from the IPA Board and the National NHS CHC Improvement Team. An improvement plan has been agreed and progress is being made particularly to reduce the number of CHC assessments that take place in an acute setting.

2.6 All eight CCG's have approved a business case to invest £1.34M over an 18 month period in a programme that will result in additional specialist support being deployed to address the near 2,700 overdue CHC and FNC reviews in Lancashire & South Cumbria. This programme of work is essential in ensuring safe and effective care is being provided and to ensure that any future model of CHC delivery commences on a sustainable basis.

2.7 The number of Open referrals over 28 days is of significant concern particularly in the Pennine and Morecambe Bay ICP areas. The IPA Programme Board Chair has met with NHS England regional CHC lead to discuss the performance and to agree a rapid action improvement plan. Additional resources are being explored with the help of MLCSU, NHSE and the Local Authorities.

2.8 Longer term sustained improvement in IPA (CHC) performance will only be achievable through the complete redesign of both the commissioning and operational delivery models.

3. Future commissioning and operational delivery of Individual Patient Activity (IPA) services

3.1 A final business case for the future commissioning and operational delivery of Individual Patient Activity (IPA) services will be presented to the JCCCG in March 2020, with an expectation that with endorsement from the JCCCG, the business case can be approved by the 8 CCG's during quarter 1 2020/21. This would enable mobilization to be enacted from Quarter 2 2020/21.

3.2 This paper forms a key part of the pre-business case engagement and focuses on:

a) The Case for Change
b) The proposed commissioning & operational delivery model

3.3 Check and Challenge sessions reviewing the case for change and proposed commissioning and operating model have been held with key staff across Lancashire & South Cumbria, including staff from MLCSU, the Blackpool Integrated CHC service, CCG commissioning staff, Lancashire & South Cumbria ICS and NHS England National CHC Improvement team.

3.4 The full Business case when presented in March 2020 will provide more extensive information on the staffing model and economic /financial information.

3.5 A presentation will be made on the day of the Joint Committee to compliment the information provided in this paper.

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4. The Case for Change

The Case for Change has been well documented over the last 12 months including;

4.1. Lancashire and South Cumbria IPA Stocktake 2018[1]
4.2. Individual Patient Activity Programme Report to the Joint Committee of Lancashire and South Cumbria CCG's May 2019[2]

Both reports made challenging reading for commissioners and providers alike. They indicated that:

4.3. There was a consistent failure to provide patients, carers and family members with a good experience of care when accessing CHC services.
4.4. The performance of the CHC service in Lancashire and South Cumbria is nationally in the bottom quartile with increasing concern being raised by the regulators over compliance against the National Quality Premium measures. (The exception is Blackpool CCG who operate with a different service model to the rest of the system)
4.5. The current service model is highly fragmented, delivered by multiple providers and is both unstable and unsustainable.
4.6. There is a loss of knowledge in the system about what exactly is commissioned from whom for different parts of different pathways leading to confusion and frustration for IPA practitioners and commissioners alike. There are no records that have been found to help provide clarity and the current contract with the principle provider Midlands and Lancashire Commissioning Support Unit does not have a specification but a series of statements in a matrix that are open to wide interpretation.
4.7. Relationships between partners, commissioners, providers, local authorities were fraught with a blame culture.
4.8. There was a failure to address some statutory responsibilities particularly in regard to overdue reviews. Some 2000 had transferred to providers from Primary Care Trusts in 2013 without any resource to address.
4.9. Most importantly the number of complaints reflecting patient experience in regard to the service has risen alongside the demands upon it associated with two changes of Continuing Health Care Framework and the introduction of Personal Health Budgets.
4.10. The projected demographic impact of the increasing number of people over the age of 65 in Lancashire and South Cumbria on the caseload for CHC is significant. By 2023 demographic pressure alone is expected to lead to an additional 236 cases per annum at a cost of over £6.3m per annum. Beyond 2023 the number of people over the age of 65 is expected to rise again.
4.11. Provider Market Management – The CHC Framework for managing the market was known to be ineffective and the contractual management with the regulated care sector was fragmented and inefficient. Relationships with many providers was strained by the lack of consistent approach to contracting, financial and quality expectations. There was little or no overarching approach to managing the market.

[1] Lancashire and South Cumbria IPA Stocktake (Julie Heywood Consulting 2018)

[2] Individual Patient Activity Programme – (Report by Jerry Hawker to JCCCG's May 2019)

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5. **What will success look like?**

5.1 At the start of the programme a set of high level success measures were agreed and shared with the JCCCG. These were;

For our population….

- A set of services that support patients, carers and families in a caring, responsive way, placing the individual at the centre of care.
- Empowering individuals with better information and choice to manage their care through NHS support services or Personal Health Budgets(PHB)
- A shift away from a system which is fragmented, reactive and adversarial to one that is proactively focusing on the most intensive care in the least intensive environment.

For the LSC System and our staff…..

- A single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICP's and ICC's.
- A single governance, business intelligence and delegated financial framework with accountability to the ICS and JC CCG.
- Delivery of all National and local quality, performance and access standards by the end of 2020.

6. **The proposed commissioning & operational delivery model**

6.1. The development of the preferred commissioning and operational delivery model has been based on four phases:

- Diagnostic of the existing service using the NHSE CHC Programme Maturity Matrix.
- Assessment of nationally recognized best practice models
- Localisation of best practice models against Lancashire & South Cumbria ICS strategy, place based integration and delivery of benefits realisation
- Check & Challenge sessions

7. **Current Service Model**

7.1. The current service model for CHC across Lancashire and South Cumbria has evolved from provision in individual Primary Care Trusts to being brought together in 2013 under one main NHS provider (MLCSU) with multiple community providers commissioned or sub-contracted to provide different elements of the pathway. The exception is Blackpool CCG who has developed an integrated model with Blackpool Borough Council. In many ways this complex and fragmented model of care has provided an ideal comparator,

each to the other and underpins much of the learning evidenced in developing the new model.

7.2. In Blackpool an end to end service is provided to a registered population of approximately 170,000 people. A team of approximately 15 staff provide this service at a cost of £750k (2018/19 figures) and the service is regarded as high performing by both NHSE and patients. The CHC service in Blackpool has worked hard to be at the vanguard of Personal Health Budget development and at the forefront of CHC development. The service across the rest of Lancashire and South Cumbria is provided primarily but not exclusively by Midlands and Lancashire Commissioning Support Unit (MLCSU). The MLCSU service has approximately 105 staff providing a service at a cost of £4.4m. It should be noted though, that this is not a like for like comparison, more a statement of fact as each service works differently. In addition there are a wide range of community services involved in the CHC pathway alongside MLCSU provision operating under block contracts. At present, it's a highly complex service delivery model taken in totality that many services that interact with it do not understand and this leads to both confusion and frustration for staff.

7.3. The MLCSU service provides a service to a population of 1.7 million and currently operates with four locality teams, South Cumbria, Pennine, North and Central supported by centralised 'back office' functions. Some of MLCSU back office functions are 'at scale' within the CSU and cover a wider geographical area than Lancashire and South Cumbria. Appendices A and B provide detailed descriptions of each of the current service models.

7.4. There is a marked difference in the performance of the two principal models of delivery. Simple key performance indicators and benchmarks illustrate some of the key differences:

8. Benchmarking against the National SIP CHC Maturity Matrix

8.1 Using the National SIP CHC Maturity Matrix members of the IPA Delivery Group were able to undertake a broad assessment of current service provision. This assessment tool takes the dimensions in the CHC SIP Maturity Matrix and provides a snapshot of system maturity against the key lines of enquiry (KLOE) within it at a set point in time. Fifteen of the dimensions are fully scoped in terms of key statements indicating maturity progression. The matrix can therefore be used to track service improvement progress. Each dimension has within it a number of key lines of enquiry ranging in number from 4 to 9 and for each line there are a set of statements ranked Initial, Developing, Progressing, Advanced and Leading. (Appendix B)

8.2 This work demonstrated that the Blackpool CCG model of delivery is very close to or at target whilst all other service providers have some distance to close the maturity gap. This was most apparent with the community/sub-contracted providers, reflecting the absence of core expertise, focus and scalability. The benchmarking work indicated that the Blackpool model should form a significant part of the new Lancashire & South Cumbria Model, representing the ideal "place-based" patient facing service that should exist in each Integrated Care Partnership. The aim of the

new model should be to bring the rest of the system up to a similar level whilst strengthening the "economy of scale" challenges the Blackpool model experiences with respect to digitization and business continuity.

9.0. Best Practice Models

9.1. A key part of the new model development involved visits to other systems and organisations to understand their commissioning and delivery model. Some of these sites have responded in recent years to similar challenges to those faced in Lancashire & South Cumbria and have been able to transform the care they provide through IPA services.

9.2. The IPA visiting team took a set of agreed questions based from the CHC maturity matrix. Visits were targeted at organisations within the same NHSE benchmarking clusters as Lancashire & South Cumbria and who all had demonstrated a sustained deliver of high standards of patient experience and care.

9.3. The organisations/areas visited and/or contracted were:

a. Blackpool
b. Cheshire & Wirral
c. Surrey Downs
d. Sunderland
e. South Devon & Torbay

9.4. A number of key points of learning has been consistent across all the best practice systems. These include:

a. a single "business unit" approach delivering end to end integrated care covering all commissioning and delivery elements.
b. the importance of keeping face to face patient contact local,
c. a level of investment in the service model (service and resources) which were significantly higher than in Lancashire & South Cumbria
d. consistent delivery of all quality standards at a lower average level of expenditure / package of care.
e. In some cases the best performing systems extended well beyond just CHC/FNC to include all complex care, ABI, provider management and in some cases end of life care.

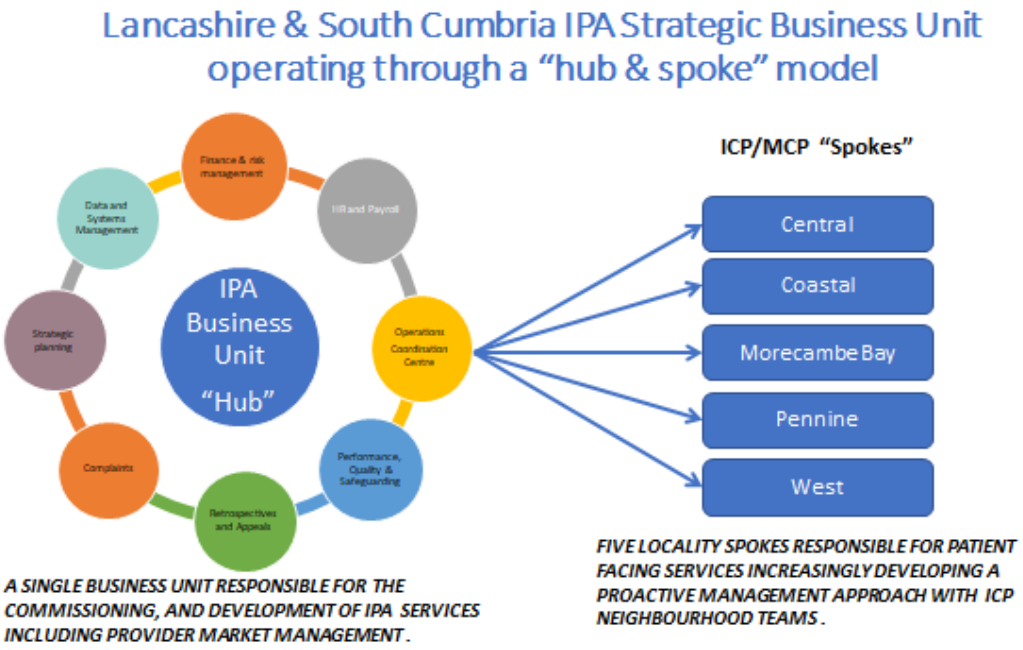
10.0. New model for Lancashire & South Cumbria

10.1. Establishment of a single Lancashire & South Cumbria IPA Business Unit accountable for the commissioning and operational delivery of all individual patient activity services (IPA). It is proposed that the business unit (in shadow form) will be accountable to the Joint Committee of CCGs in 2020/21 and any successor CCG organization from 2021/22 with a defined and delegated operating budget.

10.2. The business unit will replace all existing commissioning and provider organisations creating a single level of accountability with a single leadership, governance and management structure.

10.3. The business unit will operate on a "hub and spoke" model with all strategic planning, commissioning and coordination through the hub with patient facing operational delivery through 5 spokes coterminous with each ICP footprint. A summary of how the model will operate across the hub and spokes is shown in Appendix C.

10.4. The business unit will assume system wide (health & social care) responsibility for provider market management. A separate business case is being developed to support this proposal and is fully supported by the Local Authority representatives on the IPA Board.



10.5. Whilst initially focused on integrating NHS Healthcare in phase 1 the Business unit hub & spoke approach is expected to quickly progress integration with Local Authorities building on the success of the Blackpool model. This phased approach has been supported by the Local Authority leaders on the IPA Programme Board.

11.0. **Finance**

11.1. The full financial modelling for delivery of the hub and spoke model will be presented as part of the full business case in March. The IPA programme board is working closely with the National CHC team and best practice partners to ensure an accurate reflection of

the resources and costs associated with delivering an efficient and effective business unit based on the hub & spoke model.

11.2. Financial modelling work will also include a population health needs assessment based on the current ageing population and potential impacts on future costs of providing appropriate packages of care across Lancashire & South Cumbria.

11.3. Where available, the IPA Programme Board is drawing on National benchmarking of eligibility and care package costs based on NHS England's Cluster profiling.

11.4. Evidence from peer comparisons, financial information from benchmarking exercises and information provided by NHS England National CHC support team all provide strong indications that underfunding of the current IPA service is a contributing factor in the systems overall poor performance.

11.5. Predictive analysis of care package costs in similar cluster areas to Lancashire and South Cumbria indicate that a high performing IPA business unit could deliver a 10% -15% productivity improvement which would significantly off-set any service cost increases.

12.0. Recommendations

12.1. The Joint Committee is requested to:

I. Note the content of the paper and the intention to present a final business case on the future commissioning and delivery of IPA services in March 2020.
II. Provide comment and support in principle for the proposed new hub & spoke operating model and highlight any concerns or risks that need to be addressed.
III. Note the continuing poor performance in LSC and the actions taken to improve.
IV. Note the need for CCG's to plan to include provisions for investment in IPA services in 2020/21

Jerry Hawker

IPA Programme Board Chair

Chief Officer – Morecambe Bay CCG

Healthier Lancashire & South Cumbria

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09 January 2020 13:00 – 15:00

Appendix A – Quality Premium Performance

Table 1 - Quality Premium - CCGs must ensure that less than 15% of all NHS CHC assessments take place in an acute hospital setting.

	August			September			October		
CCG	Number of DSTs completed in the month	Number of DSTs in acute Hospitals	%	Number of DSTs completed in the month	Number of DSTs in acute Hospitals	%	Number of DSTs completed in the month	Number of DSTs in acute Hospitals	%
Blackburn with Darwen	1	0	0%	5	1	20%	2	0	0%
East Lancashire	13	6	46%	10	1	10%	17	3	18%
Blackpool			tbc	34	2	6%	37	1	3%
Fylde and Wyre	29	1	3%	35	3	9%	11	1	9%
Chorley and South Ribble	17	1	6%	22	5	23%	12	2	17%
Greater Preston	10	2	20%	16	4	25%	15	2	13%
Morecambe Bay	41	8	20%	48	13	27%	19	0	0%
West Lancashire	7	0	0%	14	0	0%	5	0	0%
Total	118	18	15%	184	29	16%	118	9	8%

Table 2 - Quality Premium - CCGs must ensure that less that no less than 80% of all NHS CHC assessments are completed within 28 days

	August			**September**			**October**		
CCG	**Number of Decisions in the Month**	**Decisions within 28 days**	**%**	**Number of Decisions in the Month**	**Decisions within 28 days**	**%**	**Number of Decisions in the Month**	**Decisions within 28 days**	**%**
Blackburn with Darwen	5	1	20%	7	4	57%	4	3	75%
East Lancashire	13	9	69%	16	10	63%	20	15	75%
Blackpool			tbc	34	33	97%	37	36	97%
Fylde and Wyre	35	17	49%	39	28	72%	31	19	61%
Chorley and South Ribble	14	11	79%	23	9	39%	25	10	40%
Greater Preston	12	5	42%	17	12	71%	27	27	89%
Morecambe Bay	44	19	43%	29	13	45%	37	25	68%
West Lancashire	7	4	57%	14	6	43%	10	5	50%
Total	130	66	51%	179	115	64%	191	137	72%

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Table 3 - Open Referrals (over 12 weeks) over 28 days (Checklists without decisions)

	Q1 2019/20	Q2 2019/20	October 2019
CCG	Open Referrals >12 weeks	Open Referrals >12 weeks	Open Referrals >12 weeks
Blackburn with Darwen	23	23	24
East Lancashire	88	99	101
Blackpool	0	0	0
Fylde and Wyre	2	6	5
Chorley and South Ribble	6	2	2
Greater Preston	3	1	2
Morecambe Bay	32	50	50
West Lancashire	10	7	2
Total	164	188	186

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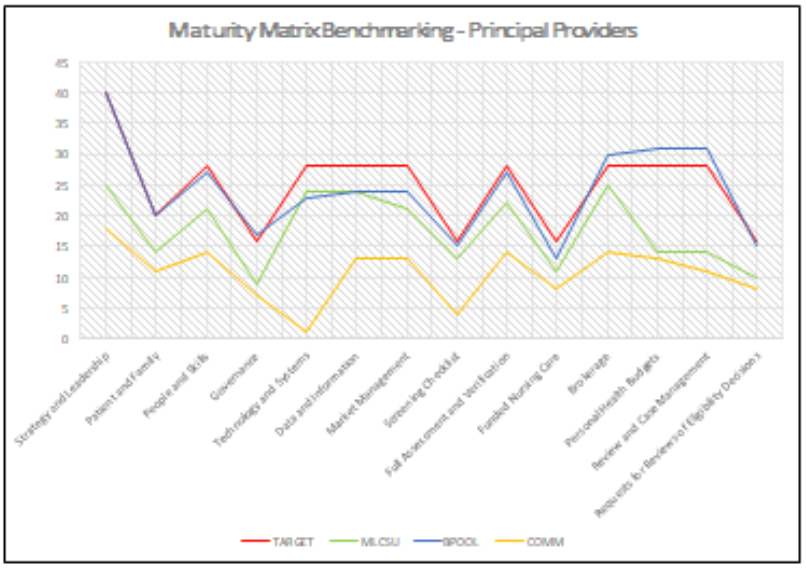
Appendix B

Key Issue - Benchmarking System View of Provision

(by members of the IPA Delivery Group)

MATURITY DIMENSION	TARGET Score within Matrix	MLCSU	SPOOL	COMM
Strategy and Leadership	40	25	40	18
Patient and Family	20	14	20	11
People and Skills	28	21	27	14
Governance	16	9	17	7
Technology and Systems	25	24	23	1
Data and Information	28	24	24	13
Market Management	28	21	24	13
Screening Checklist	16	13	15	4
Full Assessment and Verification	28	22	27	14
Funded Nursing Care	16	11	13	8
Brokerage	28	25	30	14
Personal Health Budgets	28	14	31	13
Review and Case Management	28	14	31	11
Requests for Reviews of Eligibility Decisions	16	10	15	8
Total	348	247	337	149
% Progress Against Target		71%	97%	43%

Initial	Developing	Progressing	Advanced	Leading



Healthier Lancashire & South Cumbria

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Appendix C: Hub & Spoke Operating Model – High level summary of functions across Hub and spokes.

Enabling Dimension	Hub or Spoke?	Comments
Strategy and Leadership	Hub	Single leadership and management team with strong links with and accountability to spokes. Integrated partnership approach to service development and delivery whilst recognising the need for a strategic system approach.
People and Skills	Hub	Hub expected to manage staff and recruit and train etc. but also offer a programme training to regulated care sector etc.
Governance	Hub	Accountable to JCCCG or successor organisation. Links to spokes through clear reporting, performance management and clear lines of accountability.
Patient and Family	Hub and Spoke	Majority of the functions sit with the Hub in terms of process but local liaison and engagement will primarily be through the spokes.
Market Management	Hub	All functions sit within the Hub to deliver a system approach with continuous local input and involvement
Technology and Systems	Hub	All functions sit within the Hub to deliver a system approach with continuous local input and involvement
Invoicing and Payment	Hub	All functions sit within the hub

Process Dimension	Hub or Spoke?	Comments
Screening	Hub	All screening via a single point of access
CHC Assessment and Verification	Hub and Spoke	Hub manages the process and provides the tools, delivery in the spokes

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Fast Track CHC	Hub and Spoke	Seen ultimately as an End of Life service and the business unit will be expected to work closely with each ICP to develop more innovative, community facing approaches through neighbourhood teams
Ratification of Eligibility Decisions	Hub	
Funded Nursing Care	Hub and Spoke	Hub manages the process and provides the tools, delivery in the spokes
Review and Case Management	Spokes	Links with hub and IT systems etc.
Personal Health Budgets	Hub and Spoke	Process at hub but case management at spokes
Brokerage	Hub	
Retrospective Reviews and Appeals	Hub	

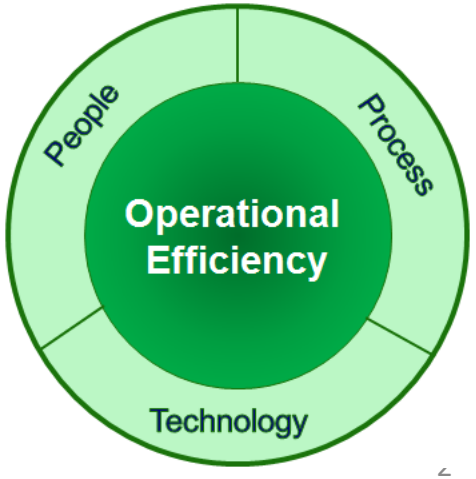
Healthier Lancashire & South Cumbria

IPA Programme Board

OUTLINE BUSINESS CASE

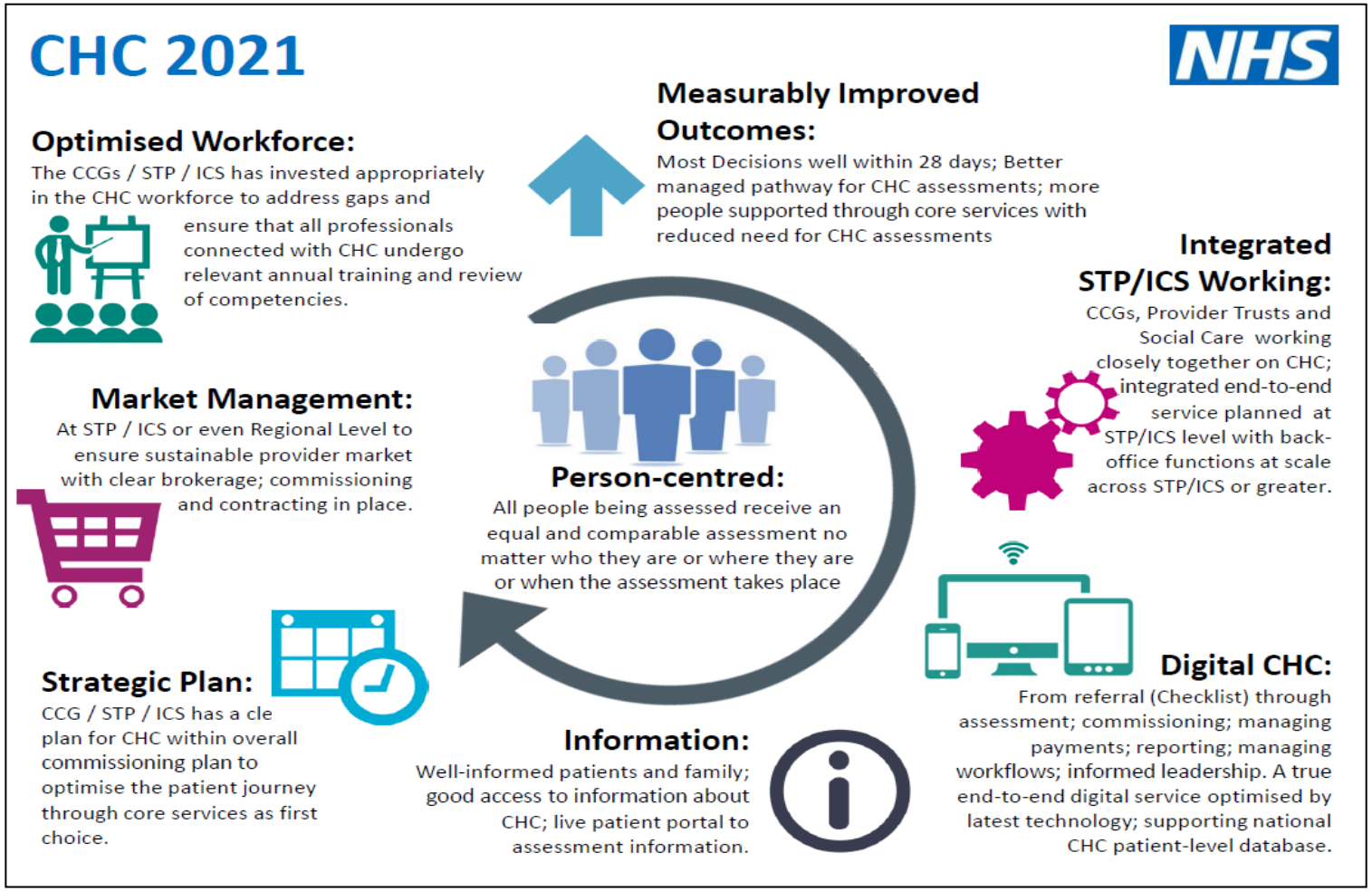
9th January 2020

The Case for Change



Future Service Vision

- **For our population….**
- A set of services that support patients, carers and families in a caring, responsive way, placing the individual at the centre of care.
- Empowering individuals with better information and choice to manage their care through NHS support services or Personal Health Budgets(PHB)
- A shift away from a system which is fragmented, reactive and adversarial to one that is proactively focusing on the most intensive care in the least intensive environment.
- **For the LSC System and our staff…..**
- A single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICP's and ICC's.
- A single governance, business intelligence and delegated financial framework with accountability to the ICS and JC CCG.
- Delivery of all National and local quality, performance and access standards by the end of 2020.

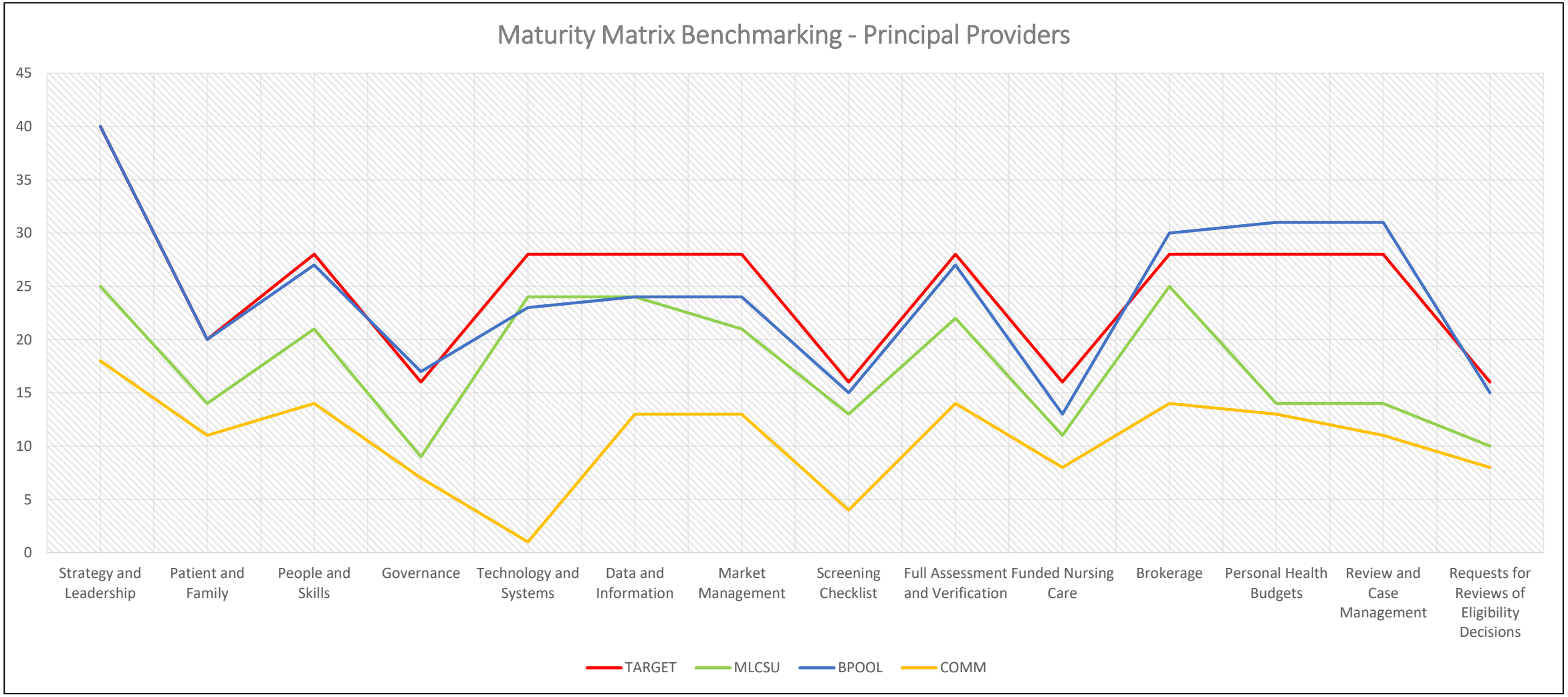


NHS Maturity Matrix Dimensions

- Nationally recommended model of end to end CHC service requirements under seven enabling and nine process dimensions
- Has detailed development descriptors under each dimension which we have used for both benchmarking and helping to map new model requirements.
- The maturity matrix tells us what ‘excellent’ looks like.

