Joint Strategic Commissioning Committee
Agenda

18th June 2019 – 2.00 – 5.00pm
Meeting Room 3, Beccles House, Beccles, NR34 9BN

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<thead>
<tr>
<th>Time</th>
<th>Chair – Anoop Dhesi</th>
<th>Lead</th>
<th>JSCC Sponsor</th>
<th>Paper (P)</th>
<th>Verbal (V)</th>
<th>Media (Pr)</th>
<th>Information (I)</th>
<th>Discussion (D)</th>
<th>Agreement (A)</th>
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<td>2.00</td>
<td>1. Welcome and Apologies: Gary Heathcote, Tracy Williams, John Plaskett, Sara Tough</td>
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<td>2. Declarations of Conflicts of Interest</td>
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<td>The Chair and members of this meeting are reminded to declare any conflicts of interests in relation to the business to be transacted, including any gifts or hospitality, as soon as practicable after the commencement of the meeting. Interests can be financial, non-financial personal or professional, or indirect. Members may be asked not take part in the consideration, discussion, or voting, as appropriate.</td>
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<td>3. Items Exempt Under Freedom of Information Act</td>
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<td>4. Minutes from 16th April 2019</td>
<td>Chair</td>
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<td>5. Matters Arising</td>
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<td>6. Action Log</td>
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Operational

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<tr>
<th>Time</th>
<th>Committee</th>
<th>Report (JCCE)</th>
<th>Lead</th>
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<tr>
<td>2.15</td>
<td>7.</td>
<td>Joint Commissioning and Contracting Executive Report (JCCE)</td>
<td>JI</td>
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<td>2.30</td>
<td>8.</td>
<td>System Finance Report</td>
<td>JI</td>
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<td>2.45</td>
<td>9.</td>
<td>Norfolk and Waveney Drug &amp; Therapeutics Committee (D&amp;TC) commissioning recommendations</td>
<td>CB</td>
<td>PW</td>
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<td>3.05</td>
<td>10.</td>
<td>Clinical Policy Development Group - Update and New Policies</td>
<td>Chris Dent</td>
<td>TW</td>
<td>P</td>
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<td>3.20</td>
<td>11.</td>
<td>Norfolk and Waveney CCGs 360° Survey Results</td>
<td>MC</td>
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Transformational

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<tr>
<td>3.35</td>
<td>12.</td>
<td>Transformation of Mental Health Services for Children and Young People</td>
<td>Andy Vowles</td>
<td>JS</td>
<td>P</td>
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<td>4.05</td>
<td>13.</td>
<td>Questions from the public on matters relating to the agenda</td>
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<td>4.15</td>
<td>14.</td>
<td>Date of Next Meeting, in public 20th August 2019, Main Hall, Aylsham CT, St Michaels Avenue, Aylsham</td>
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In accordance with the Public Bodies (Admission to Meetings) Act 1960, the public and members of the Press will be excluded from the meeting where there is business of a confidential nature to be transacted, publicity concerning which could be prejudicial to the public interest.

Please could any questions from the public be submitted prior to the meeting via Norwich.CCG@nhs.net
<table>
<thead>
<tr>
<th>Title</th>
<th>First Name</th>
<th>Last Name</th>
<th>Position / Base</th>
<th>Details of Interest</th>
<th>Direct / Indirect</th>
<th>Date: from</th>
<th>Date: to</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>Dr Hilary Byrne</td>
<td>Executive Director, Adult Social Services</td>
<td>Chair, South Norfolk CCG</td>
<td>GP Partner at Attleborough Surgery. Attleborough Surgery is a part-dispensing Practice.</td>
<td>Direct &amp; Indirect</td>
<td>Apr-13</td>
<td>Present</td>
<td>To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary. Where the CCG make decisions about working collaboratively with Suffolk CCG, conflict will be declared and individual is prepared to leave the room if necessary.</td>
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<td>Mrs Melanie Craig</td>
<td>Chief Officer, Great Yarmouth &amp; Waveney CCG</td>
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<td>None</td>
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<tr>
<td>Dr Anoop Ghasi</td>
<td>Chair, North Norfolk CCG</td>
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<td>GP Partner at Stalhe Surgery. Stalhe Surgery is a dispensing Practice. Practice is a member of IENI Healthcare Practice. Practice is a member of NNPCC Member of Norfolk and Waveney Local Medical Council Commission Representative Governor Norfolk and Norwich Foundation Hospital Trust. External Assessor Cambridgebridge &amp; Peterborough CCG Primary Care Trust.</td>
<td>Direct</td>
<td>Current</td>
<td>To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary. In the event the Governing Body is asked to discuss or make a decision directly or indirectly relating to the interests declared, individual is prepared to leave the meeting if appropriate.</td>
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<tr>
<td>Mr Peter Franzen</td>
<td>Lay Member, North Norfolk CCG</td>
<td>Committee Member of Priscilla Bacon Hospice appeal</td>
<td></td>
<td>Direct</td>
<td>2017</td>
<td>2018</td>
<td>To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.</td>
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<td>Mr Andrew Goff</td>
<td>Assistant Director of Planning, Performance and Quality Assurance for Children's Services, NCC</td>
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<td>None</td>
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<td>Mr Stephen Griffee</td>
<td>Lay Member, PPE, South Norfolk CCG</td>
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<td>Patient of Constituent Practice</td>
<td>Indirect</td>
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<td>To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.</td>
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<td>Ms Sara Hall</td>
<td>Director of Integrated Commissioning - Adult Social Services</td>
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<tr>
<td>Mrs Sue Hayter</td>
<td>Nurse Member, Governing Body, North Norfolk CCG</td>
<td>Trustee of St Nicholas Care Hospice</td>
<td>Chair of the Clinical Committee. Professional advisor to Suffolk CCG, quality visits to care homes with nursing and Chair of the independent CHC panel.</td>
<td>Direct</td>
<td>Sept 2010</td>
<td>Present</td>
<td>Present</td>
<td>All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc.</td>
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<tr>
<td>Mr John Ingham</td>
<td>Chief Finance Officer, NCCG</td>
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<tr>
<td>Dr Robert Mallinson</td>
<td>Secondary Care Doctor, North and South CCG</td>
<td>Consultant at Ipswich Hospital. Acute Physician and Divisional Director of Medicine.</td>
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<td>Mr John Mallinson</td>
<td>Lay Member (Audit and Governance)</td>
<td>Lay Member (Audit and Governance) for NHS Great Yarmouth and Waveney CCG. Lay Member (Audit and Governance) for NHS Norwich CCG. Lay advisor to Breckland District Council on Governance and Audit Committee.</td>
<td>Direct</td>
<td>01.12.2018</td>
<td>Current</td>
<td>All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc.</td>
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<td>Mr Frank Mills</td>
<td>Chief Officer, South and North Norfolk CCGs</td>
<td>Trustee to Sussex Samaritans Fund Charity</td>
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<td>Indirect</td>
<td>April 2018</td>
<td>Current</td>
<td>All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc.</td>
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<td>Dr S. J. Mitchell</td>
<td>Director of Public Health, NCC</td>
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<td>Mrs Angela Scott</td>