Key Issue - Benchmarking System View of Provision

(by members of the IPA Delivery Group)



Learning from best practice…

Surrey Downs
Sunderland
Cheshire & Wirral
Blackpool
Stockport

- a single “business unit” approach delivering end to end integrated health & care covering all commissioning and delivery elements.
- the importance of a single coordination centre (single point of access) but keeping face to face patient contact local
- a level of investment in the service model (service and resources) which were significantly higher than in Lancashire & South Cumbria
- consistent delivery of all quality standards at a lower average level of expenditure / package of care.
- In some cases the best performing systems extended well beyond just CHC/FNC to include all complex care, ABI, provider management and in some cases end of life care.

Lancashire & South Cumbria IPA Strategic Business Unit operating through a “hub & spoke” model

A SINGLE BUSINESS UNIT RESPONSIBLE FOR THE COMMISSIONING, AND DEVELOPMENT OF IPA SERVICES INCLUDING PROVIDER MARKET MANAGEMENT .

ICP/MCP “Spokes”

- Central
- Coastal
- Morecambe Bay
- Pennine
- West

FIVE LOCALITY SPOKES RESPONSIBLE FOR PATIENT FACING SERVICES INCREASINGLY DEVELOPING A PROACTIVE MANAGEMENT APPROACH WITH ICP NEIGHBOURHOOD TEAMS .

Hub and Spoke Mapping – Maturity Matrix Enablers

Dimension	Hub or Spoke?	Comments
Strategy and Leadership	Hub	Has to have strong links with and accountability to spokes/partnership approach to service development and delivery whilst recognising the need for a strategic system approach.
People and Skills	Hub	Hub expected to manage staff and recruit and train etc but also offer a programme training to local providers etc.
Governance	Hub	Links to spokes through clear reporting, performance management and clear lines of accountability.
Patient and Family	Hub and Spoke	Majority of the functions sit with the Hub in terms of process but local liaison and engagement also required.
Market Management	Hub	All functions sit within the Hub to deliver a system approach with continuous local input and involvement
Technology and Systems	Hub	All functions sit within the Hub to deliver a system approach with continuous local input and involvement
Invoicing and Payment	Hub	All functions sit within the hub

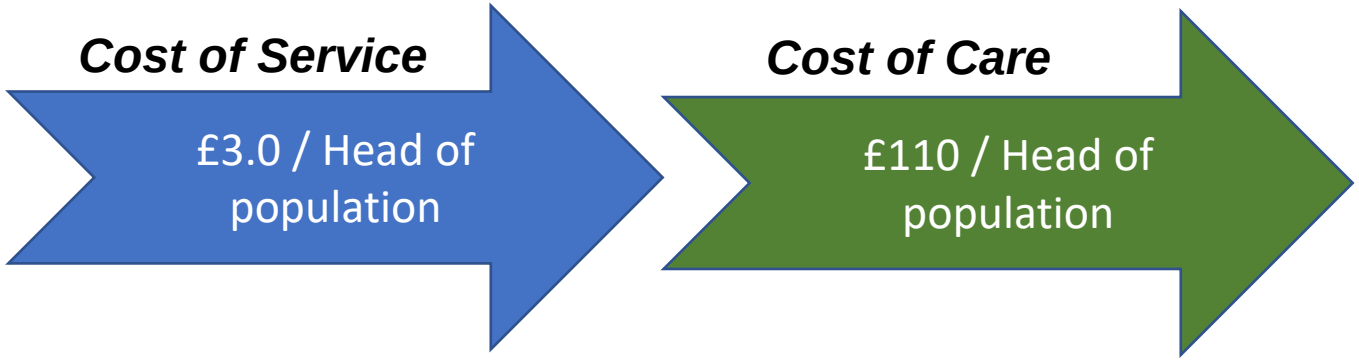
Hub and Spoke Mapping – Maturity Matrix Process

Dimension	Hub or Spoke?	Comments
Screening	Hub	Preference for a single point of access expressed
CHC Assessment and Verification	Hub and Spoke	Hub manages the process and provides the tools, delivery in the spokes
Fast Track CHC	Hub and Spoke	Seen ultimately as an End of Life service and expected to come out of CHC eventually but in the interim hub initially and spoke reviews
Ratification of Eligibility Decisions	Hub	
Funded Nursing Care	Hub and Spoke	Hub manages the process and provides the tools, delivery in the spokes
Review and Case Management	Spokes	Links with hub and IT systems etc?
Personal Health Budgets	Hub and Spoke	Process at hub but case management at spokes
Brokerage	Hub	
Retrospective Reviews and Appeals	Hub	

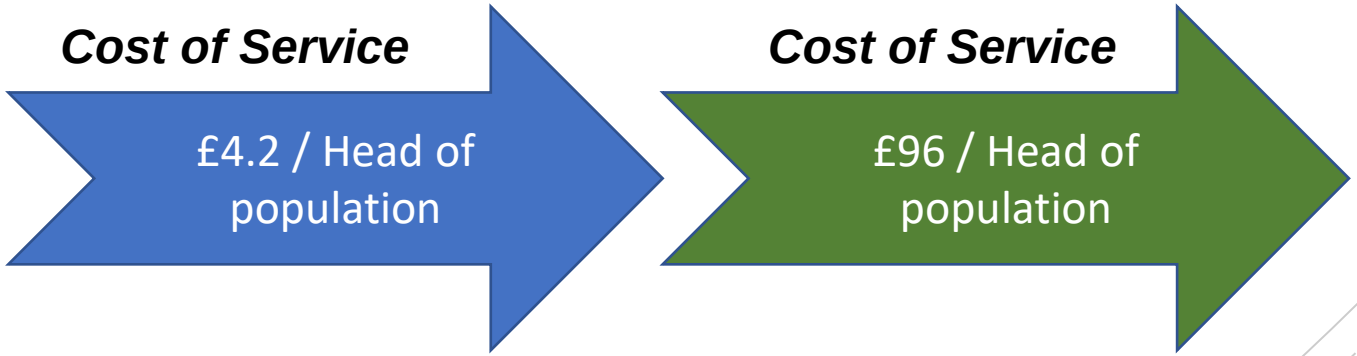
Economic Case

(NHS costs only)

Current Lancashire & South Cumbria Cost Profile



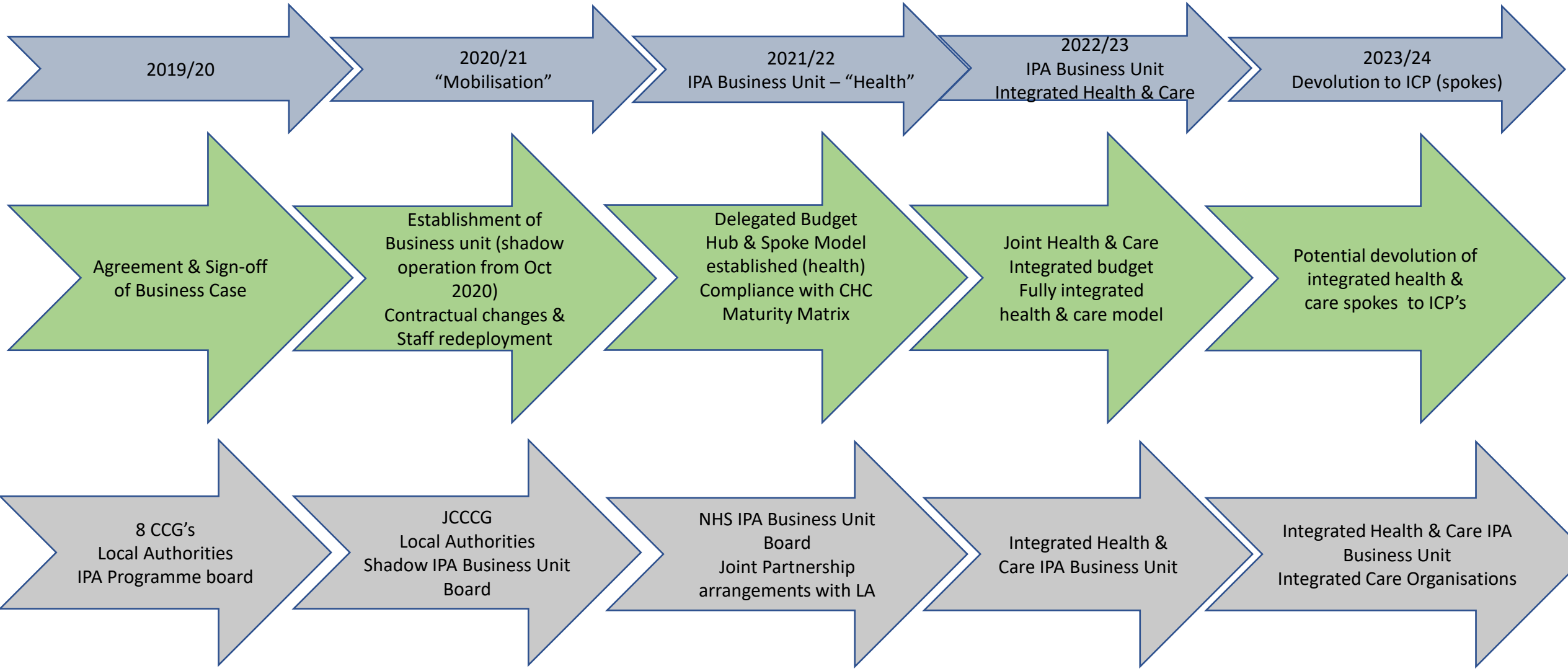
Cost Profile of best practice peers (similar CHC cluster)



The benefits

- Improve patient, carer and family experience
- Delivers personalisation
- Population health is a focus – moving to prevention
- Facilitates integration
- Strengthen community links
- Deliver equity of access
- Will support greater financial control /aim to control growth expenditure (at least)
- Ensures a mature relationship with individuals, families, teams, providers in our communities
- Reduces the number of handoffs
- Improves quality and performance

Proposed road map to implementation



JCCCG Meeting
09 January 2020 13:00 – 15:00

Title of Paper	Lancashire and South Cumbria Older Peoples Residential and Nursing Care Homes Service Specification		
Date of Meeting	9th Jan 2020	Agenda Item	06

Lead Author	Steve Thompson, Director of Resources, Blackpool Council	
Contributors	Caroline Waddington, Liz Williams, MLCSU	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	y
	For Decision	
Executive Summary	The NHS Long term plan requires delivery of the Enhanced Health in Care Homes Framework (EHCH), one of the seven key elements is: Joined-up commissioning and collaboration between health and social care - Shared contractual mechanisms to promote integration. The LSC care homes service specification objective is: A single contract specification between health and social care for the same Regulated Care service with the same provider. The aim is to rationalise requirements for care home providers to support the delivery of quality services for the service users in Lancashire and South Cumbria. The service specification is an amalgamation of different specifications to a clear single set of requirements to be commissioned irrespective of whether this sits within a Local Authority or NHS contract.	
Recommendations	1. Endorse the Service specification and aim of implementing a single service specification across 8 CCGs and 4 Local Authorities in ICS. 2. Facilitate the signing off the service specification in each of their own CCGs and Local Authorities by March 2020. 3. Support implementation of the service specification alongside contracts as they become ready for renewal from 1st April 2020.	
Next Steps	CCGs and Local Authorities have been requested to take approval of the service specification through their local governance procedures by March 2020.	

Equality Impact & Risk Assessment Completed	Yes		
Patient and Public Engagement Completed	Yes		
Financial Implications			Not Applicable

Risk Identified		No
If Yes : Risk		
Report Authorised by:		

JCCCG Meeting
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Lancashire and South Cumbria Older Peoples Residential and Nursing Care Homes Service Specification

1. Introduction

1.1 Delivery of a Lancashire and South Cumbria Older Peoples Care homes service specification is guided by the Care Act 2014, NHS long term plan and NHS England Enhanced Health in Care Homes Framework (EHCH). The NHS Long Term Plan includes a commitment to upgrade NHS support to all care home residents.

1.2 Across Lancashire and South Cumbria there are over 800 providers of regulated care, employing 46,000 staff, equal to the number of staff in NHS and with a considerably larger bed population of 17,000 in care homes alone, far higher than that of acute care, without accounting for the care providers delivering care in the person's own home.

1.3 Delivery of MDT approaches in health and care significantly reduce the impact on acute settings. One in seven people aged 85 or over are living permanently in a care home, however evidence indicates many of these people are not having their needs properly assessed and addressed.

1.4 The framework for Enhanced Health in Care Homes (EHCH) is based on a suite of evidence-based interventions, which are designed to be delivered within and around a care home, and which can be applied to all care providers in a coordinated manner to make the biggest difference to recipients of care. The framework identifies seven core elements of the model and how they can be commissioned to deliver joined-up services, one of which is - Joined-up commissioning and collaboration between health and social care.

1.5 HLSC's joint service specification approach is to give clarity and efficiency to ICS partners and to providers who would have a common delivery requirement for the same care commissioned by different organisations and a common set of performance indicators, and potentially, harmonised performance monitoring with less duplication of effort.

1.6 Other initiatives already rolled out across HLSC include the Contract and Quality monitoring tool to allow HLSC wide sharing of care homes quality data, the Capacity tracker to allow for ease of access to care bed vacancies and the championing of the Data Security and Protection Toolkit (DSPT) to allow personal identifiable information to be shared securely across NHS mail between health and social care partners.

2. Appendix A

2.1 The Regulated Care Workstream – Finance, Markets, Contracts and Procurement Sub-group have agreed a Lancashire and South Cumbria older peoples residential and nursing care home service specification. The collaboration on the work has taken place with colleagues and experts in CCGs, NHS England, Local Authorities, ICS, NHS Trusts, CQC, care providers and service user representatives.

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2.1 This paper is to inform the JCCCG and gain commitment to implement the service specification across the 8 CCGs and Local Authorities, working to a timeline of 1st April 2020 in line with the NHS contract renewal.

- ***Background***

2.3 The need for a Healthier Lancashire and South Cumbria service specification was initially identified in 2017 by the HLSC Regulated Care Workstream to strengthen partnership working and enhance quality as part of a package of collaboration across health and social care across the footprint.

2.4 Lancashire and South Cumbria's older peoples care home service specification has been developed with the aim of simplifying care delivery across health and social care, meaning that the same service standards will be expected from commissioners, irrespective whether they are Local Authority or NHS.

2.5 The service specification also has the aim of reducing the time needed to spend on administrative tasks and consolidating reporting requirements, allowing for more time to be spent with service users.

2.6 The Enhanced Health in Care Homes framework applies equally to people who self-fund their care and to people whose care is funded by the NHS or their local authority: everyone has the right to high quality NHS services. The EHCH drives equitable quality provided by each service as designated by commissioners.

2.7 All the original service specifications from the various organisations across Lancashire and South Cumbria were reviewed and a working group, reporting into the Regulated Care Finance, Markets, Contracts and Procurement Subgroup, was formed to achieve a consensus view and a single amalgamation of requirements.

2.8 An early decision was made to base the specification on the current Cumbria specification as this was the most recently delivered as part of contract renewal in March 2017 and it was agreed a person-centred outcomes based approach would be best practice.

2.9 Colleagues and experts from Local Authorities, CCGs, ICS, LCFT, ELHT and NHS England have reviewed each outcome to ensure it reflects the requirements of each organisation. The service specification has been shared with colleagues from Care Quality Commission (CQC) to ensure that the expectations of the service specification are within the requirements of regulatory 'good' care.

2.10 A LSC wide survey was sent to all care providers via provider forum networks – one response has been received from a collaboration making up approx. 20% of care sector providers, plus a further eleven individual replies.

2.11 An open invitation was sent to take part in a Provider engagement event to discuss the specification in September 19 with attendance from care providers, Local

Authority representatives, CCG representatives, CQC, NHS England, facilitated by MLCSU.

2.12 Further amendments have been made to the specification following these engagement activities and actions are being taken to source dependency tools /supervision standards for providers and to review response times to care homes from health colleagues, e.g. referrals into services SALT, mental health etc. Version 10 and amendments were sent to all key partners for final review and no further comments received.

2.13 It is important to note that the service specification is not a contract, this service specification will sit alongside the NHS/ Local Authority contract which will remain the same and continue to set out the local terms and conditions expected from each Local Authority or NHS organisation. The service specification will be implemented across Lancashire and South Cumbria in a phased approach in line with contract renewal.

- ***Governance and Reporting***

2.14 The work to develop the service specification has been undertaken by a task and finish group consisting of representatives from the four Local Authorities, CCGs and CSU. This group was established under the Regulated Care Finance, Markets, Contracts and Procurement Sub-Group which who report back into Regulated Care Programme group, whose membership contains wider representation across health and social care and provider representation, and which in turn reports into the Healthier Lancashire and South Cumbria governance structure.

2.15 Governance of the agreement to deliver the service specification lies within each organisation, however all organisations (with the exception of Cumbria) will use the centralised Contract and Quality Management System to monitor performance and quality data.

2.16 Each Local Authority and CCG will use the HLSC service specification alongside their own contract, which will be rolled out as contracts are renewed.

3. Conclusion

3.1 Clinical Commissioning Board (CCB) reviewed the Lancashire and South Cumbria Older Peoples Residential and Nursing Care Homes Service Specification and welcomed the work that the Regulated Care working group had done in pulling this service specification together.

3.2 The following decisions were made at CCB on 12th November:

- Agreed a final draft of the HLSC joint older peoples care home service specification v10

- Agreed collective acceptance of the specification across 8 CCGs and 3 Local Authorities (not including Cumbria County Council, as an early version of the service specification is already in place)

- Agreed to support the sign off process of the Specification through the partner organisation they represent by March 2020.

- Agreed that the service specification must be available to issue alongside the NHS new framework contract from 1st April 2020. The specification will be implemented as contracts become ready for renewal from April 2020 onwards. Blackburn with Darwen Council, Blackpool Council and Lancashire County Council to rollout in line with their contract renewal after April 2020.

4. Recommendations

4.1 The JCCCG Board is requested to:

1. Endorse the Service specification and aim of implementing a single service specification across 8 CCGs and 4 Local Authorities in ICS.

2. Facilitate the signing off of the service specification in each of their own CCGs and Local Authorities by March 2020.

3. Support implementation of the service specification alongside contracts as they become ready for renewal from 1st April 2020.

Liz Williams

20th December 2020

5. Appendix 2

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Introduction & All Outcomes

Workstream:	Regulated Care: Finance, Markets Contracts & Procurement		
Date:	18/9/19	**Release:**	Draft v10
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Aim:	For Review and Agreement		

Notes: Please note the term (Localisation) has been used to note areas where each Local Authority/ CCG commissioner will need to personalise the contract.

Distribution

This document has been distributed to:
Regulated Care Finance, Markets, Contracts and Procurement Subgroup
Regulated Care Programme Group
Regulated Care Quality of Care Group
Regulated Care Workforce Group
Provider representatives
Midlands & Lancashire CSU Contracts, Continuing Healthcare & Individual Patient Assessment teams
ICS Palliative Care Workstream
ICP Leads across Lancs & South Cumbria
8 Lancashire & South Cumbria CCGs
NHS England
Care Quality Commission
Health and Social Care Partnership Lancashire
Healthwatch
Care providers
Service user representative groups, e.g. Lancs LGBT, Older peoples forum, Age UK, Alzheimer's Society, Carers network

Additional Consultation has been undertaken with experts from within:
Lancashire Care Foundation Trust
East Lancashire Hospitals Trust
Lancashire County Council (LCC) Social Work Team Leaders
LCC Mental Capacity Act Leads
LCC Quality, Performance & Improvement Leads

Residential and Nursing Care Specification

1. INTRODUCTION

1.1. This document sets out the care specification and standards, which apply to the (Localisation) contract for the Provision of Older Adults Residential & Nursing Care Services.

1.2. The Commissioners are committed to the development of a range of care services in which the Local Authority and Clinical Commissioning Groups and independent providers work in a spirit of consultation, co-operation and partnership to ensure that appropriate services are available to meet the needs of (Localisation) Lancashire people.

1.3. This document sets out agreed Service User focused outcomes in line with the Care Quality Commission's The Fundamental Standards and in the context of other legal requirements and key national best practice guidance.

2. LEGAL REQUIREMENTS AND CONTEXT

2.1. The Agreement places an obligation on the Provider to comply with all legislation and regulations relevant to the provision of the services.

2.2. This Specification reflects how the Provider supports the Commissioners in meeting the requirements of the Care Act 2014 for the care and support needs of people in a care home to ensure that services:

- provide quality and choice;
- are sustainable;
- innovate to meet the diversity of outcomes for people; and
- deliver cost-effective outcomes.

2.3. The Person-Centred Outcomes in the specification relate to how Service Users' wellbeing can be assured whilst supporting person-centred care and support. Wellbeing is defined as follows in line with Care Act guidance:

- personal dignity (including the way people are treated and helped)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control over day to day life (including making choices about the way care and support is provided)
- participation in work, education, training and recreation
- social and economic wellbeing
- domestic, family and personal relationships
- suitability of living accommodation
- the individual's contribution to society

2.4 Collaboration between the Commissioner and Provider is important. This includes the workforce and people with care and support needs, carers and families, facilitating the Commissioner in meeting Care Act requirements.

2.5. The Providers' adult safeguarding policies and procedures will reflect the statutory guidance and the (Localisation) Lancashire Safeguarding Adults policy with the clear aim to support the reduction or removal of safeguarding risks as well as to secure any support to protect the adult and, where necessary, to help the adult recover and develop resilience. A partnership approach will encourage proportionate responses and improve the involvement of Service Users themselves in the decision-making and involvement in prevention and developing resilience for themselves.

2.6. The Provider shall be registered with the Care Quality Commission (CQC) in accordance with the Health and Social Care Act 2008 and comply with all related requirements. The service offered to the Commissioner shall not exceed the "Type of Service" and "Specialism/Services" registered.

2.7. National Performance Indicators that apply relate to the Department of Health Adult Social Care Outcomes Framework (ASCOF) as follows:
Service User views on the service relating to: -

- how much control they have over their daily life
- how they feel about themselves because of the way they are treated and helped
- how clean and presentable they feel
- the food and drink they want and when they want it
- feeling safe
- how much social contact they have
- spending time together doing the things they value and enjoy

2.8. Active engagement and openness between Commissioners and Providers is also important for meeting duties relating to potential "Business Failure" (meaning an event such as the appointment of an administrator, the appointment of a receiver or an administrative receiver) or "Service Interruption" to the whole of the regulated activity, meaning an imminent jeopardy and there is no likelihood of returning to a "business as usual" situation in the immediate future, leading to the need for joint action by the Commissioner and the Provider. In these situations, the Provider and all parties will cooperate fully as identified by the Commissioner.

2.9. The Social Care Institute of Excellence (SCIE) Think Local Act Personal partnership provides guidance for social care and health.

2.10. The National Institute for Health and Care Excellence (NICE) provides guidance, advice and information services for health, public health and social care professionals.

2.11 The Code of Conduct for healthcare support workers and adult social care workers provides guidance for the standards of conduct expected of workers.

2.12. Public Health England provides guidance on matters such as infection control, Resuscitation Council UK and Royal Pharmaceutical Society Guidelines.

2.13. From time to time, the Commissioner may seek the Provider's agreement to comply with the standards and recommendations issued by any relevant professional or by the National Institute for Health and Social Care Excellence (or any other equivalent body).

2.14. The Provider will comply with General Data Protection Regulations 2016 (GDPR) shown in Appendix 1

2.15. Whilst the Commissioner aims to refer Providers to good practice guidance in this specification, the Provider is expected to know and keep up to date with best practice.

3. OUTCOME BASED SERVICES

3.1. The aim of an outcome-based approach is to shift the focus from tasks and processes to the impacts of these on Service Users. Success by achievement of individual outcomes will be evidenced primarily but not exclusively by the satisfaction levels of Service Users and their carers and their experiences in the service and the impact on their wellbeing.

3.2. Achievement of the individual outcomes identified in the Service User's care and support plan shall ensure that Service Users: -

- are valued – involved, more in control, listened to, told what is happening, given choices, at the centre of what is happening to them
- retain their strengths and independence – ensuring that an individual's quality of life is maintained by keeping active and alert, maintaining mobility/physical health, maintaining hygiene, maintaining social contact and keeping safe and secure
- are supported through change - e.g. post-operatively, at the end of their lives and in situations where poor care or self-care has resulted in a reduction in their independence
- are safe – services are well managed and provided by staff who work competently with Service Users because they are appropriately trained and supervised to take person centred approaches.

(Localisation - Cumbria)
3.3. Guidance on the banding of Service Users' needs is detailed in the Council's Care Home Banding Guidance which may be amended from time to time. This guidance is intended to support wider assessment of Service User needs and the Provider will therefore have regard to this guidance in delivery of the Services.
(Localisation - Cumbria)
3.4. The current Care Home Banding Guidance is included at Appendix 2

3. SERVICE STANDARDS AND MONITORING

4.1. The Council has responsibilities under the Care Act 2014 to ensure that the services delivered to people in a care home:

- provide quality and choice;
- are sustainable;
- innovate to meet the diversity of outcomes for people; and
- deliver cost-effective outcomes.

4.2. The Provider will supply information on request so that the Commissioner can inform its commissioning activities and work with the sector to achieve these outcomes.

4.3. The following **Service Standards** have been developed and will be used as the basis for monitoring the Service provided:

- 4.3.1. The Person-Centred Outcomes set out in Section 5 of this Specification;
- 4.3.2. (Localisation) The Council's "Quality and Outcome Measures – What does good care look like" which are included at Appendix 3
- 4.3.3. The Framework for Enhanced Health in Care Homes;
- 4.3.4 (Localisation) Lancashire Safeguarding Adults Board; and

- 4.3.5. Any other quality requirements set by the Council, the CCG or any other relevant professional or regulatory body.

4.4. The Provider is required to demonstrate that the Service Standards are being achieved. The Commissioner will seek evidence of this via a number of methods, including (Localisation) the Contract and Quality Monitoring tool and quality assurance visits.

4.5. There is an expectation that the Provider will take into account other good practice standards and guidance not included in the Service Standards and will strive for continuous improvement of the Service.

4.6. Where the Provider is delivering care to Service Users under Dementia banding the Provider will work towards nationally recognised good practice standards such as King's College, Stirling University or equivalent.
(Localisation)
4.7. The Provider will fully participate in and co-operate with the Council's multi-agency quality, performance and improvement planning (qpip) process, this may include; attending meetings, providing information, production and implementation of a service improvement action plan and facilitating service reviews with the multi-agency quality improvement team. The process may change from time to time, guidance on the current process is shown at Appendix 4
(Localisation – Cumbria)
4.8. The Provider will complete e-forms upon request and submit electronically to the Commissioner via the contract and quality monitoring system.

4.9. The Provider will supply vacancy information to the Commissioner upon request in the format requested by the Commissioner.

4.10. The Provider will share the results, action planning and improvements made through internal quality monitoring processes including those detailed at Outcome 29: Quality Assurance.

Contents – Person Centred Outcomes

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Outcome 2 - Pre-admission Assessment/Needs Assessment
Outcome 3 - Care and Support Planning/Person Centred Care and Record Keeping
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Outcome 6 - Provision of and Access to Health and Social Care
Outcome 7 - Meeting Communication Needs
Outcome 8 - Medication Management
Outcome 9 - Privacy, Dignity and Respect
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Appendices

Appendix 1 - Processing, Personal Data and Data Subjects
Appendix 2 – (Localisation) Cumbria County Council Care Home Banding Guidance & Tables: Physical Frailty, Memory, Cognition & Behaviour
Appendix 3 - (Localisation) Cumbria Quality and Outcome Measures – 'What does good care look like?'
Appendix 4 - Provider Information – Quality Improvement Process
Appendix 5 - Monthly reporting criteria

5.1. **PERSON CENTRED OUTCOME 1**

Provider Service Information
Service Users have the information they need to exercise informed choice about where to live and have the opportunity to visit and assess the quality, facilities and suitability of the home prior to admission.

5.1.1. An introductory visit for individuals, their family or friends shall be facilitated by the Provider upon request.

5.1.2. Where a period of short-term care has been requested by the Commissioner, the Provider will assess suitability and negotiate a placement.

5.1.3. Service Users will have private single accommodation (unless shared accommodation is requested by choice) which they call their own to use as and when they wish. Service Users are offered a reasonable choice about the nature of the room which may include personalisation and the ability to lock their room, in line with Mental Capacity Act.

5.1.4. Service Users will be encouraged to bring personal possessions into the care home, including small items of furniture where practical. Arrangements will be put in place by the Provider for the recording of Service User's property and secure storage for valuables, and the Service User and/or representative is informed of any items unable to be stored dependent on the Provider's level of insurance cover.

5.1.5. The Provider shall produce a Service Users Guide which will state what is available within the service to assist people in deciding if the care home is right for them (e.g. indoor and outdoor facilities, social and community activities, cultural aspects, opportunities for education or work, recreation and leisure, IT and electronic communications). The Service User Guide will state how the Provider intends to meet specific needs, including aids and adaptation, what Service Users can expect by way of quality and how the Provider can show they are achieving this. Details of any additional services and costs not covered by Commissioner fees should also be clearly communicated with the Service User through the Provider's procedures.

5.1.6. This Specification and attached Contract and takes precedence over the home's own Contract. The Provider's own contract should be in line with the attached Contract and Specification.

5.2. **PERSON CENTRED OUTCOME 2**

Pre-admission Assessment/Needs Assessment
Service Users are only admitted on the basis that the home has carried out a comprehensive pre-admission assessment in order to demonstrate that they can meet their assessed and ongoing needs.

5.2.1. New Service Users, including those receiving short periods of respite, will be admitted only based on a full and holistic assessment undertaken by a competent person to satisfy themselves that the service can meet the needs and wellbeing outcomes relating to the level of care they require. Such assessments where possible should involve the prospective Service User, his/her representatives (if any) and relevant professionals.

5.2.2. Following admission, the Provider will build on the assessment referred to in 5.2.1 to develop a personalised care and support plan, which determines the Service User's self-care and includes functional abilities, physical, emotional, social, mental health and spiritual needs.

5.2.3. Where, during the period of stay a significant change in the level of need or service arises for an individual Service User, the Provider shall review and update relevant care plans, risk assessments and dependency levels. If the change in level of need impacts on service demand the Provider shall also inform the Commissioners within 7 days. A re-assessment of the individual's needs shall then be undertaken by the Adult Social Care Teams and/or relevant Health Professional with timescales explained at the time the referral is accepted

5.2.4. Where an admission has been agreed by the Provider as an emergency, the full assessment and interim documentation will be completed within 48 hours of the admission.

5.2.5. Any additional resources needed to meet a Service User's needs will be recorded and progressed, for example, bespoke equipment or referrals to Health Professionals.

5.2.6. Where admissions are funded by the Commissioner, the Provider's assessments will be based on the Commissioner's assessments and care and support plans. If adequate information is not provided by Commissioners, the Provider will notify the Commissioner at the earliest opportunity.

5.2.7. Any requirement for Deprivation of Liberty Safeguards will be identified and referred to the Commissioner. The Provider is responsible to undertake the request for authorisation and the Provider will, where possible, apply for authorisation in advance of the admission. (Localisation) Applications are to be sent securely by email to the Local Authority's designated inbox email address: csc.acscustomerservices@lancashire.gov.uk as amended from time to time.

5.2.8. It is the Provider's responsibility to review Deprivation of Liberty Safeguard applications regularly and inform of any changes to circumstances which may affect the application or its urgency. Additionally, it is the Provider's responsibility to follow up outstanding applications and document accordingly.

5.2.9. The Provider shall record what accommodation is accepted by the Service User and any change must be agreed by the Service User and/or their representative.

5.2.10. The Provider will confirm prior to admission with Commissioners, Service Users, or their representatives, their fees and any additional costs or supplementary fees on top of the Commissioner's agreed rates. Documentary evidence of funding arrangements and agreements will be kept for review as required.

5.2.11 The Provider will confirm prior to admission with self-funding service users the possibility that a top-up will be applied if their savings falls below the threshold and a commissioning organisation takes on the funding responsibility.

5.2.12. The Provider shall have a register of all Service Users within the home including room numbers, funding authority, next of kin and General Practitioner details. Such information must be kept up to date and be accessible upon request by the Commissioner if this is required.

5.3. **PERSON CENTRED OUTCOME 3**

Care and Support Planning/Person Centred Care and Record Keeping
Service Users' ongoing health and social care needs are set out in individual person-centred care and support plans. Service Users' rights and best interests are safeguarded by the Provider's record keeping policies and procedures.

5.3.1. Following a comprehensive assessment, individual risk assessments will be undertaken, and person-centred care and support plan produced for all identified and potential needs, promoting self-care and independence. A Service User who has the capacity to decide may not wish to eliminate risk, so risk management will be proportionate and a reasonable response to a risk which doesn't interfere with the Service User's desire to live the quality of life they wish.

5.3.2. Care documentation will be clear, legible and up to date. Where possible, support plans will not be hand-written, they will be in an appropriate format and of a length that staff are able to read and process the information. Care and support plans will be provided to the Commissioner on reasonable request.

5.3.3. Care documentation will follow the process of assessment, planning, implementation and evaluation and provide clear, concise and directive information that reflects the care required to meet the Service User's individual needs. Care and support plans shall include goals for independence and maintaining Service Users' abilities. Care and support plans and risk assessments will be reviewed as a minimum on a monthly basis or as and when the Service User's needs change.

5.3.4. All nursing documentation will be concise and accurate and will meet Nursing Midwifery Council Guidelines for Record and Record Keeping.

5.3.5. All records, including care records, daily records and charts must be legible to the reader, made at time of care delivery, or as soon as possible within reason, and in chronological order.

5.3.6. All documentation must reflect good practice guidance and meet legal requirements. It should also include relevant evidence-based nursing knowledge and current clinical guidelines both nationally and locally where appropriate to Service User needs.

5.3.7. Service Users and/or their representatives, including advocacy support, must be involved in the production of care and support plans and invited to attend care review meetings. Care and support plans will explicitly identify whether the Service User has consented to the plan. Where the Service User is unable to consent to the plan, the Provider will demonstrate they have followed the principles of the Mental Capacity Act, with documented evidence to demonstrate decision specific mental capacity assessment and how a best interest decision was made.

5.3.8. All Service User records will be stored in a secure place and will be available to appropriate staff. Records will be up to date, adhere to professional record keeping standards and be constructed, maintained and used in accordance with GDPR, the Data Protection Act 1998 and other statutory requirements. The Provider will describe in their Privacy notice what data they hold and how Service Users can have access to their records and information held about them by the Provider.

5.3.9. The Provider will undertake monthly audits of care and support planning and record keeping in order to demonstrate the accuracy, quality and consistency of information,

measure the outcomes of care and ensure that risks to Service Users are minimised. Where actions have been identified through audit, the Provider will record and demonstrate that appropriate action has been taken including lessons learnt.

5.3.10. The Provider will ensure there is provision for a range of equipment necessary to meet Service User assessed needs and shall allow for variations in height, weight and size of Service Users. Risk assessments will be completed by a competent individual and, where bespoke equipment is needed, implementation will include a demonstration of the use of equipment, reducing risks as far as possible. Service Users will be included in the assessment, where practicable, to support understanding of how and why equipment is used. Care will be taken to ensure a Service User's privacy and dignity is maintained.

5.4. **PERSON CENTRED OUTCOME 4**

Meeting Needs and Outcomes/Continual Evaluation/Review
Service Users and their representatives know that the home they enter will endeavour to meet and continue to meet their needs and agreed outcomes.

5.4.1. The Provider will be able to demonstrate the ability to manage and respond to the assessed needs and outcomes of Service Users living in the home to ensure they receive the appropriate care, support and treatment in a timely manner.

5.4.2. Documentation and measurable outcomes will be maintained to clearly evidence the continual evaluation and review of Service Users' needs.

5.4.3. Where evaluation and review indicate a change in the Service User's health and/or Social Care needs, the Provider shall make referrals through appropriate pathways to Health and/or Social Care Professionals for assessment. The Provider will document details of referrals, advice and/or recommendations made within the Service User's care records and relevant care and support plans are updated accordingly.

5.4.4. The Provider will ensure that staff individually and collectively have the skills, experience and qualifications to deliver the services and care which the home reports it will provide.

5.4.5. Specialised and appropriate services, including equipment will be offered and provided where assessed as needed. Where Service Users refuse equipment, the Provider will follow the principles of the Mental Capacity Act and retain evidence of appropriate assessments.

5.5. **PERSON CENTRED OUTCOME 5**

Short-term Care
Service Users receiving short-term care are supported to meet their identified outcomes and are supported to move on to alternative services at the end of the agreed placement period

5.5.1 Short-term care arrangements may be requested by the Commissioner in a number of circumstances, including, but not limited to:

a) As time-limited alternative whilst a longer-term care package is sought to meet the

Service User's needs;

b) Where the Service User requires a more in depth and on-going assessment of their circumstances or the agreement of their assessment by the Commissioner. Reasons may include:-

- Need for long term residential or nursing home care;
- Assessment of mental capacity for specific decisions related to their care;
- Resolution of family issues; or
- Safeguarding concerns surrounding the Service User's departure.

c) Where a Service User is admitted for a prescribed period of rehabilitation and/or therapy, the Service User may receive support from the NHS including occupational therapy and physiotherapy and other Health and Social Care professionals as appropriate to meet agreed outcomes.

d) In order to provide respite, for a prescribed period of time, for the Service User or their Carers.

5.5.2 It should be recognised by the Provider that short-term care in a care home can be a particularly difficult time for Service User and they will require extra support and reassurance during this period of great change. Providers should ensure that Service Users are kept fully informed at all times.

5.5.3 The Provider shall comply with this specification in the same manner as a long-term placement and shall meet any specifically identified outcomes such as those included in this clause.

5.5.4 Particular consideration should be given to Service Users with dementia care needs having short-term care or placements, which should be seen as an opportunity to spend time with people who will be interested in them as individuals and provide stimulating opportunities to try new things and make new memories where possible.

Short-term care for prescribed periods (also known as respite care)

5.5.5 Short-term placements should be approached in a way to support Service Users, families and carers in maintaining important relationships, maintaining and developing new skills, and should underpin and sustain the overall wellbeing of both individuals and families. Care and support should be flexible and individualised.

5.5.6 Where placements are planned in advance Service Users and their carers and families should be given the opportunity to talk about their expectations and individual outcomes so that the benefits of a short stay in the care home are maximised.

5.5.7 At the end of a short-term placement, the Provider shall support both the Service User and the Commissioner to manage a smooth transition to the next service or location. Any relevant care planning information will be shared on request with the Commissioner and any alternative care provider identified to support the Service User.

Short-term care for prescribed periods of rehabilitation and/or therapy

5.5.8 The Provider will co-operate and work alongside with rehabilitation and therapy services being delivered at the care home. Service Users care and support plans will adequately reflect the programme of rehabilitation and therapy or the requirements for achieving independence outcomes with clearly evidenced continual evaluation and review. It

is expected that care and support plans will be reviewed on a more frequent basis appropriate to the type of stay and identified care needs and outcomes.

5.5.9 The Provider will ensure that staff individually and collectively have the skills, experience and qualifications to meet the identified outcomes and support identified needs.

5.6. **PERSON CENTRED OUTCOME 6**

Provision of and Access to Health and Social Care
Service Users receive appropriate evidence-based health and social care and have access to community services and specialist input to meet their assessed needs and maximise their health, independence and wellbeing.

5.6.1. Service User's health, independence and wellbeing will be promoted, monitored and maintained and referrals will be provided in a timely manner to relevant primary care and specialist health and social care services to meet assessed individual need.

5.6.2. Service User's physical, psychological and mental health will be proactively monitored, and early preventative and restorative care provided or arranged in order to improve health, promote independence and wellbeing and maintain their quality of life including: -

- Tissue viability and the management of wounds, as appropriate
- Continence management including the management of urinary catheters and stoma care
- The management of malignant and long-term conditions including but not limited to, Ischaemic Heart Disease, Stroke/TIA's, Diabetes, Chronic Airways Disease and Asthma, COPD, Parkinson's Disease and Multiple Sclerosis
- Health promotion, screening and preventative care
- Infection prevention and control
- Maintenance of mobility, functional ability and falls prevention
- Pain management
- End of life care
- Nutritional screening and support including the management of Service Users who suffer with dysphagia or require PEG feeding
- Oral health care including preventative care where the Service User needs carer support and access to appropriate dental services.

5.6.3. The Provider will provide care and support to Service Users to manage multiple long-term conditions in line with NICE guidance.

5.6.4. Service Users and/or their representatives are involved in decision making around care and health intervention.

5.6.5. The Provider will cooperate and implement reasonable recommendations made by relevant health and social care professionals.

5.6.6. Service Users shall have access to specialist health and social care aids and equipment according to assessed need and the Provider shall ensure staff are trained and assessed as competent in the safe usage of this equipment. The Provider shall ensure that they adhere to the requirements of the Commissioner's equipment policy.

(Localisation) Add reference

5.6.7. The Provider will facilitate Service Users to have regular health checks including specialist and medical reviews of their health and medication and proactive screening and management of chronic disease processes.

5.6.8. The Provider will facilitate where appropriate access to digital systems, assistive technologies/ telehealth equipment in order to improve the functional ability of Service Users with long term conditions and support them to manage their condition and promote independence. Where telemedicine is in commissioned the Provider must engage with the service.

5.6.9. If support is required for Service Users to access appointments, wherever possible a relative, friend, or representative should take the Service User to such appointments. Where this is not possible, the Provider may be given the option to charge the Service User for an escort for planned health appointments. The Provider has the ultimate responsibility to enable Service Users to attend health appointments outside the Home. Health appointments do not solely mean NHS appointments in hospital. They can include dentist, primary care, optician, etc.

5.6.10. In no circumstances shall charges be applied to unscheduled visits to hospital, e.g. following a fall or collapse. In such circumstances, the Provider will undertake a risk assessment and determine if the Service User is able to attend hospital without an escort. Handover information will be comprehensive and will adhere to local hospital transfer pathway guidance, e.g. Red bag scheme.

5.6.11. The Provider shall inform the Commissioner where the Service User remains in hospital for 4 weeks or more

5.6.12 The Provider will co-operate with the requirements of Red Bag schemes, where available, and ensure that the Service User has the appropriate documentation and personal items with them on entry to hospital, as required by the Commissioner.

5.6.13 The Provider will co-operate with hospital initiated discussions to prepare for a service user’s discharge from hospital.

5.7. **PERSON CENTRED OUTCOME 7**

Meeting Communication Needs
Communication with Service Users is conducted in a way that maximises their independence, choice, control, inclusion and enjoyment of rights.

5.7.1. Communication will be conducted in a way that is understandable to the Service User and in a way in which they can make themselves understood based on their individual needs. Service Users say that the way they are communicated with makes them feel better about themselves. If required, referrals will be made to advocacy services to facilitate this process.

5.7.2. The communication needs of each Service User will be identified and include recognition of primary language, visual, hearing and cognitive difficulties. The Provider will ensure they find sources of information and advice and understand how to deal with any difficulties relating to communication.

5.7.3. Communicating in inclusive ways will be dependent upon: -

- A Personalised care and support plan using accurate information on how to get communication right for each Service User. This may be in the form of a communication passport
- Staff awareness and knowledge of a range of resources that support inclusive communication approaches.
- Having and using a range of resources that support inclusive communication
- Enabling the use of digital media e.g. Skype or other similar communication method
- Support from management and senior staff
- Use of relevant external support when required, e.g. Speech and Language Therapy
- Understanding primary language if English is not the Service User's first language

5.7.4. The Provider and staff will communicate and provide information in a format that each Service User and/or their representative can understand.

5.7.5. Service Users will be supported to interact with others and express themselves in line with their individual preferences.

5.8. **PERSON CENTRED OUTCOME 8**

Medication Management
Service Users are protected and supported by the Providers policies and procedures for the management and administration of medication.

5.8.1. The Provider will have clear policies and procedures which demonstrate recognised best practice.

5.8.2. The policies will make it clear who is accountable and responsible for using medicines safely and effectively in the care home. The policies will be evidence based and include the principles of: -

- Sharing information about a Service User's medicines including when they transfer to another care setting
- Accurate and up to date recording keeping and (E)/MAR charts
- Identifying, reporting and reviewing medicines-related problems
- Keeping Service Users safe (safeguarding)
- Accurately listing a Service User's medicines (medicines reconciliation)
- Medication review
- Safe handling of medicines and controlled drugs including ordering, storage and disposal
- Self-administration
- Care home staff administration of medicines including 'when required' medication
- Staff training and competence requirements
- Covert administration
- Homely Remedies/Minor Aliments

- Palliative care
- Verbal orders, and communication with prescribers including adverse reactions
- Administration via a feeding tube
- Correct use of infusions and injection devices in care homes with nursing
- Monitored Dosage Systems and Compliance Aids.

5.8.3. In care homes with nursing, responsibility for medicines administration may be delegated to care staff who will be appropriately trained and assessed as competent. Any delegation must be detailed in a care plan. When the Provider is advised it is not appropriate to delegate medicine administration it must not be delegated. Registered nurses will remain accountable for medicines administration in the home and should provide supervision to care staff undertaking the task.

5.8.4. All Registered Nurses and other relevant staff will complete a medicines management assessment as part of the induction process and provide evidence of ongoing continuing professional development in medicines management.

5.8.5. The Provider will regularly assess and provide documentary evidence of the competency of all Registered Nurses and other relevant staff in the management of medication to ensure that practices are compliant with the standards outlined in the policies and procedures.

5.8.6. Information and advice will be sought from a pharmacist, where appropriate, in relation to administering, monitoring and reviewing medication.

5.8.7. The Provider will ensure that they have an up to date list of medications for each Service User at the start of service delivery.

5.8.8. The Provider will support Service Users to take medicines independently or administer medicines when they are unable to do so.

5.8.9. Records will include details of any capacity assessments and Best Interest decisions made on behalf of any Service User lacking capacity to consent to medication.

5.8.10. Any arrangements for covert medication must be made in accordance with Mental Capacity Act guidance and NICE guidelines. Such arrangements will be clearly documented including medical recommendations, capacity assessment and best interests decision-making record. Where covert medication is given, this will clearly be recorded in the care and support plan and reviewed on a monthly basis.

5.8.11. Any self-administration of medication by Service Users will be undertaken within a risk management framework and suitable lockable facilities provided.

5.8.12. Service Users' medication will be reviewed with their General Practitioner six monthly or more frequently as required. The Provider will support, co-operate with and provider information for the service users medication reviews.

5.8.13. Medication Administration Records (MAR charts) will be audited monthly to provide an audit trail of stock control and storage of medicines including monitored dosage systems and evidence that correct procedures have been followed.

5.8.14. Audits will include monitoring the administration, recording and disposal of medicines. Audits will be robust and comprehensive and identify that measures are in place to ensure safe practice such as: -

- The use of photographs to identify that medicines are being administered to the right Service User (when consent is given by the Service User)
- Specimens of staff signatures to identify care staff or the Registered Nurse responsible for the administration of medication
- The correct and accurate completion of (E)/MAR charts
- Satisfactory procedures for transcribing medication onto MAR charts and recording dosage changes onto MAR charts which include obtaining countersignatures from another registrant or competent health professional.

5.8.15. The Provider will monitor the effect of each Service User's medication and act if their condition changes including side effects and adverse reactions. In addition to this requirement, the Provider will request Service Users taking anti-psychotic medication are reviewed to assess for benefit within four weeks of antipsychotic initiation, which will be evidenced in the care and support plan.

5.8.16. The Provider shall have arrangements in place to record and report drug related incidents including findings of their service review and lessons learnt in order to reduce the risk of repetition, and follow local safeguarding guidance if the threshold is met

5.8.17. Service Users will be notified of any errors in relation to the administration of their medication or their representative, and appropriate medical advice will be taken.

5.8.18. Records will be maintained to reflect the safe disposal of medication.

5.9. **PERSON CENTRED OUTCOME 9**

Privacy, Dignity and Respect
Respect towards Service Users means they are supported and treated in a way that makes them feel better about themselves

5.9.1. The Provider will promote a culture that reflects and demonstrates that Service User privacy, dignity and respect is embedded in the beliefs and values of the service. Service Users will say they exercise choice and control and feel better about themselves because of the way they are treated.

5.9.2. There will be suitable facilities available and staff practices will always enable modesty and protect privacy, particularly when supporting them with their personal care needs.

5.9.3. Staff will uphold Service Users right to confidentiality and the protection of personal information relating to communication and recording. This includes any method of communication individual to the Service User.

5.9.4. Service Users will be cared for in a polite and courteous manner and agreement will be reached with them regarding how they would prefer to be addressed.

5.9.5. Care and support will aim to exercise choice and control and promote the Service User's self-confidence, self-esteem, sense of belonging and wellbeing, and maximise their individual abilities.

5.9.6. Service Users will be treated as individuals, receiving a personalised service encouraging choice and control. They will be listened to and supported to express their

needs and wishes.

5.9.7. Staff will not make judgemental statements about the lifestyle or standards of any Service User, either in verbal or written communication.

5.9.8. Service Users will be facilitated to make and receive personal phone calls in private. This will include provision for those who are unable to use a phone independently.

5.9.9. Providers will promote contact between Service Users and their family/friends both in person and over the telephone or by other means.

5.9.10. Where the Provider considers contact between a Service User and any visitor is having a detrimental impact on their well-being, or where visitors are having a disruptive influence on support, those health and social care professionals involved will be notified, and Safeguarding considered. Where risk management requires restrictions on contact with any particular Service User, the Provider will contact the health and social care professionals involved, principles of the Mental Capacity Act will be followed, any best interests' decision shall be recorded with appropriate consideration given to the Service User's right to private and family life.

5.9.11. The Provider will nominate a Dignity Champion within the home, evidence will be available that evaluation has taken place on a regular basis to evaluate and ensure that quality of service that respects a Service User's dignity is being provided e.g. audits or observations.

5.10. **PERSON CENTRED OUTCOME 10**

Autonomy, Choice, Independence and Fulfilment
Service Users are assisted to express informed choice and control over their daily lives and supported in maintaining their personal identity, individuality and independence.

5.10.1. Service Users shall be encouraged, supported and empowered to make independent choices as individuals in order to determine their needs, beliefs, culture, identity, preferences and values.

5.10.2. Service Users shall be supported and empowered to make decisions for themselves and the Provider will take all practicable steps to assist them to make informed decisions.

5.10.3. A Service User's ability to make their own decisions will be assumed unless assessed as otherwise, in accordance with the requirements of the Mental Capacity Act (2005). Service Users shall have the right to think and act without having to refer to others, including the right to decline support.

5.10.4. The Provider will ensure that all staff understand how the Service User's right to autonomy, choice, independence and fulfilment is maintained within the context of the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and other current legislation. Examples could be through training, supervision and team meeting discussions.

5.10.5. Service Users will identify the people they wish to be involved in their life (e.g. partners, relatives, friends) and state how they would like them involved and consent to sharing information will be explicitly gained and recorded. These people will be provided with adequate and timely information so they can be involved in accordance with the Service

Users' wishes, which will be reviewed

5.10.6. Service Users and/or their relatives and friends shall be informed of how to contact external agencies (e.g. advocates), who will act in their interests.

5.10.7 Service Users will have a range of information available to assist them to make informed choices about all aspects of their life.

5.10.8 The Provider will ensure that staff support Service Users to access a range of meaningful activities of their choice both within the home and the community.

5.10.9 The Provider will ensure that staff are trained to enable Service Users to maintain their independence.

5.10.10 The Provider will actively listen to the Service User and ensure all their rights are upheld.

5.10.11 The Provider will actively seek the views of the Service User to ensure that they feel they have autonomy, choice, independence and fulfilment.

5.10.12. The Provider will ensure that Service User feedback is proactively gathered to support development of the service and there is evidence that this has been actioned. This could include regular Service User's meetings, consultation on available activities and menu options.

5.11. **PERSON CENTRED OUTCOME 11**

Rights
Service Users' legal rights are respected, protected and upheld.

5.11.1. Service Users are individuals, irrespective of their living situation. They retain all their legal rights and entitlements as individuals when they enter a care home and shall be helped to exercise those rights. This includes participation in government elections and other civil processes.

5.11.2. Service Users human rights under the Human Rights Act 1998 shall be promoted, regardless of their capacity to consent to the support arrangements. Where Service Users do not have capacity to consent to their support arrangements, Providers will conduct all support in accordance with the Mental Capacity Act including:

- Appropriate best interests decision making for any care interventions
- Appropriate respect for private and family life, and the need to refrain from interfering with contact between Service Users and their family/friends without appropriate legal process being followed
- Compliance with Service Users right to liberty and the Deprivation of Liberty Safeguards including
- Granting urgent authorisations where permitted by the legislation and the Deprivation of Liberty Code of Practice

- Making requests for standard authorisations for all Service Users to whom the Deprivation of Liberty Safeguards apply in a timely manner, including renewal applications where applicable. Such applications to be made by secure email to the designated inbox (see section 5.2.7)
- Co-operating with and sharing necessary information with assessors instructed as part of the authorisation process and appointed Relevant Persons Representatives and Independent Mental Capacity Advocates
- Complying with any conditions placed upon standard authorisations
- Notifying the Supervisory Body of any change in circumstances which would require a review of the authorisation

5.11.3. When a Deprivation of Liberty Safeguards authorisation is granted, the Provider must provide the relevant person information of their rights (including the right to challenge the authorisation), both orally and in writing. This information will also be given to the relevant person's representative.

5.11.4. The Provider is responsible for requesting a further standard authorisation, prior to an authorisation ending, if they consider that the Service User will still need to be deprived of their liberty after the authorisation ends. There is no statutory time limit on how far in advance of the expiry of the authorisation the Provider can apply for a renewal. However, it needs to be far enough in advance for the renewal authorisation to be given before the existing authorisation ends. The Provider must inform the relevant person they have done this.

5.11.5. The Provider will record the name and contact details of the relevant person's representative in the Service User's care and support plan. The Provider is also required to monitor how often the representative visits. If they have concerns that the representative has not been having an appropriate level of contact with the person to enable them to offer effective support, they will consider informing the Supervisory Body.

5.11.6. Service Users shall be assisted to exercise their right to be a full citizen in whichever way they choose.

5.11.7. Service Users' rights will be written into the Provider's statement of values, aims and objectives.

5.11.8. Service Users will have formal mechanisms to be consulted about the running of the home, e.g. residents' meetings

5.11.9. Service Users will have the right to take risks. Risk taking is a normal part of everyday life, so Service Users shall be involved in agreeing any controls or interventions that may be put in place. Risks shall be fully assessed and reasons for actions clearly documented.

5.11.10. Referrals shall be made to Independent Mental Capacity Advocates where appropriate.

5.12. **PERSON CENTRED OUTCOME 12**

Diversity, Equality and Individuality – Expression of Beliefs
Service Users live in an environment that is committed to promoting a culture which respects diversity, equality and individuality and their experiences reflect this commitment.

5.12.1. The Provider will understand and be committed to promoting a culture for both Service Users and staff which reflects and demonstrates that diversity, equality and individuality is embedded in the beliefs and values of the service adhering to the Equality Act 2010.

5.12.2. A strategic approach will be adopted by the Provider in delivering education to staff so that they understand the: -

- Organisation's aims and objectives
- Relevant policy provisions
- Difference between acceptable and unacceptable behaviour
- How personal attitudes and values can affect behaviour
- Role they play in making the management of diversity a reality
- Meaning of diversity including cultural
- Meaning and impact of discrimination in the workplace.

5.12.3. Service User's beliefs and values will be considered throughout the Provider's assessment process and recorded in the appropriate section of the care and support plans. The Provider will have adequate processes in place to communicate Service Users' individual needs with the staff throughout the home.

5.13. **PERSON CENTRED OUTCOME 13**

Dementia/Mental Health/Learning Disabilities
Service Users whose emotional or mental wellbeing are affected by memory or cognitive impairment or similar condition are assured that the care and support they receive promotes their quality of life.

5.13.1. The Provider shall ensure staff are aware and understand difficulties experienced by Service Users with dementia and mental health issues and how best to support that person. These can relate to emotional and psychological changes including fluctuating mood and disorientation, which may also affect their normal pattern of behaviour and functional ability.

5.13.2. Symptoms of aggression, confusion and disorientation may be as the result of dementia or mental disorder or due a delirium/toxic confused state due to infection, dehydration, constipation or the side effects of medication. Providers shall monitor these aspects to assist with differentiating between causes and symptoms and Service Users shall be referred to a General Practitioner for a physical health review and subsequently where appropriate the GP will refer to a specialist mental health assessment in line with NICE guidelines.

5.13.3. Care and support planning will be completed in collaboration with the Service User

and appropriate representative and shall reflect the impact of these symptoms and direct staff how to meet the Service User's individual outcomes and needs.

5.13.4. Staff shall consider Service Users' sense of reality from moment to moment and respond in a way that is meaningful to them and support them to safely express themselves.

5.13.5. Staff shall monitor for changes in a Service User's condition and look for behavioural cues that may indicate a change being required. This may be in the way that care and support is provided or a deterioration that may require a referral to the General Practitioner.

5.13.6. The Provider shall ensure staff work as part of any multi-agency team to support Service Users to include effective liaison with primary mental health services and the Service User's General Practitioner.

5.13.7. Providers shall recognise when their service may need additional support or a more specialised service to meet the needs of Service Users and refer this to the appropriate support services for a review to be instigated in a timely manner.

5.13.8. The Provider shall ensure accurate and person-centred documentation is maintained and is available in a timely manner, staff will receive appropriate and relevant training to complete paperwork.

5.13.9. The Provider shall adapt the physical layout and facilities within reason, day to day routines and staff culture within their service so it allows for a suitably flexible and stimulating environment for each Service User and supports their individuality, their sense of reality, and their mental and emotional wellbeing. This includes religious beliefs and practice and privacy and dignity around sexuality.

5.13.10. The layout and facilities will help Service Users to understand and make use of all spaces and facilities. It will support Service Users' abilities and maximise their independence; limiting the impact of their disabilities and minimising confusion and distress.

5.13.11. Security and other safety arrangements for the building, garden and other areas and activities will mean that Service Users freely use facilities whilst being protected from harm.

5.13.12. The Provider will ensure that there are opportunities for Service Users with memory and/or cognitive impairment to access the outdoors on a regular basis where this is beneficial to their wellbeing. If the home has a garden, it should to be maintained in such a way that it can be utilised safely by all Service Users.

5.13.13. The Provider shall organise staff to allow time for supporting Service Users in groups or one-to-one to include, where relevant, connections to social network, community facility or external environment that is meaningful to them. Evidence of this shall be clearly recorded.

5.13.14. The Provider shall arrange for the environment, surroundings, daily routine and the way staff behave to uphold the mental and emotional wellbeing of Service Users, inline with current best practice guidance.

5.13.15. The Provider will ensure that staff have the necessary training, skills and knowledge of people's individual needs and behaviour in order to deliver effective person-centred care including and not limited to;

- Interpersonal skills in communication including non-verbal

- Adapting own behaviour to promote relationships
- Build meaningful interactions to include promoting empathy and unconditional positive regard, maintaining Service User's personal world, identity, personal boundaries and space
- Recognise the signs of anxiety and distress resulting from confusion, frustration or unmet need and respond by understanding the events the Service User is experiencing and diffusing their anxiety with appropriate therapeutic responses
- Monitoring and effectively reviewing the effects and side effects of specialist medications e.g. anti-psychotic medication
- Meaningful occupation/activities and stimulation as a part of effective therapeutic intervention and care and avoiding isolation. Understanding the changing nutritional care needs of those with dementia and providing services and support in a flexible, person-centred manner
- Being flexible about the physical layout, facilities and routines
- Effective management of behaviours that challenge and how agitation and aggression is a method of communicating unmet need
- Risk assessment and management, emphasising freedom of choice and reasonable risk taking
- Promoting social and community networks and relationships.

5.13.16. Where appropriate, the home has a lead, for example a Dementia Champion, to role model, coach and embed training into practice, and to monitor the quality of dementia care.

5.14. **PERSON CENTRED OUTCOME 14**

Managing Behaviours that Challenge
Service Users who present behaviour that challenges services are supported in a way that helps them to communicate and to safely deal with situations they find difficult.

5.14.1. The Provider shall ensure the application of practice that focuses on person-centred and positive support to Service Users whose behaviour challenges in line with good practice guidance.

5.14.2. Positive Behaviour Support shall be planned in a proactive way that reduces the likelihood of behaviours that challenge happening. There will be a focus on preventative strategies, identification of early warning signs and plans will show staff how to support Service Users in an individual way that meets their needs. The care and support plan will direct staff on how best to respond to a Service User when they are displaying behaviours that challenge which supports de-escalation of the situation.

5.14.3. The Provider must work in line with the principles of the Mental Capacity Act 2005; all forms of restrictions and restraint will be proportionate to the harm being prevented and in the Service User's best interest where the Service User lacks the capacity to make the decision. The Provider will consider a Deprivation of Liberty application.

5.14.4. Interventions used to control behaviours that challenge shall always be the least restrictive for the minimum amount of time and only considered when all other options have

been exhausted. Physical restraint and medical intervention for behaviours that challenge will always be discussed and documented with all parties involved.

5.14.5. The Provider will ensure that where physical restraint is necessary, that techniques and approaches pose the least risk to the Service User and staff are supported in understanding individual approaches.

5.14.6. The Provider will ensure staff are suitably trained and competent in implementing proactive and preventative strategies to manage and de-escalate situations where individuals display behaviours that challenge. Where physical restraint is required for Service Users, the Provider must ensure staff receive regularly updated training, at least annually, in line with NICE guidelines and a relevant industry best practice, such as the Restraint Reduction Network (RRN) Training Standards.

5.14.7. Following incidents where restraint has been used, the Provider shall have a clear process for recording and debriefing for the staff team and involve the service user where this is possible. This will provide opportunities to reflect on the practice, to learn from situations and how similar incidents could be prevented. Where appropriate, changes to the Service User's care and support, staff approaches or referrals to Professionals will be clearly documented.

5.14.8 Where there is involvement from external health professionals, the care and support plan will be based on any assessment and/or recommendations. The care and support plan will identify what behaviours need to be addressed based on what is important for the Service User and an assessment of risk. An understanding of the reasons for these behaviours shall be determined with the Service User and others involved in their life.

5.14.9. The Provider will support Service Users to be involved in all aspects of their care and support planning wherever possible, taking into consideration their individual needs and functioning. Where they are unable, an appropriate representative will be involved, and documentation should be clear.

5.14.10. The plan shall involve, as relevant, appropriate Local Authority and Health Teams and Professionals involved in the Service User's care and support e.g. (Localisation) General Practitioner, Community Learning Disability Team, Community Mental Health, Rapid Intervention and Treatment Team (RITT), Recovery Team for Older People, CHESS team, Dementia In-Reach Team, Intensive Support Team or Community Adult Asperger's Service. The Provider will ensure there is evidence of on-going multi-disciplinary working and effective liaison with specialist services.

5.14.11. The care and support plan shall include procedures to be followed after an incident of behaviours that challenge to include a description of how the Service User is likely to look and behave as they recover, along with details of the support the Service User requires at this time.

5.14.12. The care and support plan must consider all aspects of the Service User's life including life story work to inform how to meet their physical, mental, social and emotional wellbeing and how this has an impact on their behaviour. The plan will identify what behaviours need to be addressed based on what is important for the Service User including an assessment of risk.

5.14.13. The care and support plan shall be recorded to ensure all those providing support use a consistent approach including: -

- a description of the Service User's behaviour

- a summary of the most probable reasons underlying the Service User's behaviours that challenge
- proactive and preventative strategies
- reactive strategies
- incident briefing
- monitoring and review arrangements
- implementation arrangements
- who was involved in devising the plan

5.14.14. Separate risk assessments and plans will be devised as necessary for specific situations (e.g. car journeys, around food).

5.14.15. Care and support plans shall be reviewed and updated on a regular basis and at other times when there is a change that may impact on Service Users or following an incident of challenging behaviour.

5.14.16. A risk assessment of the impact of potential incidents of behaviour that challenge on staff and other service users needs to be taken into consideration, using the lessons learnt to ensure that the home has appropriate staffing levels to deliver the care required.

5.15. **PERSON CENTRED OUTCOME 15**

Social Contact, Activities and Community Contact
Service Users are supported to spend their time in a way that matches their preferences, and meets their needs for social, cultural, religious, educational and recreational participation.

5.15.1. Service Users will be supported to spend time, of their choosing in a way that is meaningful and stimulating for them via activities made available by the Provider and those accessed by the Service User themselves. This may include leisure and recreational activities in and outside the home, which suit their needs, preferences, aspirations, lifestyle, choices and capacities. Service Users will be empowered to increase and maintain confidence, enhance self-esteem and to minimise social isolation. Evidence of this will be recorded in care and support plans.

5.15.2. Service Users will be encouraged to exercise their lifestyle, cultural and spiritual beliefs through both planned and spontaneous activities.

5.15.3. Staff facilitating group or individual activities will be appropriately trained and skilled to deliver effective and meaningful activities that are suitable to meet individual needs and supports the Service User to maintain their independence.

5.15.4. Consideration of meaningful activity provision will be given to Service Users with needs which means they may not be able to fully participate in activities without support. This could include dementia and other cognitive impairments, those with sensory impairment, those with physical disabilities or learning disabilities and Service Users who are unable to access communal areas within the home.

5.15.5. The Provider will support Service Users to access available resources from

organisations with specialist knowledge and expertise.

5.15.6. Where appropriate, comprehensive life histories will be undertaken in partnership with the Service User and/or their representative and a plan of care developed so that past and present life experiences, along with priorities for the future, can be agreed and met. The Provider should be able to evidence attempts to undertake and any refusals to undertake life history work.

5.15.7. Service Users will be supported to have visitors, in line with their wishes and links with family, friends and local community will be in accordance with individual preference.

5.15.8. Up to date information about activities in and outside the home will be available to all Service Users in formats that meet the needs of individuals.

5.15.9. Service Users' participation in activities will be recorded and evaluated regularly to ensure that outcomes and Service User needs continue to be met.

5.15.10. Service Users will be fully involved in activities planning in the home and have opportunities to influence the range of activities offered by the Provider.

5.15.11. Service Users will be supported to be involved in community groups, should they indicate a preference to do so, in order for them to be able to influence the wider health and social care agenda.

5.15.12. Where the Provider provides transport for the Service Users for purposes not covered by their assessed need, e.g. Home mini-bus for private outings, the Provider may agree a reasonable rate of payment for the transport. If external transport is used, e.g. taxi, the Service User is expected to pay for such transport.

5.15.13. The Provider will make every effort to connect with the local community to support the development of new connections.

5.15.14 The Provider will engage with the relevant community/neighbourhood teams (where appropriate) and assist residents to access to a wide range of health, social care and community-based support and services within the Lancashire and South Cumbria locality.

5.16. **PERSON CENTRED OUTCOME 16**

Pressure Area Care, Tissue Viability and Wound Management
Service Users receive care that supports healthy tissue viability and wound management. (Localisation)
Delivery of elements of this Outcome will differ for Homes registered with the Care Quality Commission to provide nursing care and those registered as a residential home. The latter will receive support from local District Nursing Teams, who will work within their own organisational policy.

5.16.1. The Provider shall have up to date policies and procedures to support tissue viability and wound management practice. The Provider will ensure that staff have evidence of training and embed requirements in their practice and have a pressure care champion to deliver training for staff.

5.16.2. The Provider will provide Service Users with care and support to prevent and manage pressure ulcers in line with NICE good practice guidance and other preventative models of recognised pressure prevention methodology.

5.16.3. Tissue viability interventions and wound management shall be overseen by competent Registered Nurses (either employed by the Provider or through community nursing services) with up to date knowledge and skills in the prevention, assessment and management of pressure ulcers and management of wounds.

5.16.4. Wound management will consider Service User's individual needs, preferences and compliance with both treatment and the care and support plan. Clear communication of essential information will enable the Service User to make informed decisions about their care.

5.16.5. Wound care documentation will be descriptive and directive incorporating a holistic assessment of the Service User's individual health needs, links into risk assessment, predisposing factors, include a rationale for the selection or change of a treatment or dressing and document clinical outcomes. Documentation will include planned preventative strategies and plans for reassessment.

5.16.6. The Provider will complete an examination of skin integrity on admission to the home, when transferred to or from hospital or where injuries e.g. bruising, red areas, pressure ulcers, cuts, wounds or burns are identified. Findings of the examination will be recorded on a body map, and if relevant a safeguarding alert will be made as required by local guidelines

5.16.7. Wound assessments and care and support plans will include: -

- The location and measurement (grade and dimensions) of the wound demonstrated by a wound map and photograph (with the Service User's consent or documentation around BIA/LPA)
- A record of any underlying or undermining intrinsic and extrinsic factors that may have contributed to the wound for example general health status, malnutrition, systemic disease, poor mobility or medication
- A description of the colour or appearance of the wound bed and status of the surrounding skin, including any undermining/ tracking sinus or fistula
- A record of any exudate, pain or malodour
- A rationale to support the selection of a treatment or dressing which may be determined by the type and position of the wound, the amount of exudate, pain, odour, any known allergies, the Service User's compliance/concordance with the dressing and the frequency of dressing changes. The wound will be evaluated and reviewed at each dressing change and documented accordingly.

5.16.8. Wound care documentation will clearly document clinical outcomes and provide a chronological history of the progress or deterioration of the wound demonstrating regular evaluation and review and any specialist input or referral.

5.16.9. Care homes without nursing will liaise with the relevant health professional if they have any concerns in relation to skin injuries and pressure areas/pressure area care and will follow the guidance provided. This may include advice in relation to (but not exclusively) hygiene, repositioning regimes or appropriate equipment to be used. Such guidance will be clearly documented in the care and support plan.

5.16.10. An appropriate and evidence-based risk management tool shall be used to assess

risk and where necessary an action plan put in place. A baseline risk assessment shall be undertaken within six hours of admission to the home and reviewed regularly thereafter.

5.16.11. Staff will be trained to identify Service Users most likely to develop pressure ulcers and will be competent to recognise pre-disposing risk factors as a part of both the pre-admission assessment and on-going assessment process.

5.17. **PERSON CENTRED OUTCOME 17**

Nutritional Care
Service Users have enjoyable mealtime experiences that meet their individual needs and that mean they eat what they like when they want it.

Nutritional Care Requirements

5.17.1. The Provider will ensure that Service User's nutritional care needs are considered which will also support independence and facilitate an enjoyable mealtime experience, assessments should include but not limited to the following areas:-

- Personal aids and equipment
- Day to day choices of food and drink
- Food and fluid consistencies
- Special dietary requirements
- Food and beverage preferences
- Where Service Users wish to eat each meal, at what time and with whom
- Good physical positioning
- Cultural, ethical/moral and religious beliefs
- Level of assistance required which may include encouragement as well as physical support
- Special occasions to be celebrated

5.17.2. Nutrition and hydration risks and needs, including allergies and intolerances, will be included as part of the holistic pre-admission assessment. See Outcome 2 for further information on pre-admission assessment. This information should be regularly updated and reviewed as more person-centred information is gathered, preferences change or medical/nutritional needs change.

5.17.3. All staff must follow the most up-to-date nutrition and hydration assessment for each Service User, the Provider shall have a process in place to notify staff of any changes to diet and hydration needs including nutritional care requirements, modified textures. Care plans should be updated at the time of these changes to be reflective of current need.

5.17.4. Providers must follow Service Users' consent wishes if they refuse nutrition and hydration unless a best interest decision has been made under the Mental Capacity Act. Other forms of authority, such as advance decisions, should also be considered.

5.17.5. Consideration and recognition will be given when Service Users are coming to the end of life phase, as nutritional needs change and reduce according to disease progression. During this phase all staff will ensure that good mouth care and comfort is a priority.

5.17.6. Service Users will be supported to maintain good oral hygiene to promote comfort,

increase appetite, enable ease and safety of eating and drinking, avoid infection and improve overall quality of daily living.

Nutritional Screening

5.17.7. On admission to the service, the Provider will nutritionally screen all Service Users using the Malnutrition Universal Screening Tool (MUST) or appropriate alternative tool. This will be reviewed on a monthly basis as a minimum (excluding those identified from a Multi-Disciplinary Approach as requiring End of Life care) or sooner when there is a clinical concern or change in need.

5.17.8. Where Service Users are found to be at medium or high risk of malnutrition, their care plan will clearly outline what specific support is required and all care and catering staff will be made aware of actions to take.

5.17.9. Strategies and actions to manage the risk of malnutrition and dehydration will be individual to the person but should include consideration of:-

- Food and drink fortification
- Documenting and monitoring food and fluid intake
- Nourishing drinks and homemade supplement drinks
- Increase in frequency of food and drink being offered
- More regular nutritional screening and weighing
- Referrals to other Professionals as appropriate including General Practitioner, Speech and Language Therapist, Registered Dietician and / or Occupational Therapist

5.17.10. Where completion of food and fluid charts are included in a Service User's plan of care, information should be recorded as accurately as possible and should be used as part of the review process to determine if further interventions are required. Staff should respond in a timely manner to address concerns or issues identified. Charts should include the following information but not limited to:-

- Details of food and drink offered and taken including type and quantities
- Information on how food and drink has been fortified
- Food and drink refused
- Alternate options offered
- Individual fluid target and fluid totals
- For some Service Users recording urine output and bowel movements may also be necessary

5.17.11. As part of the Provider's governance process, the accuracy of nutritional screening using MUST or equivalent tool should be audited quarterly and where required, any areas for improvement identified should be actioned.

5.17.12. Providers will ensure that equipment and scales used to measure Service User's weight and height are suitably and regularly calibrated and maintained in order to provide reliable and accurate measurement.

Dietary Supplements and Thickeners

5.17.13. Prescribed dietary supplements and thickeners will be used in accordance with the medication policy and subject to the terms of the prescription. The International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines and framework to standardise the terminology and definitions to describe texture modified foods and thickened fluids will be followed.

5.17.14. If food or fluid texture is required to be modified, then catering and care staff will be aware of the relevant descriptor recommended by the Speech and Language therapist.

Menus

5.17.15. Menus and meals will reflect the ethnic, social, cultural and religious needs of the Service Users and include general programmes of events e.g. Pancake Day, Passover etc.

5.17.16. Menus will offer adequate hot and cold choices appropriate to the needs of the Service Users e.g. dysphagia needs or service users requiring finger foods. Menu cycles will be over a minimum of three weeks, seasonal and all meals and snacks will be recorded.

5.17.17. Service Users will have a choice of meal options each day and where required, will be offered support to make their choices in line with their assessed needs.

5.17.18. The Provider will actively involve Service Users in the development of menus and ensure they are provided with opportunities to give regular feedback on this e.g. choice, variety, availability, presentation quality and quantity.

5.17.19. Information about allergens used within the food made and served will be available and updated as and when menu changes occur and when suppliers/brands of ingredients change.

Meal Times

5.17.20. Mealtimes should be enjoyable experiences and promoted as a social activity. Dining rooms and other eating areas should be pleasant, environments conducive to eating that are welcoming, clean, tidy and free from malodours. Dining spaces need to reflect the needs of Service Users.

5.17.21. If the nutritional care requirements highlight assistance or encouragement to eat and drink is required, it shall be provided ensuring sensitivity and respect for Service Users' dignity and individual abilities. Enough staff will be available to support those in need of assistance and/or encouragement to eat.

5.17.22. Service Users will be enabled and encouraged to serve themselves where assessed as able and safe to do so; a family style food service will be encouraged.

5.17.23. Food, including that which is texture modified, will be presented in an appetising way that respects dignity.

5.17.24. Protected meal times (an environment conducive to Service Users enjoying their meals and being able to safely consume their food and drink without being interrupted by non-urgent activities) will be encouraged, Service Users will be able to invite friends and family to join them but will not be disturbed by other interruptions e.g. GP's, hairdressers etc.

5.17.25. Snacks or other food should be available between meals for those who prefer to eat 'little and often'.

Hydration

5.17.26. Water must be available and accessible to Service Users at all times. Other drinks will be made available periodically throughout the day and night and Service Users will be

encouraged and supported to drink. Suitable adjustments should be made for seasonal changes.

5.17.27. Staff will be aware of the possible early warning signs and symptoms of inadequate hydration and take appropriate action to address these signs, based on the presentation of the person. Actions should be undertaken to counteract warning signs such as pushing fluids through a range of high fluid content alternatives and contacting the GP where this is felt necessary.

Training

5.17.28. The Provider will ensure staff receive appropriate induction and ongoing training to enable them to carry out their role effective supporting effective management and monitoring of Service Users' dietary and hydration needs including but not limited to:-

- All care and catering staff will be trained in the importance of good nutrition and hydration, how to recognise the signs of poor nutrition and hydration and how to promote adequate nutrition and hydration.
- All staff responsible for undertaking nutritional screening will be trained in the use of the validated screening tool e.g. MUST.
- Staff involved in the handling, preparation of food or assist at mealtimes receive training in Food Safety and Hygiene.
- Where appropriate to the needs of the Service Users within the home, additional training may be required such as diabetes management, thickened fluids, dementia, chronic illness or management of swallowing difficulties.

5.18. **PERSON CENTRED OUTCOME 18**

Complaints
Service Users and their relatives and friends are confident that their complaints and concerns will be listened to, taken seriously and acted upon effectively without any negative impact.

5.18.1. The Provider will operate a complaints procedure. This will be easily accessible and allow Service Users, their carers or advocates to make a complaint, raise concerns or appeal. Response times / expectations are clearly stated within the complaints procedure.

5.18.2. The Provider shall demonstrate a positive and open attitude to complaints and facilitate verbal or written complaints to be made or made on behalf of the Service User and shall not seek to obstruct, delay or interfere with the Service Users' rights in this regard.

5.18.3. The Provider will ensure that all complaints are thoroughly investigated by a competent person and records are kept demonstrating how they have been managed, a timescale for responses and how Service Users are informed of the outcome including their level of satisfaction.

5.18.4. Actions taken or changes made as a result of concerns, complaints or grievances to address problems and shortfalls will be identified within and across the organisation. Such action will also include learning and improvements implemented as a result of complaints and concerns and will be audited on a regular basis for themes and trends.

5.18.5. The Provider shall provide contact details for other relevant organisations for Service Users to escalate complaints outside of the Provider's organisation.

5.18.6. The Provider will record compliments and use them to learn from positive experiences.

5.19. **PERSON CENTRED OUTCOME 19**

Safeguarding Adults
Service Users live in an environment where they are confident that the Provider will take practical measures to prevent harm from occurring and will safeguard them in a way that supports them in making choices and having control about how they want to live.

5.19.1. The Provider will have robust procedures in place for safeguarding Adults at Risk and responding to concerns (including "whistle-blowing") of abuse/neglect to ensure the safety and protection of Service Users.
(Localisation)

5.19.2. The Provider's procedures will reflect the local Safeguarding Adults policy. The Provider will ensure a copy of the local Safeguarding Adults policy and Procedures is available and accessible to all staff (Localisation) For Lancashire Safeguarding Adults Board organisations this includes the Guidance for Safeguarding Concerns

5.19.3. The Provider's employees will follow the procedure set out in their organisations' policy and that of the Local Safeguarding Adults Board immediately if they suspect that a Service User or otherwise dependent person has suffered any form of abuse or is otherwise thought to be at risk.

5.19.4. The Provider will clearly display in formats accessible to all what service users, staff and visitors should do to report any suspected abuse.

5.19.5. Preventative practice will be in place to support safeguarding, including employment, management and security of the environment.

5.19.6. The safety and wellbeing of the Service User will be paramount and, in the event that an alleged abuser is a member of staff or a volunteer, action will be taken immediately to ensure the protection of Adults at risk(s) from the possibility of further abuse while an investigation is carried out. This will also apply where the alleged abuser is the Registered Manager/Person in charge.

5.19.7. The Provider will co-operate fully in any safeguarding enquiries and comply with any agreed requirements of a safeguarding/risk management plan which may include a referral by the Provider to the Disclosure and Barring Service and/or the Nursing and Midwifery Council. Failure to comply with procedures or outcomes/actions from safeguarding enquiries may be regarded as a fundamental breach of the (Localisation) contract.

5.19.8. Training in Safeguarding, including whistleblowing, will be explicitly included in induction and ongoing training for all staff and volunteers employed by the Provider and updated every three years.

5.19.9. The Provider will ensure that systems within the home protect Adults at Risk in accordance with the legal requirements of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

5.19.10. The Provider' management practices ensure controls will be instigated to protect victims of alleged abuse/neglect from alleged perpetrators during investigations.

5.19.11. The Provider will ensure whistle-blowers are protected from adverse treatment.

5.19.12. The Provider will seek advice at the earliest possible opportunity if they are unsure if a concern should be raised through the safeguarding procedures.

5.19.13. The CQC must be notified of incidents and events that are required to be reported to them.

5.19.14. The CQC must be notified under its health and safety regulation when someone has suffered harm.

5.19.15. The Provider should pay due diligence to the duty of candour and offer apology in accordance to this.

5.19.16. The Provider will offer the opportunity following the conclusion of safeguarding enquiries if the Service User or their relative wishes to make a complaint. They will also be given the option of referral through to independent advocacy, eg (Localisation: http://www.government-online.net/advocacy-services-for-lancashire-county-council/)

(Localisation)
5.19.17. The Provider will actively engage with the LSAB Safeguarding Adult Reviews (SAR) as appropriate; enabling staff, where relevant, to attend and contribute to practitioner events and facilitate sharing and embedding of any learning that may result.

5.20. **PERSON CENTRED OUTCOME 20**

Safe Working Practices/Health and Safety
The health, safety and welfare of residents and staff is promoted and protected. Procedures are in place to ensure the safety of Service Users in the event of an emergency.

5.20.1. The Provider will ensure that staff are provided with accredited risk management, health and safety, moving and handling and falls prevention training. Moving and handling refresher training or competence assessment will be provided yearly as a minimum. Refer also to clause 5.26.15 regarding staff training.

5.20.2. The Provider will have clear processes in place for the prevention and management of falls.

5.20.3. Serious untoward accidents and incidents, COSHH and RIDDOR will be reported to the appropriate body, for example, Health & Safety Executive, Health Protection Agency and the Care Quality Commission. (Localisation) Add a Local Authority/ NHS lead to report into if appropriate.

5.20.4. Individual risk assessments relating to the health, safety and welfare of Service Users must be completed and reviewed regularly.

5.20.5. Assessments, planning and delivery of care will be based on risk assessments and include measures to mitigate risks to Service Users, this will be reviewed and amended to address changing needs or practice.

5.20.6. The Provider will ensure the decontamination of medical devices, maintenance of reusable equipment and appropriate use and disposal of single use equipment.

5.20.7. There will be evidence of awareness of Department of Health Medical Device Safety Alerts.

5.20.8. Fire precautions shall be in place and include Fire Safety Training for all staff and conform to HM Government guidelines, 'Fire Safety, Risk assessment, Residential Care Premises 2006' or subsequent guidelines.

5.20.9. A Fire Risk Assessment shall be in place which is reviewed annually or when there is a significant change to your premises or Service Users. Fire safety records shall be maintained and used to manage compliance with fire safety law.

5.20.10. The Provider shall maintain a Fire Emergency Plan and Evacuation plan appropriate to the establishment and the Service User group. The Provider will ensure that Service Users, staff and visitors are aware of an emergency plan and escape routes.

5.20.11. For Service Users who are not able to reach a place of safety unaided or within a satisfactory period in the event of an emergency, the Provider will create Personal Emergency Evacuation Plans (PEEPs), where possible in conjunction with the Service User to agree what type of assistance is needed and appropriate arrangements put in place. PEEPs will be reviewed on an ongoing basis, every six months, or if there is a change to the Service User's needs for example health, mobility, medication or behaviour.

5.20.12. A trained First Aider will always be on duty.

5.20.13. The Provider shall ensure that all staff, including temporary or agency, are aware of the procedures for dealing with medical emergencies and calling emergency services.

5.20.14. The Provider shall maintain a business contingency plan which protects the Service Users who use the service in the event of an emergency, e.g. loss of power, loss of heating, sudden staffing shortage, flood, and which clearly designates roles and responsibilities of employees on duty. The Provider will ensure all staff are fully aware of their individual and collective roles in the procedures to adopt in the event of an emergency.

5.20.15. The Provider will have a written procedure for dealing with situations where a Service User is missing which includes informing the Registered Manager (or their representative) immediately and the Police. At the earliest opportunity the relatives will also be informed, even if the Service User has subsequently returned. (Localisation) Add representative from the Council/NHS who also needs to be informed

5.20.16. The Provider will have a written health and safety policy and organisational arrangements for maintaining safe working practices which are evident and understood by Service Users and staff.

5.20.17. The physical environment will be fit for purpose and safe for Service Users and staff.

5.20.18. The Provider will ensure that equipment is available to Service Users and that they adhere to key legislation relating to Equipment Safety, ensuring that equipment is well maintained and visually checked before use, any defects, damage or wear is reported and

actioned.

5.21. **PERSON CENTRED OUTCOME 21**

Infection Prevention and Control (IPC)
Service Users reside in a clean environment where standard precautions and safe practice ensure that avoidable infections to Service Users, staff and visitors are prevented.

5.21.1. The Provider shall ensure that policies or procedures are in place to protect Service Users, staff and visitors from Health care Associated infection (HCAI). These should include:-

- Environmental hygiene
- Optimum hand hygiene in accordance with WHO 5 moments and adherence to 'Bare Below the Elbows' when carrying out personal or clinical care
- Safe handling and disposal of clinical waste
- Managing accidents, dealing with spillages, especially body fluid spillages
- Provision, wearing and disposal of personal protective equipment and clothing
- Service User hygiene including hand hygiene
- Cleaning and decontamination of reusable equipment
- Management of laundry and soiled/infected linen
- Management and disposal of sharps and inoculation injury
- Reporting of Health Care Acquired Infections (HCAI's) and engagement in the Post Infection Review process
- Management and notification of infectious diseases, including outbreak control
- Clinical procedures compliant with aseptic technique
- Safe procedure for the collection and storage of specimens
- Management of indwelling devices
- Staff training and education including IPC lead and Care Champion. IPC induction and mandatory training
- Prevention and control of Legionella bacteria including an up to date Legionella assessment with a plan of preventative maintenance to include monthly testing and recording.

5.21.2. Infection control procedures will be explicitly referred to within all staff job descriptions, induction, development and on-going training for all staff. The Provider will have a designated lead/link person for infection prevention and control

5.21.3. The environment will be designed and managed to minimise reservoirs for micro-organisms and reduce the risk of cross infection to Service Users, staff and visitors. The premises should be kept clean, hygienic and free from offensive odours throughout. Laundry facilities should be housed in a separate room which is not to be used for any other purpose. The room should have a dirty to clean workflow system. Sluice facilities should not be housed within the laundry.

5.21.4. The Provider will comply with optimum hand hygiene in accordance with WHO 5 moments and adherence to 'Bare Below the Elbows' when carrying out personal or clinical care
Hand washing facilities will be prominently sited in areas where infected material and/or and health and social care waste are being handled and this will include liquid soap and disposable hand towels.
Service User hygiene including hand hygiene will be promoted.

5.21.5. Protective equipment will be available and worn for all aspects of care which involve contact or potential contact with blood or body fluids or where asepsis is required.

5.21.6. All Service Users' equipment will be cleaned and maintained appropriately to prevent cross infection.

5.21.7. A local outbreak policy will be in place for the surveillance, recognition, control and management of infection and outbreaks with information available to Service Users and their visitors. Staff will be trained and aware of actions to take including reporting to Public Health England. All infection outbreaks will be reported to Public Health England within two days of an outbreak.

5.21.8. Notifiable diseases and infections that could be a potential risk to others will be recorded and reported to Public Health England, local Environmental Health and the Care Quality Commission in accordance with local arrangements.

5.21.9. An annual Infection Prevention and Control assessment will be completed, and an action plan developed to address any areas of non-compliance.

5.21.10. Monthly audits will be undertaken to determine best practice is maintained and include incidence/prevalence rates for HCAI wound infections, urinary tract infections, notifiable infections, antibiotic prescribing, hand washing and decontamination of equipment.

Audits will be carried out to ensure staff follow correct infection prevention and control measures.

5.21.11. The Provider will have a policy/guidance for staff on transfer of information relating to infections when Service Users are admitted to hospital or another care environment to ensure that information related to infections will be shared with other health and social care providers.

5.21.12. The Provider will engage in the Post Infection Review for specific infections as required.

5.22. **PERSON CENTRED OUTCOME 22**

Accident/Incident Reporting
The safety and wellbeing of Service Users is assured through the Provider's Accident and Incident Reporting processes. Lessons are learnt from accident/incident/near miss reporting processes

5.22.1. The Provider's policies will reflect the procedures to be undertaken following an accident or incident and staff, including agency and any temporary staff, are fully aware of the processes.

5.22.2 The Provider will have a policy around what actions will be taken following an injury. Regular checks on staff awareness of said policy will be undertaken through staff 1 to 1's/supervisions/PDR and Team Meetings.

5.22.3 The Provider will adhere to reporting procedures as required by the commissioner

5.22.4. All accidents and incidents will be comprehensively and contemporaneously documented. Within a care home with nursing, such records must be completed or countersigned by a registered nurse.
Additional records, such as falls diaries and behavioural charts will be implemented and maintained daily/weekly/monthly as appropriate to support ongoing monitoring and management. These records will be audited regularly by the Provider's management team/nominated individual to ensure that consistency and accuracy of information is maintained and to be reviewed regularly against risk assessment records.

5.22.5. Details of accidents and incidents will also be recorded within Service Users' daily records together with information to reflect the Service Users' health, safety and wellbeing. This information will be audited regularly by the Provider's management team/nominated individual to ensure that consistency and accuracy of information is maintained, and appropriate risk assessment reviews are carried out as part of a Service User's care and support plan.

5.22.6. Injuries, including bruises that are sustained following an accident or incident, shall be fully documented, using body maps where possible. Treatment required following an accident or incident will be clearly documented, including the precise treatment and support and any necessary health or social care professional input i.e. Paramedics, District Nurses, General Practitioner, Community Psychiatric Nurses.

5.22.7. From audits undertaken in respect of accidents and incidents a comprehensive monthly analysis will be undertaken and documented to identify themes, patterns or trends in order to investigate and put in place timely measures to minimise or prevent such events reoccurring.

5.22.8. Repeated accidents and incidents, such as falls or aggressive behaviour, will be referred to specialist health and/or social care professionals to seek support and guidance in managing such situations effectively and in the best interests of the Service User. This will evidence a dynamic approach which attempts to pre-empt hazards/potential triggers and a proactive response before an incident occurs. All contact with external professionals will be recorded and any advice or guidance given will be reflected within a Service User's care and support plan updates.

5.23. **PERSON CENTRED OUTCOME 23**

End of Life Care/Dying and Death
Every person living in a care home gets the high-quality, genuinely compassionate care they should expect, and that through the care and support that they receive, live as well as possible until they die

5.23.1. End of Life care relates to the last 12 months of life. Good end of life planning will ensure that the Service User's wishes are acknowledged and recorded and that the Service User remains at the centre of all decisions. The Provider will have a policy which reflects NICE quality standards QS13 end of life care for adults and QS144 care of dying adults in the last days of life.

5.23.2 The Provider will work with other health care professionals and in particular, GP's to pro-actively identify Service Users who may be approaching the end of life and support a

regular coordinated review of care.
(Localisation) Each Local Authority/CCG to add equivalent clause for Lancashire/Blackpool/Blackburn with Darwen
5.23.3. The Cumbria Partnership Do Not attempt Cardio-Pulmonary Resuscitation (DNACPR) Policy (https://cdn.cumbriapartnership.nhs.uk/uploads/policy-documents/Do_Not_Attempt_Cardio_Pulmonary_Resuscitation_DNACPR_Policy_POL-001-067V2.pdf) is in place which complies with the legal requirements of the Mental Capacity Act (2005) and ethical guidance issued by the BMA/RCN and Resuscitation Council (UK 2007), including guidance for DNAR using the recognised documentation within Cumbria.

5.23.4. The Provider shall ensure that the appropriate planned comfort, support and compassion is provided to Service Users when it is recognised that they are entering the end of life phase. Sensitive open and honest communication will take place with the Service User, and all decisions will be taken in line with their wishes which will be appropriately reviewed with the Service User and their family or representative should the Service User wish. Any advance care and support plan wishes will also be considered at this time. This will include decisions made by the Service User about their care or treatment. The home will respect a Service User's advance care plan and offer support to meet any dying wishes wherever possible.

5.23.5 The Provider will support timely return of patients from hospital to their home when it has been identified they are approaching the end of life and their preference for place of care is the home.

5.23.6. Service Users will be referred in a timely manner to specialist services, in line with local referral policies where required.

5.23.7 The Provider will have the equipment, where appropriate, to support care at end of life for e.g. syringe drivers and be able to evidence that staff trained to be able to use the equipment

5.23.8. The Provider shall provide a quiet and comfortable private space for Service Users and those people who are important to them, to remain close in the last days of life. Relatives and partners will be able to spend as much time with Service Users as they wish in line with Service Users' individual preferences, and where possible accommodation and refreshments will be available for relatives who want to stay/sleep overnight at the home.

5.23.9. All deaths will be managed with dignity and propriety and Service Users' spiritual needs, rites and functions will be observed. There will be systems in place to ensure, when death is expected, that Service Users do not die alone unless it is their wish.

5.23.10. Where Service Users require end of life or palliative care, an assessment will be co-ordinated by an appropriately trained nurse to assess whether the right care can be provided by the existing Provider, or by other relevant professionals, and any changes required are actioned in a timely manner. All assessments will be subject to continuous ongoing review.

5.23.11. The nursing assessment will involve advance care planning (ACP) where possible, to determine Service Users' wishes, indicating personal preferences concerning place of care and death, in agreement with carers and family and will include Service Users' wishes relating to resuscitation, if this is stated. Utilise nationally or locally recognised ACP tools and documentation.

5.23.12. Sensitive and compassionate end of life care be co-ordinated and delivered in accordance with Service Users' personal care and support plan. Service Users' end of life care will be planned to include relatives or important people in their lives if desired, so that

Service Users and relatives know what will happen and are able to prepare.

5.23.13. Clear, accurate and dignified records will be maintained and meet the standards for record keeping of the relevant professional groups.

5.23.14. A keyworker will co-ordinate Service Users' care pathway and ensure continuity of care including out of hours support.

5.23.15. The home has an end of life champion who has a clearly defined role and is supported to carry out their duties effectively.

5.23.16. The home will have a plan in place for respecting and remembering the Service User after they have passed away.

5.23.17. The care pathway will include care after death and information on support agencies and bereavement counselling.

5.23.18. There will be a policy and procedure in place for the verification of death and verification of expected death (if appropriate by competent registered nurse).

5.23.19. The Provider will ensure compliance with the National Institute for Clinical Excellence NICE 2011 End of Life Care Standard for Adults QS13 and that all staff have access (where relevant) to specialist training including the QCF Level 3 Award in Awareness in End of Life Care which will:-

- Support the development of an open culture and awareness towards death and dying
- Facilitate collaborative learning and promote a supportive, palliative approach to end of life care
- Ensure that practitioners have the skills and confidence to talk with all Service Users and relatives/ carers about end of life care and how to document these discussions
- Prepare practitioners clinically and raise their awareness of cultural and ethical considerations
- Assist in the identification of Service Users who may be approaching the final stages of life
- Ensure care evolves as a part of a systematic, multidisciplinary care pathway and optimise the quality of care providing a seamless approach
- Ensure that systems are in place to reduce the risk of Service Users being inappropriately admitted to hospital at the end of life.

5.23.20. Staff will be appropriately trained to manage the processes and procedures sensitively, to ensure Service Users are treated with dignity and respect and receive appropriate care and symptom relief.

5.23.21. Practitioners/ staff will require specific training for Service Users who are cognitively impaired or require complex care e.g. Dementia, Motor Neurone Disease or Learning Disabilities.

5.23.22. The Provider will keep up to date with current and new approaches to end of life care.

5.23.23. On-going supervision will be provided to staff to support them and to provide an opportunity to consider and reflect upon their own cultural beliefs, values and attitudes to death and dying and enable staff as a team to reflect on care and dying within the home. Wellbeing of staff will be considered, and bereavement counselling promoted.

Learning from and continuous quality improvement will be integrated into the home's communication strategy.

5.23.24. The Provider as a minimum will be able to demonstrate that they have a strategic approach to managing end of life care with policies in place reflecting local and national guidance and education for staff.

5.23.25. The Provider will notify the Commissioner without delay about the death of a Service User and inform the Care Quality Commission.

5.23.26. The Mental Capacity Act 2005 guidance is to be followed.

5.23.27. When a Service User dies in the home where there is either an authorised Deprivation of Liberty Safeguard in place or an application submitted to the Local Authority, the Provider will comply with the relevant legislation and guidance. The current guidance can be found here:

http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2017/03/GUIDANCE-No16A-DEPRIVATION-OF-LIBERTY-SAFEGUARDS-3rd-APRIL-2017-ONWARDS.pdf

5.23.28. Information will be available for the Service User and their families in an accessible format.

5.24. **PERSON CENTRED OUTCOME 24**

Staff Recruitment and Retention

Staff employed are fit and competent to meet the health and welfare needs of Service Users.

5.24.1. The Provider will operate a robust staff recruitment and selection procedure, in line with CQC regulations, which takes all reasonable steps to ensure that all individuals employed, including volunteers, those appointed through an agency and workers from other countries, are in all respects appropriate persons to work with vulnerable people. This includes all individuals employed in the home including and not limited to maintenance, cleaning, personnel, kitchen and administrative staff. A written policy and procedure shall be in place to reflect this practice.

5.24.2. The Provider will adhere to all equal opportunities and wage legislations and will be expected to embrace the principles of equality and diversity.

5.24.3. The Providers' staff recruitment and selection procedure must include a Disclosure & Barring Service (DBS) check at the appropriate level in accordance with the Safeguarding Vulnerable Groups Act 2006 requirements.
Photographic evidence of the staff member will be included on file and checked against a passport, driving licence or photo ID.

5.24.4. Providers employing staff who are required to obtain permission to work in the United Kingdom either directly or through an agency must ensure that employees have received clearance to work, have the necessary permits and relevant documentation available prior to employment; copies of which must be evidenced in their personal file for inspection and monitoring purposes.

5.24.5. When recruiting staff, the Provider shall ensure that at least two appropriate written references are taken up one of which must be from the individual's last employer and shall demonstrate the means by which the suitability of all staff has been assessed. Where the reference provided only gives dates of employment the Provider must be able to demonstrate that all attempts have been undertaken to ensure a safe system of recruitment. The Provider shall include documented evidence of telephone contact with previous employer.

5.24.6. Staff will go through a full recruitment process including completion of an application form which provides complete employment history and addresses any gaps in employment history.

5.24.7. Staff, including those whose first language is not English, must have the personal qualities and caring attitudes which enable them to relate well to Service Users and carers, as well as the required skills in spoken English, written literacy and numeracy to do the tasks required for caring for and supporting Service Users.

5.24.8. Contemporary evidence of professional registration/PIN number checks will be obtained for all qualified nursing staff employed and regularly reviewed.

5.24.9. Providers shall maintain a personnel file for every employee which evidences all required documentation for inspection and monitoring purposes. Such documentation will include evidence of a written record of interview to demonstrate the applicant’s suitability for the post.

5.24.10. Providers employing agency staff will obtain a staff profile prior to commencement of the employment. This will include photographic ID, relevant skills and competencies for the position, qualifications, professional registration and an up to date training record.

5.24.11. Providers employing volunteers in the home will ensure volunteers are fit and competent to meet the health and welfare needs of Service Users. This will include photographic ID, relevant skills and competencies for the position, professional registration and an up to date training record and a Disclosure & Barring Service (DBS) check at the appropriate level in accordance with the Safeguarding Vulnerable Groups Act 2006 requirements.

5.25. **PERSON CENTRED OUTCOME 25**

Staffing Levels and Workforce Planning

Service Users are supported to achieve their maximum life potential and care needs by the provision of the appropriate level of professional expertise and skill mix.

5.25.1. The Provider’s staffing levels will enable the Provider to meet all the service

standard requirements as detailed in this specification, both day and night, with the right competency, skills and experience, and to build in flexibility and promote sustainability of the workforce

5.25.2. The Provider must be able to fully evidence the method used for determining staffing levels in the home, for example by utilising or developing a staff ratio to service user dependency tool.

5.25.3. Staffing levels must be based on the dependency needs of all the Service Users, will be reviewed on a regular basis and evidence made available to ensure and demonstrate that they reflect the changing needs of the Service Users.

5.25.4. Staff numbers and skill mix will be matched to all Service Users' needs and reflect a high quality of care provision.

5.25.5. In determining the level and frequency of professional nursing expertise and intervention required (in care homes with nursing) the Provider will demonstrate the following:-

- The level, frequency and quality of time and intervention provided by a registered nurse undertaking actual care delivery, including clinical/technical or therapeutic activities on the Service User's behalf, is enough to meet their assessed needs and provide the ongoing management of care interventions
- The level and frequency of supervisory skills required by a registered nurse for teaching, guiding, advising, supporting and monitoring both Service Users and staff is enough to meet the Service User's assessed needs and promote and maintain standards of care
- The Registered Nurse providing nursing care demonstrates the skills, knowledge, clinical judgement and expertise to accurately assess and manage the stability and predictability of the Service Users' health.

5.25.6. The Provider will have contingency plans–also included within the Provider's Business Continuity Plan/Policy - in place to cover staff absence, sickness, annual leave and succession planning and will provide to the Commissioner on request.

5.26. **PERSON CENTRED OUTCOME 26**

Staff Induction and Training/Education

Service Users are cared for and supported by professionally inducted, trained, and competent staff, utilising best practice and this will be reflected in the standard of care that they receive.

5.26.1. The Provider will ensure that there is a staff induction, training and development programme, which will meet core skills training standards and include dementia, end of life and person-centred care training, which can be accessed through Skills for Care's Education and Training Frameworks.
Where registered nurses are employed, NMC Code of Professional Conduct Practice Guidance will be followed. These expectations will be clearly included in written policies and procedures to reflect a commitment to a supportive working and learning environment.

5.26.2. The Provider will ensure that staff new to care enrol on the Care Certificate within twelve weeks of commencing employment. All existing staff will be able to demonstrate that they also meet the standards of the Care Certificate.

5.26.3. The Provider will ensure that all staff working within the home are fully trained and assessed as competent to meet the individual needs of Service Users including all mandatory training and specialist and clinical education.

5.26.4 The Provider will ensure training provided, both internally and externally, is of high quality and that content is appropriate and is evidence based to reflect up to date specialist and social care and clinical guidance.

5.26.5. The Provider will undertake a training needs analysis for all staff which is reviewed regularly and updated and formulated into staff personal development plans.

5.26.6. The Provider must have an appropriate and deliverable training matrix in place that clearly identifies and timetables training and development needs of all staff within the home.

5.26.7. The Provider will be able to demonstrate assessment of staff competency and performance management and documented evidence will be made available; this could be through observations, supervision and appraisal processes or feedback from staff, Service Users or relatives. Where identified or required, the Provider will provide learning and development opportunities.

5.26.8. The Provider will ensure that staff understanding of training given is checked regularly through observation and supervision, including discussion at staff meetings, ensuring knowledge is embedded so that staff are confident to apply learning in their areas of work and that opportunities are offered for staff suggestions and feedback on running of the home and Service User needs.

5.26.9. Where there are identified concerns related to social care practice or the clinical practice competencies of individual employees this will be effectively managed by the home with evidence of the provision of mentorship and supervision.

5.26.10. Staff in charge of the home unsupervised will have the appropriate level of clinical and management competencies.

5.26.11. Where a Provider employs a newly qualified registered nurse or registered manager, they will ensure that preceptorship/ mentorship is provided for the first six months in post.

5.26.12. Providers who support student nurse placements and nurses' registration and adaptation programmes will be able to provide evidence of accreditation with a participating University.

5.26.13. Providers supporting candidates undertaking Nursing Adaptation Programme placements will ensure appropriate mentoring and provision of the required period of protected learning in accordance with Nursing and Midwifery Council requirements.

5.26.14. Providers will have a system in place to confirm new employees have successfully completed induction competencies prior to completion of the probationary period.

5.26.15. Staff will not commence duties unsupervised until they have been assessed as competent for the role.

5.26.16. The Provider will be responsible for determining that the training provider is suitably qualified and that the content of the courses meets the requirements of Adult Social Care Services.

5.26.17. Learning undertaken by individuals prior to employment with the Provider shall not give automatic exemption to the training requirements.

5.26.18. Casual staff/trainees and student workers will be subject to the same requirements of all permanent staff.

5.26.19. When booking or recruiting Agency Staff for the home, the Provider must ensure that individuals are suitably trained to meet the needs of the individual Service Users and ensure a full induction has been provided. The Provider must be able to demonstrate safe recruitment of agency in line with good practice guidance from the Lancashire Safeguarding Adults Board (LSAB).

5.27. **PERSON CENTRED OUTCOME 27**

Staff Supervision and Appraisal

Service Users are cared for by staff who are suitably and regularly supervised, monitored, supported and appraised and this will be reflected in the standard of care that they receive.

5.27.1. A written policy and procedure will be in place to support the Provider's practice regarding supervision and appraisal.

5.27.2. All staff will receive formal supervision, including clinical supervision, where appropriate, in accordance with the Provider's policy. Where appropriate, staff must be supervised until they can demonstrate required/acceptable levels of competence to carry out their role unsupervised. Supervision and appraisal sessions will be documented.

5.27.3. Staff will receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained, and at least six times per year.

5.27.4. Supervision will be systematically used to guide the work of staff, to reflect upon their work practices and as a means of support for staff to facilitate good practice, and better outcomes for the Service Users they support. Casual staff including agency staff, trainees and student workers will receive proportionate supervision support and review.

5.27.5. Service Users are supported to contribute to the supervision of their care staff.

5.27.6. Supervision and appraisal sessions will be documented.

5.27.7. Clinical supervision will be a critical element in the provision of safe and accountable nursing practice and inextricably linked to professional development. It is an exchange between practising professionals to enable the development of professional skills. It is also an opportunity to reflect on practice and necessary to enable practitioners to establish, maintain and promote standards and innovations in practice in the best interest of Service Users.

5.27.8. Robust appraisal systems will be in place and all staff receive an annual appraisal/personal development review.

5.27.9. Supervisors will be trained and supported in their supervisor role.

5.27.10. Staff that require membership of a professional body in order to practice will provide evidence of continued registration as part of the appraisal process. Employees will support the requirements for the Nursing and Midwifery Council (NMC) Revalidation in their supervision and appraisal processes.

5.27.11. Poor performance or staff conduct is identified, challenged and managed and documentary evidence made available to demonstrate that appropriate support has been provided and action taken.

5.27.12. The Provider must make a referral to DBS where the required conditions are met, this applies even when a referral has also been made to a safeguarding team or professional regulator and following dismissal/resignation during any investigations. Current guidance can be found on https://www.gov.uk/guidance/making-barring-referrals-to-the-dbs

5.28. **PERSON CENTRED OUTCOME 28**

Management and Leadership
The service is led so that individual Service User outcomes are achieved and sustained for the whole time Service Users live within the home.

5.28.1. The Provider will take responsibility for the leadership through the Registered Manager as well as their own investment of finance, interest and time.

5.28.2. The philosophy within the service is person-centred and promotes the benefits of open, trusting and collaborative relationships between staff, Service Users and their social and professional networks.

5.28.3. The Provider shall ensure that the home is managed is such a way that it complies with all requirements under the Health and Social Care Act 2008 and the Care Quality Commission (Registration) Regulations 2010, or any amending legislation.

5.28.4. The Provider promotes a clear understanding of the organisations purpose, values and vision and encourages learning and innovation by rewarding reflection, creativity, flexibility and positive risk management.

5.28.5. A manager shall be appointed and registered with the Care Quality Commission or will have applied to be registered with the Care Quality Commission within three months of commencement of employment within the home.

5.28.6. The Manager clearly demonstrates up to date knowledge and skills, leadership, competence and experience to effectively manage the home on a daily basis and has a sound understanding of the requirements set out in the contract terms and conditions and Service Specification.

5.28.7. The Manager will have experience to the equivalent of, or qualification in, or be working towards QCF Level 5 Diploma in Leadership in Health and Social Care within three months of appointment and completed within two years.

5.28.8. The Provider and Manager will keep up to date with good practice guidance in quality and ensure that this is shared and acted on throughout the service, where

appropriate reviewing policies and procedures in line with changes.

5.28.9. The Manager maintains and demonstrates personal and professional competence and credibility in line with current practice and will ensure they delegate appropriately with clear lines of accountability.

5.28.10. The Manager is a self-directed role model, committed to practice development and improving the care of Service Users, providing formal support, coaching and mentoring of all staff.

5.28.11. The Manager will ensure that staff will work collaboratively as an effective team in a culture of openness, promoting mutual support and respect with an appreciation of each other's roles.

5.28.12. The Provider shall ensure the following are in place to effect the continuous and sustained delivery of the service: -

- Proactive and reactive support so that the manager can competently meet all requirements of the service
- Contingency arrangements that plan for potential failure or service interruption
- Business planning so that continuity of the service is ensured and to assure those who rely on the service that it will continue to be provided
- Adequate programme so that the fabric of the building, fixtures and fittings, decoration and furniture is maintained and in good order.

5.28.13. The Provider shall co-operate with the Commissioner in times where the contingency plans require a joint response to interruptions, including reasonable requests for information.

5.28.14. The Provider will ensure processes and procedures are in place that promote continuous improvement within the home, both proactively and reactively.

5.28.15. The Manager will ensure that Service User views are at the core of quality monitoring and assurance arrangements. Feedback is sought from Service Users, Families, Staff and Professionals and there is evidence that Service User's views and experiences are acted on to shape and improve the home and culture.

5.28.16 The Provider will inform the Commissioner when the Registered Manager post is made vacant or appointed to.

5.28.17 The Providers representatives, including the Proprietor, Directors, Senior Managers and Registered Manager are fit and competent to meet the health and welfare needs of Service Users.

5.29. **PERSON CENTRED OUTCOME 29**

Quality Assurance
Continuous quality improvement systems are in place to ensure the home is run in the best interests of Service Users, demonstrates the quality and consistency of information, measures Service User outcomes and ensures that risks to Service Users are minimised.

5.29.1. The Provider will have quality assurance and monitoring systems in place which:-

- Seek the views and experience of Service Users, relatives, friends and health and social care professionals, incorporating community contacts: e.g. schools, faith visitors, friends, where possible.
- Enable realistic assessment of the services provided.
- Support evaluating and learning from current practice to drive continuous improvement and manage future performance.

5.29.2. All staff will be actively involved in the quality assurance and monitoring processes. Quality services will be recognised as a motivating force and staff will strive for continuous improvement and best practice.

5.29.3. Quality Assurance will demonstrate: -

- Measurable organisational improvement
- Training that provides staff with the skills and tools to analyse problems and working processes
- Staff who are empowered and supported to make positive changes (analysing dilemmas/problems and suggesting solutions)
- Positive attitudes and working relationships
- Continuous building on good practice
- Introduction of new procedures.

5.29.4. All Registered Nurses will participate in clinical audit and reviews of clinical care in accordance with Nursing and Midwifery Council guidance.

5.29.5. Providers will be required to assist Commissioners in evaluating the quality of effectiveness, not only of the care to the individual Service Users but also compliance with the Contract Agreement. This will be undertaken on a schedule and by means as defined by the Commissioner.

5.29.6. The Provider will have a robust governance and auditing process which encompasses the following audits on a regular basis in line with their organisational policy;

- Care records, care and support plans and record keeping
- Medicines management
- Training
- Falls
- Infection prevention and control, including health care acquired infections (HCAI's)
- Medical device management
- Nutritional screening and support
- Tissue viability and wound care practice
- Accidents, incidents and complaints (including safeguarding alerts)
- Hospital Admissions
- Call bell responses if such technical systems are in place.

5.29.7. Findings from audits, inspections, assessments and reviews are clearly documented, trends are analysed, and details of actions taken including the responsible person and timescales for completion are documented. This information is used to support continuous

improvements within the service.

5.29.8. The Provider will have effective processes in place to ensure learning from information such as safety incidents, near misses, investigation findings or feedback takes place to make sure action is taken to improve safety and quality across relevant parts of the service.

5.29.9. Staff and Service User and/or representatives' meetings will be used as a forum to identify, take stock and reflect on areas for improvement. Such forums demonstrate that the home will be committed to involving and encouraging others to be included and listened to in the day to day running of the home.

5.29.10. A variety of feedback systems will be used which are suitable for the Service User group. These will be recorded, analysed objectively and published. Examples include:

- Verbal
- Written
- Observational tools
- Symbols/pictures
- Built into activities
- Group
- One to one (enables safe disclosure)
- External evaluation e.g. citizen checker, or at least assessors that are not part of day to day services.

5.29.11. The Provider will have a governance framework where responsibility and accountability are understood at all levels of the Provider organisation to ensure governance arrangements are properly supported. The Registered manager is supported by board / trustees, the Provider and other Managers where appropriate to deliver high standards of care and drive continuous improvement.

5.30. **PERSON CENTRED OUTCOME 30**

Financial Procedures/Personal Finances
Service Users are safeguarded by the accounting and financial procedures of the home. Service Users decide how to spend their money in the knowledge that personal finances are safeguarded by robust controls and audit procedures in the home.

5.30.1. Service Users' personal allowances must not be included as part of the fees. The Service User will retain control of their own money except where they state that they do not wish, or lack capacity and safeguards are in place to protect the Service User.

5.30.2. Providers shall ensure that all staff that handle money on behalf of Service Users clearly understand the procedure for receipting and recording all transactions. All such transactions, and recording thereof, will be audited regularly by the nominated individual for the service and/or significant other associated with the service e.g. Proprietor/Director.

5.30.3. The Provider will ensure that all staff understand how the Service User's right to autonomy, choice, independence and fulfilment is maintained within the context of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards in relation to any financial

management issues.

5.30.4 Service User monies and related financial items (e.g. bank cards, cheque books etc.) will be kept in a place of safety e.g. a safe, by the Provider where requested by the service user.

5.30.5 The Provider will ensure a policy is in place regarding the personal finances of service users, and if any activity relating to Service Users finances is considered to be illegal appropriate bodies will be informed. Provider HR/Personnel codes of conduct will reflect this, and due process and protocol will be followed in respect of any such activity.

Appendix 1 Processing, Personal Data and Data Subjects

Subject matter of the processing	Processing personal data and special category personal data for the provision of residential care services to service users
Duration of the processing	As set out in the main body of the contract
Nature and purposes of the processing	**Processing**: the obtaining, recording or holding the information or data or carrying out any operation on the information or data, which include:

	• organisation, adaptation or alteration of the information or data, • retrieval, consultation or use of the information or data, • disclosure of the information or data by transmission, dissemination or otherwise making available, or • alignment, combination, blocking, erasure or destruction of the information or data. **Purpose:** • to safely and effectively deliver the terms of The Contract and Specification, • statutory obligations • employment processing directly linked to service delivery • such other purposes as the Purchaser may notify to the Provider from time to time
Type of Personal Data	• Health & Care Services ID • Given Names • Preferred Names • Gender • Marital Status • Address • Previous Address • Date of birth • NI number • NHS number • GP • Professional Involvement • Name, age, gender, contact of relationships • Name, age, gender, contact of dependants • Telephone number • Next of Kin • Legal representation • Disability • Languages • Ethnicity • Images • Health & Medical • Sexuality • Religion • Employment history • Advocates • Financial Agents • Emergency contacts • Power of Attorney • Advanced decisions • Authorised representative • Contextual information for care delivery • Personal preferences • DoLs information • Reviews • Safeguarding Adults meeting minutes • Multi Agency Review minutes • Contact details for people listed in this section • Allergies • Sensory Impairment
Categories of Data Subject	• Service Users
Plan for return and destruction of the data once the processing is complete UNLESS requirement under union or member state law to preserve that type of data	As per The Contract

Appendix 2

(Localisation) Cumbria County Council Care Home Banding Guidance

This guidance is intended to support wider assessment of Service User needs and the Provider should therefore have regard to this guidance in delivery of the Services.

The bands are:

- Residential
- Physically Frail – Residential & Nursing*
- Residential Dementia
- Nursing* Dementia

*Funded Nursing Care (FNC) assessed and paid for by the relevant CCG.

The Care Home Banding Guidance consists of two tables of need; Table 1: Physical Frailty and Table 2: Memory, Cognition & Behaviour.

Each table has three levels of care dependency; Low dependency (columns A), Moderate dependency (columns B) and Higher dependency (columns C).

Table 1 is reviewed to indicate whether the Physically Frail band applies, then Table 2 to indicate if the Dementia band applies.

Table 1 demonstrates that:

- Providers of **Residential** care will need to support Service Users with moderate needs that generally fall below those within column (C). (Service Users may some exhibit needs as set out in column (C) in these cases the ASC assessment will determine the overall level.)
- Providers of **Physically Frail** Care will need to support Service Users with high levels of dependency such as those set out in column (C)

Table 2 demonstrates that:

- Providers of **Residential Dementia** will be required to support Service Users with high levels of dependency such as those set out in columns (B) & (C)
- The **Nursing Dementia** band will apply to Service Users who have met the criteria for Nursing Care and have higher levels of dependency as established above.

Needs listed in each of the tables are indicative of the level of care to be provided within Care Homes and are not exhaustive. It is recognised that Service Users may display needs across bandings, in these cases the Social Worker's professional judgement will prevail.

(Localisation) CUMBRIA COUNTY COUNCIL CARE HOME BANDING GUIDANCE TABLE 1: PHYSICAL FRAILTY			
	Low dependency (A)	Moderate dependency (B)	Higher dependency (C)
	Providers of <u>Residential Care</u> will need to support Service Users with moderate needs that generally fall below those within column (C). Service Users may some exhibit needs as set out in column (C), in these cases the ASC assessment will determine the overall level. *Providers of <u>Physically Frail Care</u> will need to support Service Users with high levels of dependency such as those set out in column (C)* *Needs listed below are indicative of the level of care to be provided within Care homes and are not exhaustive.*		
Communication	Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or additional support may be needed either visually, through touch or with hearing.	Regular assistance and encouragement to communicate needs. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.	Unable to regularly and reliably communicate their needs, even when all practicable steps to assist them have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.
Mobility/ personal care	Assessed as being at high risk of falls Able to transfer with a Standaid or independently onto commode for example (transfer only). Occasionally requires 2 carers for moving & handling Occasionally requires hoisting at times i.e. in the presence of infection/illness.	Not able to consistently weight bear. Regularly able to cooperate with moving and handling and personal care. Occasionally requires 2 carers for moving & handling	Needs to be hoisted for all transfers. Requires 2 carers to support with moving and handling the majority of the time. Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate. Requires regular turns and or positioning to meet specific pressure care needs. Full intervention and practical support with all personal care tasks. Regular assistance required during the night time
Nutrition	Needs supervision, prompting with meals and may need feeding /support with feeding of meals Able to finger feed and use a spouted cup Requires a specialised diet – diabetic, adjusted food and fluids (thickened, pureed etc.)		Regular one to one assistance prompting and or active assistance with eating and drinking Specialist diet as directed by Speech and Language Therapist i.e. soft diet, fork mashable, stage 1,2 & 3 fluids.
Changes in consciousness	History of altered states of consciousness but effectively managed and there is a low risk of harm.	Occasional episodes of altered states of consciousness that require the supervision and intervention of a carer or care worker to minimise the risk of harm.	Regular episodes of altered states of consciousness that require the supervision of a carer or care worker to minimise the risk of harm/ occasional episodes that require skilled intervention to reduce the risk of harm.

NOTES: By *occasional* we mean something that happens from time to time i.e. infrequently or irregularly.
By *regular* we mean something that happens uniformly and frequently

(Localisation) CUMBRIA COUNTY COUNCIL CARE HOME BANDING GUIDANCE TABLE 2: MEMORY, COGNITION & BEHAVIOUR			
	Low dependency (A)	**Moderate dependency (B)**	**Higher dependency (C)**
	Providers of Residential Care will need to support Service Users with needs that generally fall below those within column (B). Service Users may some exhibit needs as set out in columns (B) & (C), in these cases the ASC assessment will determine the overall level. *Providers of Residential Dementia will need to support Service Users with high levels of dependency such as those set out in columns (B) & (C)* *The Nursing Dementia band will apply to Service Users who have met the criteria for Nursing Care and have higher levels of dependency as established above.* *Needs listed below are indicative of the level of care to be provided within Care homes and are not exhaustive.*		
Behaviour	Some incidents of behaviours with a risk assessment that indicates that the behaviour does not pose a risk to self, others or property or a barrier to intervention. The person is compliant with all aspects of their care.	Incidents of behaviours that follow a predictable pattern that can be managed by care workers to maintain a level of behaviour that does not pose a risk to self, others or property Occasionally non-complaint during personal care input	Regular behaviours that poses a risk to self, others or property. Full practical support with personal care and engages in daily non-compliance Risk of retaliation from others due to level of behaviour the Service User presents i.e. invading personal space
Cognition	Cognitive impairment that requires some supervision, prompting and/or assistance with daily living activities. Some awareness of needs and basic risks is evident. Some supervision, prompting or assistance with more complex activities of daily living, e.g. finance and medication. Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. At risk of wandering to due impaired orientation Some direction to facilities required but can sequence tasks such as using the toilet for example requires some prompting to ensure personal care/hygiene but still retains practical abilities	Is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.	Cognitive impairment that could include frequent short-term memory issues and maybe disorientation to time and place. Awareness of only a limited range of needs and basic risks. Finds it difficult, even with supervision, prompting or assistance, to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.
Psychological/ Emotional	Requires daily reassurance to promote their emotional wellbeing Respond to prompts and reassurance in periods of anxiety and distress Requires prompts to motivate self towards activity and to engage in care planning, support and/or daily activities.	Mood disturbance or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance	Mood disturbance or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or well-being. Requires reassurance several times a day to promote their emotional wellbeing Withdrawn from any attempts to engage them in care planning, support and daily activities.

NOTES: By *occasional* we mean something that happens from time to time i.e. infrequently or irregularly.
By *regular* we mean something that happens uniformly and frequently

Appendix 3 (Localisation)

Cumbria Quality and Outcome Measures – 'What does good care look like?'

1 **Promoting Independence -** the care and support needs of Service Users are met in a way that enables each to achieve their own personal goals, promotes their wellbeing and enables them to live as active and fulfilling lives as possible.

1.1 *Evidence of systems and practice that demonstrates Service Users have contributed to their own goal or outcome setting based on individual strengths and what is important to them*

1.2 *Evidence that Service Users have been provided with any aids or equipment they may need to support them to undertake tasks of daily living as independently as possible and they know how to use it*

1.3 *Evidence that consideration is given to Service Users' sensory needs and any equipment that will enhance communication and engagement*

1.4 *Evidence that the physical environment enhances independence*

1.5 *Evidence that there is sufficient flexibility within systems and routines, which allow Service Users the necessary time to complete any activity independently*

1.6 *Evidence of timely and responsive care, e.g. early intervention and support for mental health, occupational therapy etc, referring to external support from specialist agencies*

1.7 *Evidence of working with statutory agencies to be responsive to the changing needs of Service Users to overcome barriers and focus on rehabilitation, recovery and progression.*

2 **Choice and Dignity –** Service Users are able to exercise choice and decision making, and are treated with respect, dignity, kindness and compassion. The individuality of each person is recognised and promoted.

2.1 *Evidence that Service Users have contributed to the development of their care and support plan and subsequent reviews or updates. Where there is a lack of capacity there is evidence that their relative or advocate has been involved with the opportunity to review or update*

2.2 *Evidence of systems that demonstrate that Service Users are involved in decision making at an individual and group level. Where there is a lack of capacity there is evidence that their relative or advocate has been involved with the opportunity to review or update*

2.3 *Evidence of how Service Users are supported to take positive risks and where they are deemed to lack capacity to make a specific decision, appropriate advocacy is made available to them*

2.4 *Evidence that Service Users are able to exercise choice about different aspects of their daily living routine, and that their choices have been acted upon*

2.5 *Evidence that Service Users and their relatives are encouraged to provide feedback without prejudice on the service they receive*

2.6 *Evidence how the service supports Service Users to make decisions, respects and acts on their decisions and resolves problems and disagreements*

2.7 *Evidence that Service Users are enabled to maintain and develop their own personal identity*

2.8 *Evidence how the service is responsive to Service Users' individuality, ethnicity, religion and sexuality*

2.9 *Evidence how the culture within the service supports staff members to spend non task centred time with Service Users with time to talk and listen.*

3 **Social Inclusion and Meaningful Activity –** Service Users are supported to maintain and develop relationships to the degree they wish to within the service, with their family and friends, as well as with their local community. Individual and group activity is tailored to the Service User's interests and goals.

3.1 *Evidence of a range of activities tailored to both individual and group activity*

3.2 *Evidence of flexibility around how and when activity or engagement takes place, ie, not just at rostered times when an activity coordinator is present*

3.3 *Evidence of how the service supports Service Users to retain or develop personal relationships with family, friends and the community*

3.4 *Evidence of how members of the local community are encouraged to engage with the service and 'bring the local community into the service'.*

4 Safety and Security – Service Users are able to live in safety, free from abuse or neglect and are supported to take and manage positive risks

4.1 *Demonstrate an understanding of what being safe means to each Service User and how this has been decided*

4.2 *Evidence of robust procedures and systems to maintain and review the safety of Service Users*

4.3 *Evidence of clear reporting mechanisms for reporting concerns about a Service User's safety or wellbeing, and evidence how this is communicated to both staff and visitors*

4.4 *Evidence of a robust Safeguarding and Whistleblowing policy which reflects the Cumbria and Pan Lancashire Safeguarding Procedures*

4.5 *Evidence that all staff have received training on Safeguarding Adults and Children and that knowledge and understanding is continuously reviewed and refreshed*

4.6 *Evidence of knowledge and understanding of the Mental Capacity Act 2005 and ADDENDUM 2007 of the Mental Capacity Act and recognise when it applies to Service Users in the service – including who to contact for more information*

4.7 *Evidence that Service Users are supported to take positive risks and knowledge of who should or could assist in the decision making process.*

5 Positive workforce culture and effective leadership – The service is delivered by a competent, confident and highly motivated workforce. Leadership is visible, proactive and connected to service outcomes.

5.1 *Evidence how the service supports a workforce culture that is open, positive and respectful*

5.2 *Evidence how the service supports the workforce to share ideas and views, or air concerns*

5.3 *Evidence how the organisational culture is supportive and embraces the importance of spending time with Service Users and their relatives (non- care delivery time)*

5.4 *Evidence of good working conditions, opportunities for learning and skills progression*

5.5 *Evidence how the leadership within the service supports the workforce and values their role and contribution*

5.6 *Use of activities to build relationships and engage more freely with Service Users*

5.7 *Evidence how leadership is visible, proactive and connected to service outcomes*

5.8 *Evidence of robust mechanisms in place to support the leadership function*

5.9 *Evidence of a clear mission statement and of policies and procedures in place that reflect and underpin the service aims, culture and leadership.*

APPENDIX 4 (Localisation)

Provider Information – Quality Improvement Process

At times a reactive response will be necessary to address quality concerns that have been identified. The Council's Quality and Care Governance Framework categorises quality concerns into three levels:

Level 1: Focused Intervention or 'Sustaining improvement'

Level 2: Broader Focus Intervention or 'Requires Improvement' Regulator rating

Level 3: Large Scale Intervention, 'Inadequate' Regulator rating or Service Closure/De-registration

Interventions will support the market to achieve/deliver high quality care and support, and enable quality monitoring via a broad range of methods as appropriate.

A Level 3 concern would trigger a multi-agency Quality Improvement process.

Level 3 may be triggered by a culmination of significant concerns or safeguarding issues accompanied by regulatory or other care quality failings, an overall 'Inadequate' rating from the Regulator or Service Closure/De-registration. A Level 3 could also be triggered through failure to meet improvements at Level 2.

The Provider will co-operate fully in the quality improvement process and comply with all requirements, including; attending meetings, providing information, production and implementation of a service improvement action plan and facilitating service reviews with the multi-agency quality improvement team. Failure to comply with procedures or outcomes/actions may be regarded as a fundamental breach of the Framework Agreement.

The Provider will be invited to an initial Quality Improvement meeting and the areas of concern will be highlighted. The meeting will include a range of relevant agencies, for example Clinical Commissioning Group (CCG), the Regulator (CQC), Cumbria County Council (CCC), Continuing Healthcare team (CHC) and the Provider. The initial letter will detail the attendees expected. Meetings will be minuted and details confidential to the attendees, unless approved for wider sharing by the Chair.

Meetings are likely to take place every 4-6 weeks to monitor progress and identify any new areas of concern or barriers to improvement.

A service improvement action plan will be required from the Provider, to address the areas of concern with appropriate actions, responsible party/lead and timescales. The action plan will form the basis for all activity and support, and details relating to progress or barriers will be recorded on the plan, thereby creating an ongoing evidential log of progress.

All Level 3 interventions are discussed and approved by a multi-agency Quality and Care Governance group including CCC, CCG and CQC who meet at least bi-monthly. There will be a collaborative approach to support providers to achieve required improvements and to hold Providers to account where there have been systematic failures.

When the concerns have been remedied and the action plan completed within the agreed timeframe, the multi-agency group will validate and the Level 3 Quality Improvement Process will be closed. The group may recommend ongoing actions to maintain quality improvement which could be via Level 1 monitoring.

Should the multi-agency group recommend a service suspension as part of the Quality Improvement Process, or should the Provider elect to voluntary suspend, this will be formally communicated to the relevant Assistant Director/ Senior Management Team for authorisation to formally suspend the service.

Where a Service is to close or de-register, a multi-agency coordinated approach will be taken to manage the process with care and due diligence. This may be due to Provider failure, or planned in response to market changes or demand. The process will maintain regular contact with all stakeholders to ensure action plans are drawn up, agreed and met.

APPENDIX 5
(Localisation)
Cumbria County Council Independent Care Home Management Information Form

See below for indicative Contract and Quality Monitoring System Questionnaire:

Contract & Quality Management system

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS

Title of Paper	The development of a Lancashire and South Cumbria clinical commissioning policy on the use of Low Intensity Pulsed Ultrasound Therapy (LIPUS): A decision paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	09 January 2020	Agenda Item	7

Lead Author	Rebecca Higgs, Policy Development Manager, NHS Midlands and Lancashire Commissioning Support Unit (MLCSU)		
Contributors			
Purpose of the Report	Please tick as appropriate		
	For Information		
	For Discussion		
	For Decision	√	
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed the development of a new commissioning policy on the use of LIPUS. The policy has been prepared for adoption across Lancashire and South Cumbria.This paper details the development process undertaken.		
Recommendations	That the JCCCGs ratify the following Lancashire and South Cumbria policy: *-Policy for Low Intensity Pulsed Ultrasound Therapy*		
Next Steps	Following ratification arrangements will be made to implement the commissioning policy within relevant commissioned services.		
Equality Impact & Risk Assessment Completed	**Yes**	No	Not Applicable
Patient and Public Engagement Completed	**Yes**	No	Not Applicable
Financial Implications	Yes	**No**	Not Applicable
Risk Identified	Yes		**No**
If Yes : Risk			
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, Healthier Lancashire and South Cumbria		

JOINT COMMITTEE OF CLINICAL COMMISSIONING GROUPS

The development of a Lancashire and South Cumbria clinical commissioning policy on the use of Low Intensity Pulsed Ultrasound (LIPUS)Therapy:

A decision paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)

1. Introduction

1.1 The purpose of this paper is to apprise the JCCCGs of the work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) to develop a commissioning policy on the use of Low Intensity Pulsed Ultrasound (LIPUS)Therapy.

2. Development rationale

2.1 None of the Clinical Commissioning Groups (CCGs) in Lancashire and South Cumbria have an existing commissioning policy on the use of LIPUS and the intervention does not form part of existing commissioned pathways.

2.2 The requirement for this policy was identified as several Individual Funding Requests (IFRs) have been received for this intervention across the geography, requesting the use of LIPUS as an alternative to the standard management approach for non-union fractures, namely surgical fixation of the fracture. This has resulted in the intervention being identified as a potential service development area.

2.3 It was also recognised that other neighbouring regions had commissioning policies for this intervention and the absence of a clear position in Lancashire and South Cumbria had been raised with CCGs via stakeholders.

2.4 The CPDIG therefore agreed that it would be helpful to develop a commissioning policy that outlined the local commissioning position, in line with the prevailing evidence base.

3. Development process

3.1 The development of this policy has been completed in accordance with the process approved by the CPDIG, which has been shared with the JCCCGs previously. That process includes the following key steps:

i. an evidence review by an Consultant in Public Health;
ii. clinical stakeholder engagement with both Specialist and General Practitioners;
iii. public and patient engagement;
iv. notification of local Health, Overview and Scrutiny Committees;
v. consideration of any financial implications
vi. an Equality Impact Risk Assessment (EIRA);

vii. consultation with Healthier Lancashire and South Cumbria Care Professionals Board (the CPB) for clinical assurance purposes.

3.2 Clinical engagement on the policy involved GP practices, Secondary Care Trusts and the Strategic Clinical Network. The feedback received from clinicians demonstrated that the policy had clinical support and was considered clear and equitable. No changes were therefore made to the policy as a result of clinical engagement.

3.3 Patient engagement was also undertaken. A very low level of response was received, none of which raised concerns regarding the proposed policy position. No changes were therefore made to the policy as a result of patient engagement.

3.4 The policy was presented to Healthier Lancashire and South Cumbria's Care Professionals Board in September 2019, who supported its development. As the policy recommends that this intervention is not routinely commissioned, the existing management pathway for this condition remains unchanged. As such, the CPDIG recognised that the existing activity and expenditure levels associated with the management of non-union fractures is expected to remain unchanged.

3.5 The final draft policy and a stage one Equality Impact Risk Assessment (EIRA)[1] was presented to the CPDIG on 19 December 2019. No equality risks were identified and so the group agreed the policy should proceed to ratification.

3.6 The final draft policy is available to view via the following link https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EdGDlFRiCkpFiVcw8_N1zDkBddnux2ND5DEz2G-wDgg6EA?e=cRq0x2

4. Recommendations

4.1 The JCCCGs is asked to ratify the following collaborative commissioning policy:

- Policy for Low Intensity Pulsed Ultrasound Therapy

Elaine Johnstone

Chair of the CPDIG

30.12.2019

References

1. Equality Impact Risk Assessment Policy on Policy for Low Intensity Pulsed Ultrasound https://csucloudservices.sharepoint.com/:b:/s/CSU/IFR/EQiKdeaWUihOt74gTsg_tHoBqjz9qSBoo6iEOcTxqJ6t1w?e=8s8dZ8

Joint Committee of Clinical Commissioning Groups

Title of Paper	Lancashire and South Cumbria Medicines Management Group Recommendations: A briefing paper for the Healthier Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	09.01.2020	Agenda Item	8

Lead Author:	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	The Lancashire and South Cumbria Medicines Management Group (LSCMMG) has developed recommendations for four medicine reviews and the implementation of NICE technology appraisals for adoption across Lancashire and South Cumbria.	
Recommendations	That the JCCCGs ratify the collaborative LSMMG recommendations on the following: - *NICE Technology Appraisals (November 2019).* - *Cariprazine for the treatment of schizophrenia in adults.* - *Octreotide and lanreotide in the treatment of non-acute recurrent gastrointestinal bleeding disorders.* - *Cyanocobalamin tablets for the treatment of: nutritional Vitamin B12 deficiency; vitamin B 12 deficiency following partial gastrectomy; tropical sprue, alone or with folic acid; pernicious anaemia.* - *Azathioprine for the treatment of Myasthenia Gravis.*	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	No	
Financial Implications	Yes	
Risk Identified	No	
If Yes: Risk	N/A	
Report Authorised by:	XXXX	

Midlands and Lancashire
Commissioning Support Unit

Development of Lancashire and South Cumbria Medicines Management Group recommendations:

1. Introduction

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

- *NICE Technology Appraisals (November 2019).*
- *Cariprazine for the treatment of schizophrenia in adults.*
- *Octreotide and lanreotide in the treatment of non-acute recurrent gastrointestinal bleeding disorders.*
- *Cyanocobalamin tablets for the treatment of: nutritional Vitamin B12 deficiency; vitamin B 12 deficiency following partial gastrectomy; tropical sprue, alone or with folic acid; pernicious anaemia.*
- *Azathioprine for the treatment of Myasthenia Gravis.*

2. Development process

2.1 LMMG produces a number of different documents to support the safe, effective and cost-effective usage of medicines. The development of recommendations has been completed in accordance with the process approved by the LSCMMG, which has been shared with the JCCCGs previously (see Appendix 1).

2.2 The review process includes the following key steps:

- an evidence review by an allocated lead author;
- clinical stakeholder engagement;
- notification of relevant local Health, Overview and Scrutiny Committees;
- consideration of any financial implications
- an Equality Impact Risk (EIRA) Assessment screen
- public and patient engagement (where applicable).

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

NICE Technology Appraisals (November 2019)

Available at https://www.nice.org.uk/guidance/published?type=ta

Cariprazine for schizophrenia in adults

Cariprazine New Medicine Assessment JCCCG.docx

Octreotide and lanreotide in the treatment of non-acute recurrent gastrointestinal bleeding disorders.

Octreotide Lanreotide GI bleeding CONSULTATION JCCCG.docx

Cyanocobalamin tablets for the treatment of: nutritional Vitamin B12 deficiency; vitamin B 12 deficiency following partial gastrectomy; tropical sprue, alone or with folic acid; pernicious anaemia.

Cyanocobalamin tablets CONSULTATION JCCCG.docx

Azathioprine for the treatment of Myasthenia Gravis.

Azathioprine in MG CONSULTATION JCCCG.docx

3. NICE Technology Appraisals (NICE TA) (November 2019)

3.1 Commissioners and/or providers have a responsibility to provide the funding required to enable NICE TA guidance to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution.

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

3.3 Of the NICE TA Guidance published in November 2019, CCGs are the responsible commissioner in the case of two TA guidance recommendations:

- TA610 - "Pentosan polysulfate sodium for treating bladder pain syndrome". NICE do not expect this guidance to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population).

3.3..1 LSCMMG agreed that this should be given a Red RAG rating in line with the criteria set out in the NICE TA

- TA613 – "Fluocinolone acetonide intravitreal implant for treating chronic diabetic macular oedema in phakic eyes after an inadequate response to previous therapy". Fluocinolone acetonide intravitreal implant is not recommended as an option for treating chronic diabetic macular oedema that is insufficiently responsive to available therapies in an eye with a natural lens (phakic eye).

3.3..1 LSCMMG agreed that this should be given a Black RAG rating in line with the indication set out in the NICE TA

4. Cariprazine for schizophrenia in adults

4.1 Cariprazine for schizophrenia in adults was prioritised for review by LSCMMG following a request from Lancashire and South Cumbria Foundation Trust (LSCFT - formerly Lancashire Care NHS Foundation Trust).

4.2 Despite the available treatments for schizophrenia there is a substantial unmet medical need especially for treatment of negative symptoms which affect up to two thirds of patients with schizophrenia. To date, no standard treatment has been established for negative symptoms.

4.3 The draft recommendation was considered by the October meeting of the LSCMMG, the recommendation considered was:

Cariprazine is recommended as a second-line therapy in patients where predominantly negative symptoms have been identified as an important feature.

- *Cariprazine is suitable for prescribing in primary care following recommendation or initiation by a specialist.*
- *Full prior agreement about patient's on-going care must be reached under a shared care agreement.*

4.4 The draft recommendation was sent out for clinical consultation by stakeholder organisations. As a result of the consultation Lancashire and South Cumbria Foundation Trust have agreed to share an internal approval mechanism for the prescribing of cariprazine. LSCMMG agreed that the MLCSU will add cariprazine to the local antipsychotics shared-care guidelines prior to agreement of the final shared-care document by the LSCMMG.

4.5 The annual acquisition cost of treating one patient with cariprazine for 1 year is **£1,048**

The estimated gross budget impact for Lancashire and South Cumbria is:
14 X £1,048 = **£14,672 in year 1**
27 X £1,048 = **£28,296 in year 5**

4.6 The issues highlighted during the clinical consultation stage highlighted that the evidence base for recommending cariprazine is limited and use was only supported for patients with negative symptoms stabilised on cariprazine if a clear pathway is defined with an associated shared care agreement.

4.7 The LSCFT approval proforma was considered by the December meeting of the LSCMMG. Following the addition of wording to make it clear that the letter to the GP needed to specify that contraceptive advice had been provided to the patient LSCMMG the group agreed the policy should proceed to ratification with an Amber 1 RAG rating.

5. Octreotide and lanreotide in the treatment of non-acute recurrent gastrointestinal bleeding disorders (including angiodysplasia, small bowel dysplasia, gastric antral vascular ectasia, haemorrhagic telangiectasia)

5.1 Octreotide and lanreotide were prioritised for review by the LSCMMG following a number of individual funding requests for the products for use in gastrointestinal bleeding disorders across the local health economy.

5.2 Octreotide and lanreotide are sometimes requested by gastroenterologists to treat a small number of patients with gastrointestinal bleeding when other measures have failed.

5.3 The draft recommendation was considered by the December meeting of the LSCMMG, the recommendation considered was:

Octreotide and lanreotide are recommended for the non-acute treatment of recurrent gastrointestinal bleeding disorders. Initiation and continued supply of octreotide/lanreotide is the responsibility of hospital or specialist services.

5.4 If 3 patients were treated with the highest dose of long-acting octreotide (most expensive permutation) the annual acquisition cost would be as follows:

3 X £11,981.76 = **£35,945**
If 2 patients were treated with the lowest dose of lanreotide (least expensive permutation) the annual acquisition cost would be as follows:
2 X £6,612 = **£13,224**

5.5 The issues highlighted during the clinical consultation stage included a request that a statement regarding prioritising the use of the most cost-effective product be added

and that, where appropriate, medicines likely to exacerbate bleeding are stopped before considering octreotide or lanreotide and that treatment should only be continued if an adequate response is achieved (e.g. a 50% reduction in the need for transfusion or parenteral iron)

5.6 LSCMMG the group agreed the policy should proceed to ratification with a Red RAG rating.

6. Cyanocobalamin tablets for the treatment of: nutritional Vitamin B12 deficiency; vitamin B 12 deficiency following partial gastrectomy; tropical sprue, alone or with folic acid; pernicious anaemia.

6.1 Cyanocobalamin 50 mcg Tablets for the above indications was prioritised for review by the LSCMMG following a request from Morecambe Bay APC to review the product.

6.2 Cyanocobalamin tablets are a potential alternative to other vitamin B12 preparations that usually are administered by injection.

6.3 The draft recommendation was considered by the December meeting of the LSCMMG, the recommendation considered was:

NOT recommended for use by the NHS in Lancashire for treatment of nutritional Vitamin B12 deficiency; treatment of vitamin B 12 deficiency following partial gastrectomy; treatment of tropical sprue, alone or with folic acid; treatment of pernicious anaemia.

6.4 One issue was highlighted during the clinical consultation stage. This highlighted that oral replacement therapy was recommended in regional and national haematological guidelines.

6.5 LSCMMG agreed with the addition of a statement making it clear that patients who require treatment of more complex conditions may be considered an exception to the policy. Following this addition, LSCMMG the group agreed the policy should proceed to ratification with a Black RAG rating.

7. Azathioprine for the treatment of Myasthenia Gravis.

7.1 Azathioprine for treatment of Myasthenia Gravis was prioritised for review following receipt of a series of emails from local clinicians suggesting that the drug may be part of routine care within the Lancashire and South Cumbria Health Economy.

7.2 Azathioprine is included in guidelines for the treatment of patients with Myasthenia Gravis, mainly as a steroid sparing agent.

7.3 The draft recommendation was considered by the December meeting of the LSCMMG, the recommendation considered was:

Suitable for prescribing in primary care following recommendation or initiation by a specialist. Full prior agreement about patient's on-going care must be reached under a shared care agreement.

7.4 One issue was highlighted during the clinical consultation stage. This related to whether the monitoring requirements were such that the medicine should be considered as an Amber level 2 medicine (with shared care and enhanced service)

7.5 LSCMMG agreed that the monitoring requirements of the new indication are expected to be in line with the monitoring requirements of the indications in the current shared care document. LSCMMG the group agreed the policy should proceed to ratification with an Amber 1 RAG rating (requires shared care).

8. Conclusion

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

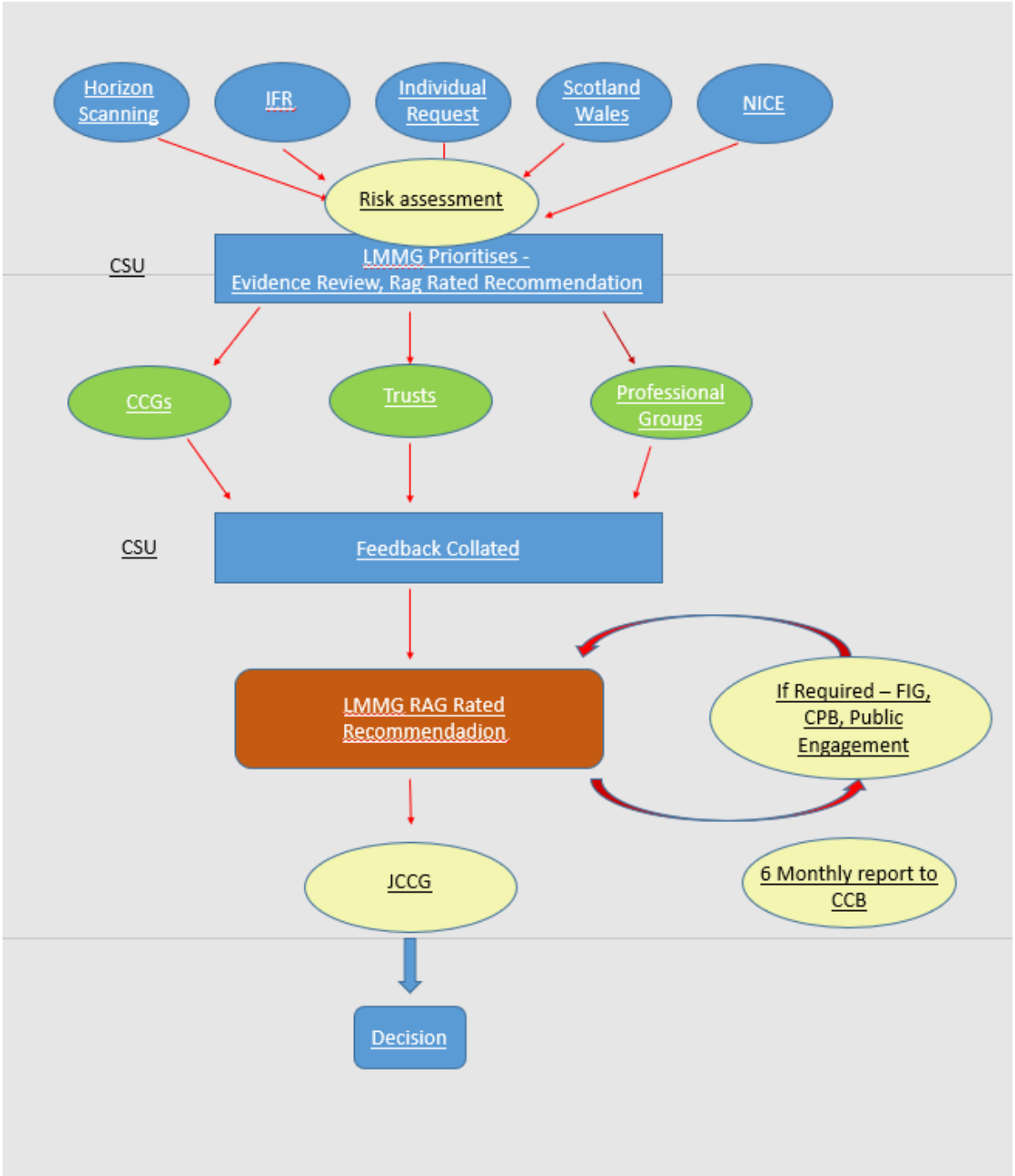
- *NICE Technology Appraisals (November 2019)*
- *Cariprazine for the treatment of schizophrenia in adults.*
- *Octreotide and lanreotide in the treatment of non-acute recurrent gastrointestinal bleeding disorders.*
- *Cyanocobalamin tablets for the treatment of: nutritional Vitamin B12 deficiency; vitamin B 12 deficiency following partial gastrectomy; tropical sprue, alone or with folic acid; pernicious anaemia.*
- *Azathioprine for the treatment of Myasthenia Gravis.*

Brent Horrell, Head of Medicines Commissioning,

NHS Midlands and Lancashire CSU

09.01.2020

Appendix 1- LMMG process including introduction of risk assessment and sign off of some recommendations by Joint Committee CCGs.



Title of Paper	Commissioning Reform in Lancashire and South Cumbria		
Date of Meeting	Thursday 09 January 20	Agenda Item	9

Lead Author	Andrew Bennett	
Contributors	Several system leaders have contributed important observations and content during development of Case for Change.	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	x
Executive Summary	This cover paper introduces two papers which have been drafted to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (LSC) over the next two years. It introduces: • A case for change document which sets out how commissioning organisations can work to accelerate the development of local integrated health and care partnerships. • Draft terms of reference which aim to reconstitute an existing oversight group to act as a formal sub-group of the Joint Committee of CCGs. It is proposed that the revised Group will oversee the continued development of plans for commissioning reform which can be considered by the Joint Committee and individual CCG governing bodies.	
Recommendations	1 Note the contents of this report. 2 Endorse the Case for Change and ask individual CCG Governing Bodies to lead a period of formal engagement from February-March 2020 with local member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups. 3 Receive the proposed Terms of Reference for the Commissioning Reform Group and agree that this group is reconstituted to act as a formal sub-group of the Joint Committee.	

Next Steps	Complete preparations for a period of formal engagement about the Case for Change with local member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups. Convene the first meeting of the Commissioning Reform Group.		
Equality Impact & Risk Assessment Completed		No	Not Applicable
Patient and Public Engagement Completed		No	Not Applicable
Financial Implications	Yes		Not Applicable
Risk Identified	Yes		
If Yes : Risk	It is expected that the Commissioning Reform Group will review risks arising from this programme of work as part of its core agenda. Individual CCGs will continue to report risks through local assurance frameworks.		
Report Authorised by:	Andrew Bennett		

Healthier Lancashire & South Cumbria

Commissioning Reform in Lancashire and South Cumbria

1. Introduction

This cover paper introduces two documents which have been drafted to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (LSC) over the next two years. It introduces:

- A case for change document which sets out how commissioning organisations can work to accelerate the development of local integrated health and care partnerships.

- Draft terms of reference which reconstitute an existing oversight group to act as a formal sub-group of the Joint Committee of CCGs. It is proposed that the revised Group will oversee the continued development of plans for commissioning reform which can be considered by the Joint Committee and individual CCG governing bodies.

2. Case for Change

2.1 The Case for Change paper has evolved from a series of development workshops attended in recent months by CCG Chairs and Chief Officers, Directors from the Midlands and Lancashire Commissioning Support Unit and Directors working across the Integrated Care System. These development sessions have enabled commissioning leaders to:

- Review the work led by CCGs since 2013 to respond to a number of significant challenges in each local area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability.
- Restate their commitment to the continued development of 4 maturing integrated health and care partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for commissioners, providers, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.
- Confirm the action taken by CCGs to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.
- Review the existing arrangements which enable CCGs to take collective decisions on pertinent issues affecting the whole of Lancashire and South Cumbria.

2.2 Based on the collective vision to continue this journey of integrated care in neighbourhoods, local places and across Lancashire and South Cumbria, commissioning leaders have identified a number of options for the commissioning arrangements which can best support this next stage of development. Each option has been assessed against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

2.3 The Case for Change document recommends Option 5 which would lead to the creation of a single CCG for Lancashire and South Cumbria. This option is also clear that the single CCG will discharge a range of its functions through place-based commissioning teams working with partners in each of the five local ICP/MCP areas.

2.4 Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups.

2.5 Further work will also be completed during January to develop proposals for the future delivery of commissioning functions at local place and Lancashire and South Cumbria levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

2.6 It is vital to emphasise that the formal decision about any option to change the number of CCGs will be taken according to each CCG's constitution through a vote of member practices. Therefore after the engagement process has been undertaken, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs and CCG Governing Bodies prior to a CCG GP Membership vote in April 2020.

2.7 Subject to the outcome of this vote, a full set of merger submission documents will be prepared in line with NHS England guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE by 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

3. Terms of Reference – Commissioning Reform Group

3.1 The second document attached to this paper is a draft set of Terms of Reference (ToR) for a group to be known as the Commissioning Reform Group. It is proposed that this Group replaces a pre-existing Group (the Commissioning Oversight Group) which was established in June 2018 to choreograph implementation of the earlier Commissioning Development Framework.

3.2 The terms of reference rename the group to reflect its responsibilities going forward and to create a formal accountability to the Joint Committee of CCGs. These ToR including the membership have therefore been updated to allow the Joint Committee of CCGs to oversee the implementation of the road map for commissioning reform in Lancashire and South Cumbria.

3.3 The purpose of the CRG is to act on behalf of the Joint Committee of CCGs to oversee the preparation and implementation of a programme which enables a continuing process of commissioning reform in Lancashire and South Cumbria. This will include the production of:

- A formal Programme Plan – which enables the 8 CCGs to take collective action and comply with national guidance
- Human Resources and Organisational Development Plan
- Communications and Engagement Plan

3.4 The Commissioning Reform Group will make recommendations to the Joint Committee in line with the scheme of delegation which applies to the Joint Committee.

3.5 It is proposed that the Commissioning Reform Group is chaired by the Vice Chair of the Joint Committee of CCGs.

4. Recommendations

The Joint Committee is requested to:

4 Note the contents of this report.

5 Endorse the Case for Change and ask individual CCG Governing Bodies to lead a period of formal engagement from February-March 2020 with local member practices, CCG staff and other stakeholders including providers, Local Authorities, Healthwatch and patient/public groups.

6 Receive the proposed Terms of Reference for the Commissioning Reform Group and agree that this group is reconstituted to act as a formal sub-group of the Joint Committee.

Andrew Bennett

31/12/2019

Lancashire and South Cumbria CCGs

Supporting Commissioning Reform and Integrated Care in Lancashire and South Cumbria

A Case for Change

Executive Summary

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out a case for changing the way that commissioning organisations work in order to accelerate the development of local integrated health and care partnerships. These increasingly ambitious partnerships offer a vehicle for commissioners, providers, local authorities and other partners to work very differently together, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and agreeing priorities to bring the system back into financial balance.

The context for the document is the work led by CCGs since 2013 to respond to a number of significant challenges in each area: poor outcomes and health inequalities, fragmented services, increasing demand compounded by workforce pressures and the need for financial sustainability [section 1]. This work has led to a broad consensus of the need for partners to work effectively together in neighbourhoods, in local places and across Lancashire and South Cumbria.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of these integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing. As PCNs develop, they will have an increasing influence on the priorities of our evolving Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. Where there are opportunities across Lancashire and South Cumbria for collective action, learning and development, these are also being taken forwards by the wider Integrated Care System (ICS) partnership.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called "integrated care organisation" could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability. The "integrated care organisation" would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

Currently, however, the 8 CCGs in Lancashire and South Cumbria are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to

develop at the pace that is needed - and to tackle the challenges we face. This is in spite of the examples of joint decision-making and shared management arrangements which have developed over the last seven years.

In section 4, this paper begins to review the way that commissioning is currently organised and evaluates a number of potential future options against the following criteria:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

As a consequence of the ambitions to reform the commissioning arrangements, the option recommended is to form a new single CCG from April 2021 with aligned local commissioning teams to each Integrated Care Partnership / Multispecialty Community Provider, to support this next stage of development.

Key issues

A number of key issues have been raised by Governing Body representatives and member practices during the development work which has led to the production of this document. These issues [section 5] clarify and confirm how the process of change in commissioning arrangements would build on the existing strengths in Lancashire and South Cumbria and can be summarised as follows:

Governance, leadership and local decision-making

The single CCG will have a constitution approved by member practices across Lancashire & South Cumbria and will ensure strong local commissioning remains in each place.

It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The method of appointment to the CCG governing body and place-based commissioning teams would be agreed as part of the new constitution.

The place-based commissioning teams will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board. Local authority membership of local partnership boards will also drive this place-based approach.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

It is proposed that the new single CCG Chair and the Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP.

Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

The CCG also expects that PCN leaders will be formally represented within the ICP partnership arrangements.

Financial allocations for commissioning

There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.

Overarching financial principles would be developed and agreed as part of the engagement process, but we propose that:

- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as being in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

Commissioning general practice services

The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.

Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.

Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Engagement and Next Steps

Once this case for change has been approved, a formal process of engagement will commence with member practices, CCG staff, partner organisations, patient and public groups. [section 6] More details on the proposed timeline for this process are set out in section 7.

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Introduction

This paper aims to support consideration and discussion about the evolution of NHS commissioning in Lancashire and South Cumbria (L&SC) over the next two years. It sets out the challenging context facing commissioners and communities. It also confirms the opportunities to continue a journey of integrated care which builds on the best work undertaken by CCGs and our partners in recent years. The document contains an options appraisal for future commissioning arrangements which is based on a number of criteria and recommends a preferred option for change. The paper also includes next steps and a high-level timeline for implementation of the preferred option.

This version of the Case for Change has been written for initial consideration by CCG governing bodies, member practices and the Joint Committee of CCGs. Wider engagement with commissioning staff, providers, local authorities and other partners will also be essential as this process develops.

Section 1: The Challenges We Face

As local commissioners, CCGs have been working with other partners since 2013 to respond to a range of familiar challenges:

Inequalities and Poor Health Outcomes

In Lancashire and South Cumbria, people in many of our communities experience ill health from an early age and die younger, especially in areas with higher levels of deprivation. There are high levels of physical and mental health problems, and we have seen increased levels of suicide in some of our communities. Cardiovascular disease, heart failure, hypertension (high blood pressure), asthma, dementia and depression are more common than the national average.

Persistent inequalities in health, employment, education and income are damaging the life chances of many citizens. There is increasing recognition that we need to support people and communities to help them to make changes in their own health and wellbeing. In future, therefore, commissioners will need to co-create a sustainable response from a range of public bodies to these issues, working with communities themselves.

Fragmented services and systems

There are multiple examples of fragmented pathways and services across the health and care system which leave patients uncertain as to where to access the most appropriate care or health professional.

At a systemic level in Lancashire and South Cumbria, the NHS model of commissioners and providers created nearly 30 years ago appears to have reinforced fragmentation in spite of the best efforts of many frontline professionals and leaders. Multiple contracts between several commissioners with the same provider e.g. for mental health services have created differential expectations and outcomes; competing organisational strategies have not enabled a clear focus on standards and outcomes. There are several examples e.g. improving stroke services, where decision-making on critical improvements has been painfully slow to achieve as individual organisations reconsider the proposals. These are not isolated examples: many have been discussed over the years in each Governing body and in our collective meetings across the whole of Lancashire and South Cumbria.

Our local providers are committed to working differently to repair this fragmentation: groups of general practices are working in neighbourhoods with other community and social care services to develop primary care networks. Attention will increase on these services with the

imminent publication of national standards/specifications for a range of community-based services.

Our major NHS providers are also exploring new models of collaboration, working firstly with general practice and community services to integrate care pathways in ICPs. They are also considering how "group" models of provision across Lancashire and South Cumbria can, for example, increase the sustainability of fragile services, create efficiencies in diagnostic and operating theatre services and improve the performance of cancer services.

Commissioners need to be working at the heart of these new models of delivery – but there is neither capacity nor resources to support these new approaches and maintain the infrastructure of eight separate CCGs.

Increasing Demand

Our health and care services are struggling to tackle the level of illness and poor overall health we face in Lancashire and South Cumbria. As demand for care increases, some people don't receive the quality of care they need and commissioners cannot afford to fund escalating levels of activity.

Workforce

Workforce pressures in the health and care sector are well documented – traditional multidisciplinary models of care are increasingly hard to sustain and this requires new thinking about workforce roles and support for frontline staff. The full benefits of new technology can only be realised if they are introduced into more integrated services, pathways and teams.

Financial Sustainability

In 2019/20 there is an estimated financial gap of £200m across the L&SC ICS, based on the allocations received by the 8 CCGs. Whilst funding for the NHS is set to increase over the next few years, tackling the challenges of persistent inequalities, fragmentation, increasing demand and workforce change is more urgent than ever. We need to consider every opportunity to streamline our systems and processes, and reduce duplication. Our aim has to be to make our financial position sustainable and our collaborative work on the Long Term Plan is progressing with that aim.

Over the last twelve months, all CCGs have been required to plan for a 20% reduction in running costs and this has already led to decisions to integrate management functions between CCGs and within ICPs/MCPs, hold staffing vacancies, review clinical leadership roles, reduce accommodation costs and work differently with the CSU.

The direction of travel towards 5 local place-based commissioning teams working through a single CCG will free up a proportion of running costs, particularly in relation to the costs of 8 Boards as well as taking further opportunities to consolidate or share management functions.

Some simple examples of where a single CCG would be more productive without affecting local clinical leadership and decision making include:

- We currently have to procure extrernal and internal auditors eight times and produce 8 sets of statutory accounts.
- As eight separate CCG's we hold collectively over 100 meetings per year to meet our statutory and constitutional duties. This could be vastly reduced freeing clinical time to focus on local place-based work.

- Commissioning areas like Ambulance services, cancer services and CHC would be much more effectively managed improving patient care and releasing savings and staff to reinvest locally.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

The table below summarises the pattern of running costs across the 8 CCGs:

Organisations	**Population**	**No. of Practices**	**2019/20 Allocation £m**	**201/20 Running Cost Allocation £m**
NHS Blackburn with Darwen CCG	177,841	23	271.3	3.5
NHS Blackpool CCG	175,012	20	333.1	3.5
NHS Chorley and South Ribble CCG	186,154	30	287.2	3.9
NHS East Lancashire CCG	387,324	50	647.6	7.8
NHS Fylde and Wyre CCG	178,682	19	310.5	3.6
NHS Greater Preston CCG	210,857	23	311.8	4.4
NHS Morecambe Bay CCG	348,208	35	570.0	7.2
NHS West Lancashire CCG	113,532	15	177.8	2.4
TOTAL	**1,777,610**	**215**	**2,909.3**	**36.3**

In summary, maintaining the costs of eight separate statutory bodies at a total cost of £36m is difficult to justify when there is such financial pressure on health spending.

Section 2: Our Journey to Develop Integrated Health & Care in Lancashire and South Cumbria

We know that tackling the challenges set out in Section 1 is not something that any single commissioning organisation can achieve in isolation. For this reason, the CCGs in Lancashire and South Cumbria have a long history of working collaboratively together and with partners across the Integrated Care System (ICS) footprint. The publication of the NHS Five Year Forward View in 2014 achieved a new level of consensus that commissioners, providers local authorities and other partners should pursue approaches to integrating health and care – joining strategies, partnerships, resources and leadership to respond to the triple aim of better health, better care, delivered sustainably.

By 2018, this journey of integrated care development was accelerating the development of 4 maturing Integrated Care Partnerships (ICPs) in Morecambe Bay, Fylde Coast, Central Lancashire and Pennine Lancashire and a Multi-specialty Community Provider (MCP) in West Lancashire. These partnerships offer a vehicle for providers, commissioners, local authorities and other organisations to work very differently, agreeing plans to improve the whole population's health, using collaboration rather than competition to improve the quality of health services and bring the system back into financial balance.

CCGs have also begun to deploy significant resources and expectations into the early development of 41 Primary Care Networks (PCNs), building on the integrated care models which have developed in neighbourhoods. There is a clear expectation in each ICP that the clinical leadership offered by GPs and other frontline professionals should be endorsed and refocused to ensure the success of PCNs and ICPs. There is also further potential to use the development of PCNs and ICPs to encourage new approaches of integrated commissioning with our local authorities.

At the same time, a Joint Committee of CCGs was established "to carry out the functions relating to decision-making on pertinent L&SC wide commissioning issues" arising from the ICS's main change programmes. This means the CCGs across L&SC already act together as the Commissioning Board (NHS) of the ICS. The terms of reference for the Joint Committee have recently been reviewed and updated and an annual work programme has been agreed. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or decisions arising from our main work programmes will take place.

The evolution of commissioning set out in this paper is not therefore a sudden jolt in our current arrangements. Our direction of travel builds on the place-based approaches being endorsed by CCGs in neighbourhoods, ICPs and across Lancashire and South Cumbria.

Recognising that the development of integrated care models would impact on the future of commissioning arrangements, in January 2018, the Joint Committee approved a Commissioning Development Framework for Lancashire and South Cumbria. The framework gave a system wide commitment to

- Listen to our communities about their priorities for health and wellbeing, connecting up the natural assets in each neighbourhood with the resources available across the public sector;
- Make shared, strategic decisions, with key partners and clinical leaders about the allocation of resources;
- Implement new, integrated models of service provision which can make significant improvements in the quality and outcomes of health and care;

- Streamline the way we do things to reduce waste and make the most efficient use of our resources.

Following approval of the Commissioning Framework, CCG commissioning colleagues across the system worked together to apply it to their workstreams and develop recommendations for place-based commissioning activity in the future. Their work addressed several examples of fragmented or variable commissioning in the current system which are leading to poor outcomes for many people. Examples include our approach to complex, individual packages of care, the availability of robust community services for people with learning disabilities and the variability of performance in cancer services. The Joint Committee agreed the recommendations and asked workstreams to develop operating and support models.

We have therefore made significant progress on our journey to develop integrated health and care for the people of L&SC and in doing so have established solid foundations for further development. ICPs/MCP and PCNs/neighbourhoods, are the fundamental foundations for a strong and effective health and care system going forward.

However, CCGs are relatively small organisations. It is becoming increasingly clear that there is insufficient capacity and capability in the system as a whole to support PCNs/neighbourhoods and ICPs/MCP to develop at the pace that is needed - and tackle the challenges, work with our communities, improve the overall quality of our health and care services and achieve better financial outcomes.

There is significant duplication in operating eight membership councils and governing bodies and the associated governance, many CCGs have similar groups to solve the same problems. Individual members of staff are trying to maintain work on several critical priorities at the same time and the work to implement new collaborative commissioning operating models across L&SC is progressing, though slowly. We therefore need to review the way we are currently organised, building on and accelerating our joint working to date, agree how best to organise ourselves to meet our challenges and deliver our vision to create a health and care system that is fit for now and the future.

Section 3: Vision

Our published vision for Lancashire and South Cumbria is that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives.

At the heart of this are the following ambitions:

- We will have healthy communities
- We will have high quality and efficient services
- We will have a health and care service that works for everyone, including our staff.

Over the next 4-5 years, we expect our system to continue its journey of integrated care, joining up the priorities of health and care organisations to achieve consistent standards of service performance and improved outcomes for patients and the public.

We are placing a premium on:

- Developing partnerships across the public sector (education, employment, housing, business, local government and NHS) in order to reduce the generational inequalities in health and life chances between our communities.
- Working with each of our communities to understand the assets available which can help people to become more engaged in their own health and well being.
- Joining up primary, community, mental health and social care services in local areas whilst at the same time ensuring that sustainable and efficient models of specialised services can be offered to the whole population.

Over the next 2-3 years, CCG leaders have already stated their commitment to the continuing development of integrated partnership models [section 2]. Clinical colleagues working in 41 Primary Care Networks are finding new ways to join up care in each neighbourhood and engage members of the public in their own health and wellbeing.

Looking further ahead (3-4 years) and as these partnerships continue to mature, there is further potential for them to take on more formal organisational responsibilities for improving the health of local people [section 3]. Our thinking at this stage is that a so-called “integrated care organisation” could be responsible for between 150-500,000 residents, delivering care directly and using alliances with other providers to create an effective local system of care. In doing so, we would expect this model of organisation to have demonstrated a transformational shift in its approach to population health, clinical leadership, board governance and accountability.

The “integrated care organisation” would work under contract to the new single Commissioner which is charged with assuring progress of the ICP/ICO, setting consistent standards and securing improved outcomes across Lancashire and South Cumbria, achieving national policy priorities and financial value for taxpayers.

In moving towards our vision, over the next 2-3 years we will continue to strengthen our partnerships in local places and across the whole Lancashire and South Cumbria system. Our priorities here are to:

- Ensure our clinical and other frontline leaders are able to lead the work to create sustainable care models in our neighbourhoods, place-based partnerships and across Lancashire and South Cumbria.

- Demonstrate to patients and communities that the ways in which we organise health and care services are leading to improved access and outcomes.
- Tackle our most difficult challenges (workforce, finance, service resilience) by agreeing clear priorities across the ICS and the decision-making arrangements we will use.
- Sustaining an open dialogue with the public about our future models of health and care.

The proposals for commissioning reform which are laid out in this document are therefore designed to help us make the next steps on this ambitious journey.

Section 4: Options for Commissioning System Reform

In developing and considering options for future commissioning reform, it is important that we do so in the context of the challenges we face, the progress made to integrate care and our commitment to build on the partnerships which commissioners have already developed. The following criteria have therefore been developed to support these considerations. If we are going to organise ourselves differently, any new model must:

- Tackle inequalities and improve outcomes for patients
- Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPs, MCP and (where there is value in acting collectively) across the ICS
- Reduce duplication of commissioning processes, governance arrangements and the use of staff time
- Support a consistent approach to standards and outcomes
- Be affordable, reduce running costs and support longer term financial sustainability
- Offer the potential for further development of integrated commissioning between the NHS and Local Authorities
- Be deliverable
- Be congruent with the NHS Long Term Plan expectation that there will "typically" be a single CCG for each ICS area.

Options Appraisal

Current Arrangements

There are currently eight CCGs within the L&SC ICS footprint with a number of CCGs operating shared commissioning arrangements that are aligned to the ICP footprints:

- NHS East Lancashire CCG and NHS Blackburn with Darwen CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements
- NHS Blackpool CCG and NHS Fylde & Wyre CCG have a single Accountable Officer, a newly-created single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- West Lancashire CCG shares the same Accountable Officer as the two Fylde Coast CCGs (from January 2020).
- NHS Chorley & South Ribble CCG and NHS Greater Preston CCG have a single Accountable Officer, a single Management Team and integrated workforce. Their Governing Bodies remain separate but already have a number of common working arrangements.
- NHS Morecambe Bay CCG was formed in 2018 following a boundary change process to incorporate South Cumbria. There is a single Accountable Officer and Governing body and clinical and executives are increasingly taking "system roles" within the ICP.

Across the ICS footprint, the CCGs oversee collaborative programmes of work and are able to make joint decisions relating to L&SC-wide issues through the formally constituted Joint Committee of CCGs, in line with an agreed annual work programme. This ensures that decision-makers and CCG Governing Bodies are clear how collective oversight and/or

decisions arising from our main work programmes will take place. The work programme is also used to seek appropriate delegations from CCG Governing Bodies into the Joint Committee where appropriate. The scope of delegation to the Joint Committee is limited at the current time.

Drawing on the criteria set out above a number of options for future commissioning system reform have been generated and appraised:

Option 1	*No change to current arrangements*
Option 2	*Merger to create five CCGs aligned with ICP footprints*
Option 3	*Single Accountable Officer and Executive Team for all eight L&SC CCGs*
Option 4	*Single CCG (all functions)*
Option 5	*Single CCG which aligns commissioning functions to each Integrated Care* ***Partnership/****Multispecialty Community* ***Partnership***
Option 6	*Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care* ***Provider/*** *Multispecialty Community* ***Provider***

A detailed appraisal of these options is set out in Appendix A. In the light of this assessment, option 5 is recommended to commence from April 2021. The details of this option are shown below.

Our Preferred Option and Benefits

Option five is our recommended option to commence from April 2021. In advance of this, shadow arrangements would be developed during 2020/21.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them

including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Merging into a unified, more strategic commissioning organisation with a strong local focus delivered through locality commissioning teams aligned to the five ICPs/MCP best supports our ambitions as described below:

1. Tackle inequalities and improve outcomes for patients

We know there are significant health inequalities across L&SC which create challenges for services and result in poorer outcomes for some of our most vulnerable and deprived communities. Our work to tackle health inequalities will be better supported by having Locality Commissioning Teams aligned to the five ICPs/MCP. This will enable us to:

- Maintain strong links and engagement with the local population;
- Ensure specialist analytics and population health capabilities can develop across L&SC and be available for each ICP/PCN to support local priorities
- Undertake service planning and targeted delivery to reflect the specific needs of local communities – working closely with local authorities;
- Ensure effective communication and engagement with local populations including seldom heard groups of people to enable them to share their views and concerns which will shape not just what services are provided but how they are delivered.

Only by organising ourselves differently can we begin to deliver the improvements that are needed for our patients

2. Get our resources and capacity in the right place to support our integrated place-based models in PCNs, ICPS, MCP and (where there is value in acting collectively) across the ICS

Locality commissioning teams will be aligned to the five ICPs/MCP. They will exercise an agreed set of commissioning functions on ICP/MCP and PCN footprints, working collaboratively with partners through ICP Partnership Boards to agree plans for population health improvement, improved service quality and financial recovery. The Local Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning with the ultimate aim of supporting ICPs/MCP and PCNs to reach a level of maturity over the next 2-3 years whereby commissioning functions and budgets can be contracted for through an Integrated Care Provider Contract. The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will have specific linked roles to local ICPs and neighbourhoods.

3. Reduce duplication

There will be a significant reduction in duplication both in terms of the capacity required to support the existing eight CCG governance structures and that deployed to support commissioning activity across eight CCG footprints. We know that our commissioning workforce is finding it increasingly challenging to balance the demands of collaborative commissioning activity across L&SC with ICP/MCP commissioning work to support the development of PCNs and neighbourhoods.

It is vital to emphasise that the primary objective here is to reduce duplication of functions in order to redirect resources to support clinical leadership in PCNs and ICPs. There is a clear commitment to retain the expertise of CCG management staff in order to provide resources for population health improvement, planning and transformation activities in PCNs, ICPs and across L&SC.

4. Support a consistent approach to standards and outcomes

As a strategic commissioner the CCG will focus on a key set of commissioning functions and activity related to standard setting for the whole population. It will focus on macro-level population health management and improving outcomes for patients.

Further development work is now being led by CCGs to set out the commissioning functions which will be exercised by Locality Commissioning Teams.

5. Be affordable, reduce running costs and support longer term financial sustainability

By streamlining our decision-making infrastructure and commissioning activity, doing things once where it makes sense to do so (e.g. finance, corporate services, committee meetings) we will reduce running costs. By re-focussing commissioning time and energy for those service areas in which recommendations have already been made to commission at L&SC level, we will make better use of clinical and managerial time and be better placed to deliver the financial efficiencies as required by NHS England and Improvement.

6. Offer the potential for further development of integrated commissioning between the NHS and Local Authorities

We will establish Locality Commissioning Teams to exercise key commissioning functions through ICP Partnership Boards, of which Local Authorities are key members. The new arrangements will support the continued journey towards more integrated health and social care at place level with ICP Partnership Boards being well placed to explore practical ways of integrating health and social care commissioning and delivery.

7. Be deliverable

Creating a single CCG with a combination of system-wide and locality-based leadership offers a deliverable and affordable model of commissioning in an integrated care system.

8. Be congruent with the NHS Long Term Plan expectation that there will typically be a single CCG for each ICS area

The NHS Long-Term Plan (LTP) is clear that each ICS will need streamlined commissioning arrangements to enable a consistent set of decisions to be made at system level. It talks about CCGs becoming leaner, more strategic organisations that support care providers through ICPs/MCP to partner with other local organisations to deliver population health, care transformation and implement the requirements of the LTP. It also talks about CCGs developing enhanced management capability for more specialist functions, such as estates, digital and workforce. Option five will allow us to bring together CCG clinical and managerial time to respond to the requirements of the LTP, and ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP, to support place-based commissioning, allowing time and support for ICPs/MCP maturity to further develop.

In summary, a single CCG which operates as a strategic organisation, working with well-resourced local teams aligned to each of our local partnerships is recommended for the next stage on our journey of integrated care.

Section 5: Governance and Decision Making

As indicated above, the importance of effective governance and decision-making will be a critical success factor for this next stage of commissioning development in Lancashire and South Cumbria. This is particularly the case in order to build on the legacies of existing CCGs, move away from competition to partnership models of healthcare delivery and ensure that local organisations remain accountable to their communities.

Under the option for a single CCG, this will clearly operate as a membership organisation with a formal Constitution and scheme of reservation and delegation agreed with the members and approved by NHS England.

Membership of the Governing Body of the CCG will include the roles formally required including Accountable Officer, Chief Finance Officer, Secondary Care Doctor, Nurse and Lay members.

Locality-based decision-making

In order to emphasise the importance of place-based leadership and decision-making in Lancashire and South Cumbria, the governance of the new CCG will include a formal approach to leadership and decision-making in each locality. It is proposed that the single CCG will have a governing body which is constituted with general practice members (Clinical Director), lay representatives, and a Managing Director for each of the 5 places (Central Lancs, Fylde Coast, Pennine, West Lancs and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

Local authority membership of ICP/MCP partnership boards will also drive this place-based approach and working relationships are expected to become increasingly close.

Given the size of the CCG, there need to be practical arrangements for ensuring member practice involvement in the accountability arrangements and governance of the organisation, particularly as many practices also want to be engaged effectively in the development of local Primary Care Networks (on the basis of 30-50000 population) as well as in their ICPs/MCP.

There is a clear recognition from commissioning leaders that further development work is required in each of the local partnerships to ensure that effective leadership, decision-making and accountability arrangements are established and agreed by all partners. As local partnerships mature, it is also vital that they demonstrate how they will involve local communities and patients in decisions about their own health and wellbeing.

Clinical Leadership

Effective clinical leadership has been at the heart of clinical commissioning in recent years. There is an explicit commitment to retain these benefits in the leadership and governance of any reformed commissioning arrangements agreed for the future.

In line with current legislation, the single CCG will remain a membership organisation with all general practices as members. We recognise that clinical leaders will continue to be involved in developing the strategy, governance and accountability of a new commissioner

(e.g. through membership of the Governing Body), as well as working with provider colleagues to drive change and improvements across the health and care system.

In the next stage of our system's development, we also know that a group of GPs and other clinicians have been asked to lead our integrated PCN models in neighbourhoods: a key driver for reorganising the resources which are currently available within CCGs. It is understood that plans are being developed in each area for PCN leads to play a full part in the governance of each ICP/MCP.

Whatever option is agreed for changes in commissioning, there will be an obligation to operate under a formal constitution with a clear model for clinical leadership which is developed and agreed with member practices.

It is proposed that the new CCG Chair and the 5 place-based Clinical Directors will agree practical engagement arrangements with member practices in each ICP/MCP. Place-based commissioning teams will also work closely with the PCN leaders, GP federations and LMC representatives as appropriate in each area.

Finance & Allocations

As indicated above, many of the NHS organisations within the ICS are currently projecting substantial deficits. These will require effective, strategic decisions to be taken if the system is to return to a stable financial base. It is recognised that existing CCGs are in different financial positions and spending on services will be variable. Much of this will be driven by historic funding variations.

It is also understood that Governing Bodies and member practices have concerns about the impact of commissioning reform on existing allocations and commitments. At this stage, therefore, it is vital therefore that the following explicit commitments are made.

In relation to commissioning allocations:

- There is a clear commitment to maintain the financial allocation for each Clinical Commissioning Group based on their "place footprint" (ICP/MCP) in line with the CCG allocations published by NHS England for the years 2021/22 until 2023/24.
- From April 2024, a single CCG could devise an allocations model which could address any remaining "distance from target" factors and top-slice specialised services commissioned across the whole of Lancashire and South Cumbria (e.g. Ambulance services.)
- From April 2024, a single CCG could also consider differential growth towards areas of higher deprivation and health inequality in Lancashire and South Cumbria, if a change to the existing allocation methodology could be evidenced as in the best interests of the Lancashire & South Cumbria population. It is likely that a pace of change policy would be required to underpin this approach.

In relation to the commissioning of general practice services:

- The funding for GMS/PMS contracts will continue to be nationally negotiated for all practices and will not be affected by the creation of a single CCG.
- Local enhanced services contracted from General Practice by CCGs will continue to be funded until March 2022. Funding after 2022 will only change if agreed by the local place-based commissioning team as a partner on the local ICP. The exception to this principle would be if a new national DES schemes was to be introduced and duplicated an existing local incentive scheme.
- Over time, it can be expected that the single CCG will publish a common set of primary care standards for general practice in Lancashire and South Cumbria.

- In the meantime, however, there is a clear commitment to member practices that payments made by CCGs to practices for locally negotiated quality incentive schemes will be maintained until March 2022.

Section 6: Stakeholder Engagement

Since June 2019, CCG Chairs and Chief Officers have worked together with ICS colleagues to draft a roadmap and a statement of intent, setting out a direction of travel for commissioning development. These have been shared with each CCG's Governing Body and take forward a dialogue to understand concerns, answer questions and consider the options outlined in this paper. In addition, a written briefing has been cascaded to staff working in CCGs and the Midlands and Lancashire CSU which has been supported in regular staff briefings held within organisations.

It is vital that a clear approach to communication and engagement now takes place, particularly with our member practices and to ensure staff in CCGs are informed and involved at each stage. CCGs wishing to consider organisational change are also required by NHS England to demonstrate effective engagement about the plans with other key system partners and the public.

To support this process, a communications and engagement plan will be developed to deliver the following objectives:

- Demonstrate we have been able to take account of the views of key stakeholders – in particular our staff, GP membership and four local Healthwatch organisations- in developing our plans for a strategic commissioner
- Ensure key audiences are aware of our plans and in particular what this might mean for them
- Ensure stakeholders – and existing CCG staff in particular – are able to ask questions and give comments, with a robust feedback mechanism
- Ensure stakeholders – and existing CCG staff in particular – are engaged in bringing the new organisation together
- Ensure staff and members are aware of any additional roles and responsibilities they may have in helping to create the new strategic commissioner.

Our communications and engagement principles are

- The communications and engagement plan is based on clear, consistent messaging that describes both the benefits of merger and any dis-benefits
- Employing a principle of 'early communication and engagement' so there are 'no surprises' particularly amongst key stakeholders
- With effective and meaningful engagement channels to capture views, timely responses to questions and feedback and published FAQs (regularly updated)
- The plan covers both internal and external audiences across all eight CCGs, including staff, memberships and practice staff, the LMC, leaders/staff across the ICS, our regulators, Healthwatch, PPGs and engagement fora, the community/ voluntary sector, other local partners, media and wider public
- With messages and approach tailored appropriately
- Underpinned by a clear activity plan and timeline which uses existing communications/engagement channels wherever possible

Section 7: Next Steps and Timeline

This Case for Change and the Options Appraisal contained in appendix A have undergone a number of iterations during the past two months based on feedback from CCG Chairs and Chief Officers, Governing Bodies and member practices. In particular, work has been undertaken to set out a vision for the continued development of integrated care in neighbourhoods, local places and across the system. More detailed proposals have been set out relating to governance, local decision-making, clinical leadership including commitments relating to financial allocations and the commissioning of general practice services.

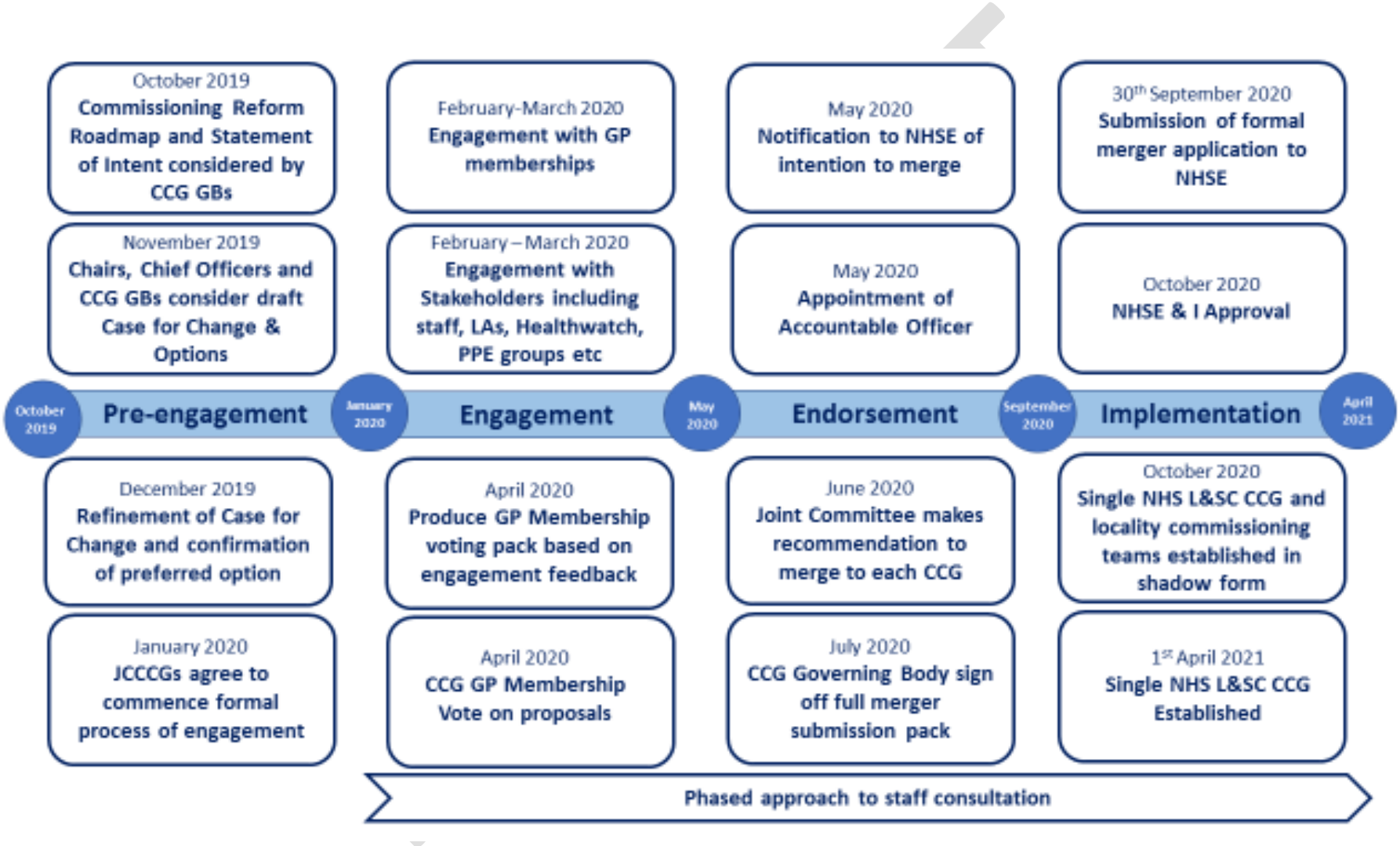
Subject to agreement by the Joint Committee at its meeting in January 2020, the next steps are to commence a period of formal engagement from February-March 2020 with member practices, CCG staff and other stakeholders including Local Authorities, Healthwatch and patient/public groups.

Work will also be completed in early January to develop proposals for the future delivery of commissioning functions at place and system levels. The outputs from this work, alongside this Case for Change and Options Appraisal will form the basis for the formal engagement process.

Following the engagement process, and taking account of any feedback received, it is proposed that a GP membership voting pack will be developed and considered by the Joint Committee of CCGs prior to a CCG GP Membership vote in May 2020. Subject to the outcome of this vote, a full set of merger submission documents will be developed in line with NHSEI guidance. Following consideration by Joint Committee and sign off by Governing Bodies, a formal merger application will be submitted to NHSE on 30th September 2020 with the aim of a single CCG for L&SC operating in shadow form from October 2020 and being fully established on 1st April 2021.

A high-level timeline for the process described above is set out below. Work is underway to develop a detailed programme plan which will incorporate development plans for the ICPs/MCPs.

Commissioning System Reform – High Level Timeline



APPENDIX A - Commissioning System Reform Options Appraisal

Option	Number of CCG's	Pro's	Con's
1. No change to current arrangements	8	Local commissioning focus continues Minimum structural change	Continuing duplication Limits capacity to support ICP and PCN development, place-based commissioning Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning
2. Merger to create five CCGs aligned with ICP footprints	5	Local commissioning focus continues Some structural change Partial release of capacity and resource to support ICPs/MCP and PCN development and place-based commissioning Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Continuing duplication of resource maintain five CCG governance structures Does not support a consistent approach to standards and outcomes across L&SC Unaffordable Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning

Option	Number of CCG's	Pro's	Con's
3. Single Accountable Officer and Executive Team for all 8 L&SC CCGs	8	Local commissioning focus continues Limited structural change May offer small efficiencies in management costs Offers potential to support a consistent approach to standards and outcomes	Continuing duplication Limits capacity to support ICP/MCP and PCN development, place-based commissioning Unaffordable Holds limited potential for integrated commissioning Inconsistent with NHS LTP Reliant on JCCCG to be vehicle for strategic commissioning Not deliverable, unworkable for a single Exec Team to relate to eight Governing bodies
4. Single CCG (all functions)	1	Reduces duplication Supports consistent approach to standards and outcomes across L&SC Economies of scale Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Limits capacity to support ICP/MCP and PCN development, place-based commissioning Significant structural change

Option	Number of CCG's	Pro's	Con's
5. Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	Significant structural change
6. Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care **Provider/** Multispecialty Community **Provider**	1	Ensures capacity is secured in each ICP/MCP and PCN to support place-based commissioning Reduces duplication Supports consistent approach to standards and outcomes across L&SC Maximises economies of scale in deployment of resources, capacity and skills for collective action across all ICPs/MCP	Significant structural change Requires Integrated Care Providers /Multispecialty Community Provider to have reached a stage of maturity to be able to take on commissioning functions on behalf of the single CCG

Option	Number of CCG's	Pro's	Con's
		Affordable Consistent with NHS LTP Potential for further integration with Local Authorities based on sharing priorities and resources (rather than straightforward co-terminosity)	

Option 1: No Change to Current Arrangements

The eight existing CCGs continue to take individual responsibility for their statutory functions and the operation of their local system, whilst at the same time working with other CCGs and with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would not require structural change. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option is increasingly unaffordable whilst also being inconsistent with the expectations set out in the NHS LTP. This option also holds limited potential for further development of integrated commissioning with Local Authorities.

Option 2: Merger to create five CCGs aligned with ICP footprints

A number of the existing CCGs would merge to form five CCGs across the L&SC ICS footprint which are aligned with the five ICPs/MCP:

- Morecambe Bay
- Central Lancashire
- Fylde Coast
- West Lancashire
- Pennine Lancashire

The new CCGs would continue to take individual responsibility for their statutory functions and the operation of their local system, whilst working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. Each CCG would retain a separate governing body and governance structure, AO and Executive Team.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions made through the Joint Committee in line with an agreed work programme, though accountability would remain with the existing CCGs

This option would mean that commissioning activity is focussed on the local ICP footprints and offers the partial release of capacity to support ICPs/MCP and PCN/Neighbourhood development and place-based commissioning. The potential for further integration with Local Authorities would be based on sharing priorities and resources (rather than straightforward co-terminosity). This option does not support a more consistent approach to standards and outcomes across the ICS footprint and would see duplication of governance structures and commissioning activity continue. This option does not benefit from opportunities for greater collaboration and economies of scale offered by other options. In the context of expectations that all CCGs will achieve 20% running cost savings this option

would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

Option 3: Single Accountable Officer and Executive Team for all L&SC CCGs

The eight existing CCGs appoint a single Accountable Officer and Executive Team for the whole Lancashire and South Cumbria footprint. Individual CCGs would retain responsibility for the delivery of statutory functions but Accountable Officer (AO) decision making would be held at the Lancashire and South Cumbria level. The AO and Executive Team would be responsible for working with their local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods. The single AO would be responsible for providing assurance to each governing body for statutory functions that continue within the CCG and for appropriate adherence to standards, targets and performance expectations.

Collaborative commissioning programmes would continue to be overseen and collaborative decisions make through the Joint Committee, though accountability would remain with the existing CCGs

This option would mean that commissioning activity remains focussed on the local CCG footprints and would require limited structural change. It also offers the potential to support a more consistent approach to standards and outcomes across the ICS footprint and may offer small efficiencies in management costs. Duplication of governance structures and commissioning activity will continue, and we will not benefit from opportunities for greater collaboration and economies of scale offered by other options. This option also limits capacity to support the development of PCNs/neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. In the context of expectations that all CCGs will achieve 20% running cost savings this option would also be unaffordable and would be inconsistent with the expectations set out in the NHS LTP.

The key issue with this option is that it would be undeliverable in practical terms for a single AO and Executive Team to relate to eight Governing bodies.

Option 4: Merger of CCGs to form a single NHS L&SC CCG (all functions)

The eight L&SC CCGS would merge to form a single new CCG which would take responsibility for all the statutory functions of the current eight CCGs and the operation of the system across L&SC working with local partners to support the further development of ICPs/MCP and PCNs/Neighbourhoods.

Collaborative commissioning programmes would be subsumed within the governance arrangements of the single CCG.

This option would see all commissioning activity focussed on the ICS footprint and would benefit from economies of scale. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP. However, with all commissioning functions focussed on ICS level activity this would limit the extent to which capacity and resource could be redirected to better support the development of PCNs/Neighbourhoods and ICPs/MCP and to accelerate the progress of place-based commissioning. This would hamper our ability to

address current pressures, improve patient outcomes, reduce health inequalities and tackle inefficiencies. It would also require significant structural change.

Option 5: Single CCG which aligns commissioning functions to each Integrated Care Partnership/Multispecialty Community Partnership

Under this option, the eight L&SC CCGs would merge to form a single new CCG which would take responsibility for all statutory functions through a single governing body. Under this option, it is proposed that the single CCG's governing body will be constituted with general practice members (Clinical Director), lay representatives, and a Managing Director who will represent each of the 5 places (Central Lancashire, Fylde Coast, Pennine Lancashire, West Lancashire and Morecambe Bay) that form the Lancashire & South Cumbria ICS.

In line with all CCG Constitutions, there will also be an Accountable Officer, Chief Finance Officer, Chief Nurse and Secondary Care Doctor.

The 5 Clinical Directors, 5 Managing Directors and 5 lay representatives who sit on the Governing body will also lead each place-based commissioning team, together with local clinical leadership and commissioning expertise. . The place based commissioning teams will retain many of the benefits member practices have indicated are important to them including responsibilities for practice engagement, primary care commissioning, population health improvement, improved service quality and financial management.

The place-based commissioning team will hold a delegated set of commissioning responsibilities through the single CCG's scheme of reservation and delegation and will act as the key NHS commissioning partner on each ICP/MCP Partnership Board.

The ICP Partnership Boards will support the development of PCNs/Neighbourhoods and ICPs/MCP and accelerate the progress of place-based commissioning.

Collaborative commissioning programmes at the L&SC level would be overseen and managed through the governance structures of the new CCG.

This option requires change to existing structures and organisations. It would see the majority of commissioning activity focussed on the ICP footprint, reducing duplication and maximising economies of scale. It also supports a consistent approach to setting standards and outcomes. This option ensures capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at this level will retain specific links to local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

Option 6: Single CCG which discharges an agreed set of commissioning functions through a contract with each Integrated Care Provider/ Multispecialty Community Provider

The eight L&SC CCGs would merge to form a single new CCG which would initially take responsibility for all the statutory functions of the current eight CCGs. An agreed set of commissioning functions, which it makes sense to undertake on ICP and PCN footprints, would be contracted for, alongside a capitated budget with each IC Provider/MC Provider through an Integrated Care Provider contract.

Collaborative commissioning programmes would be overseen and managed through the governance structures of the new CCG.

This option would require significant structural change. It would see the majority of commissioning activity focussed on the ICP footprint, would reduce duplication and would maximise economies of scale. It would also support a consistent approach to standards and outcomes. This option would ensure capacity is secured in PCNs/Neighbourhoods and ICPs/MCP to support place-based commissioning, allowing time and support for ICPs/MCP maturity to develop.

The single CCG will retain clinical commissioning capacity and resources in order to commission services for a population in excess of any one ICP/MCP (i.e. 500,000+). It will also commission those service areas in which recommendations have already been made to commission at L&SC level. Commissioners working at the Lancashire and South Cumbria level will retain links with local ICPs and neighbourhoods. In the context of expectations that all CCGs will achieve 20% running cost savings this option would be affordable and would be consistent with the expectations set out in the NHS LTP.

This option requires ICPs/MCP to have reached a level of maturity whereby integrated care provider contracts could be established and budgets delegated. At this point in time, it is proposed that further development of local partnerships is required to reach this stage of maturity.

Integrated Care System (ICS) Commissioning Reform Group (CRG)
Terms of Reference

Document Control			
Title	Terms of Reference for the ICS Commissioning Reform Group (CRG) (formerly Commissioning Oversight Group)		
Responsible Person	ICS Executive Lead for Commissioning		
Date of Approval			
Approved By			
Author	Carl Ashworth/Dawn Haworth		
Date Created	8th June 2018		
Date Last Amended	18.12.19		
Version	0.2		
Review Date			
Publish on Public Website		**Yes** ☑	**No**
Constitutional Document		**Yes**	**No** ☑
Requires an Equality Impact Assessment		**Yes**	**No** ☑

Amendment History		
Version	**Date**	**Changes**
0.2	18.12.19	Updates to purpose, membership and specific roles of the Group

1	**Purpose and objectives**
1.1	These Terms of Reference (TOR) relate to the Lancashire and South Cumbria ICS Commissioning Reform Group (CRG), and set out the membership, remit, responsibilities and reporting arrangements for the Group.
1.2	During Summer and Autumn 2019, CCG Chairs, Chief Officers and Directors from the CSU held workshops to devise a roadmap for the continued evolution of commissioning across Lancashire and South Cumbria. As a consequence of the continued development of four integrated care partnerships, a multi-speciality community partnership (MCP) and the wider ICS system, a Case for Change document has been drafted. This lays out options to consult member practices and other partners about the creation a single strategic commissioner in Lancashire and South Cumbria.
1.3	The CRG replaces the Commissioning Oversight Group which was established in June 2018 to choreograph implementation of the earlier Commissioning Development Framework. The group has been re-named to reflect its responsibilities going forward and to create a formal accountability to the Joint Committee of CCGs. These ToR have therefore been updated to allow the Joint Committee of CCGs to oversee the implementation of the road map for commissioning reform in Lancashire and South Cumbria.

1.4	The purpose of the CRG is to act on behalf of the Joint Committee of CCGs to oversee the preparation and implementation of a programme which enables a continuing process of commissioning reform in L&SC. This will include the production of: • A formal Programme Plan – which enables the 8 CCGs to take collective action and comply with national guidance • Human Resources and Organisational Development Plan • Communications and Engagement Plan These and other materials will be considered as appropriate by the Joint Committee of CCGs, individual Governing Bodies and NHS England.
1.5	Commissioning reform is one of the agreed partnership priorities of the Lancashire and South Cumbria ICS and this is reflected in the leadership, membership and support for the Commissioning Reform Group.
1.6	The CRG will ensure that appropriate and effective communication and engagement with staff, partners and other key stakeholders is undertaken through the implementation period.
1.7	In undertaking the role described at section 1.4, CRG should ensure that any proposed shifts in resourcing and staff deployment associated with implementation are undertaken in line with the shared principles for change that have been agreed across the North (see appendix 1). To undertake this role, the Commissioning Reform Group will be supported by HR & OD SMEs.
1.8.	The CRG also provides a forum for further development of place-based commissioning arrangements of specialised services commissioning. Whilst this remains a function of NHS England, the opportunities to agree joint priorities, pathways and joint approaches to decision-making will be explored further.
2. Membership	
2.1	The Chair of the ICS Commissioning Reform Group will be the appointed Vice Chair of the Joint Committee of CCGs.
2.2.	The membership of the Commissioning Reform Group is proposed as follows: • Chair – (Vice Chair of the Joint Committeee of CCGs) • One CCG Executive acting as a representative from each ICP (i.e 5 representatives) • One CCG Governing body Clinician or Lay Member drawn from each ICP (i.e. 5 representatives) • Midlands and Lancashire CSU – Executive Director • ICS Chief Officer • ICS Executive Director of Commissioning • ICS Executive Director of Finance • Chair of L&SC CCGs CSU customer forum • Locality Director NHS England • Specialised Commissioning representative - NHS England • ICS Strategy and Policy Director

	• Commissioning Reform Programme manager • HR/OD Advisors • ICS Communications and Engagement lead
3	**Governance & Reporting**
3.1	The CRG will report directly to the Joint Committee of CCGs with the expectation that formal plans and materials developed will also be shared with CCG Governing Bodies and other decision-making fora.
4	**Access and Attendance**
4.1	The meetings are not held in public.
4.2	Other CCG, CSU or NHSE Directors and staff, representatives from partner organisations may be required to attend meetings to speak on specific matters.
5	**Programme and Supporting Papers**
5.1	The agenda and supporting papers will be circulated by email prior to the meeting.
5.2	Minutes will be produced. Actions will be recorded and followed up at each meeting.
5.3	Programme plans will be maintained and regular reports provided to the CRG to ensure that the group can oversee delivery of objectives and milestones, risks and issues.
6	**Meeting Arrangements**
6.1	The CRG will be held every month at 08.30am on the second Tuesday.
7	**Review**
7.1	The Joint Committee will review the CRG role, function and ToR annually or earlier if required as the ICS evolves.

Appendix A

Principles for ICS (and constituent ICP) resourcing deployment and support agreed across the North

1. Develop and use a common language for resourcing and HR issues so that all staff can understand how ICSs/ICPs are being taken forward, and their role in that in the North.

2.Recognise the skills, experience and contribution of our workforce by having a clear and transparent resourcing model to support staff to work in different, more integrated ways with partners for the benefit of patients.

3.Promote transparency and fairness with equality of opportunity for ICS/ICP roles that are recruited or seconded to. Ensure that it is clear which work and roles are aligned, assigned or embedded as appropriate as ICS/ICPs progress and as teams work in different, more integrated ways at both ICS/ICP footprint and in 'place.'

4.Minimise the number of different concurrent or consecutive changes experienced by staff by co-ordinating our work locally as we develop our ICS/ICP wherever possible.

5.Take all reasonable steps to avoid redundancies by managing establishments in the context of significant budget reductions signalled in the Next Steps on the FYFV.

6.Undertake appropriate engagement with staff side and staff to work in partnership for the benefit of staff and patients.

7.Learn from other ICS/ICPs in the North and nationally and build on our existing OD approaches to support the success of teams working across organisational boundaries.

8.Base our approach on the values set out in the NHS Constitution, and all relevant employment law.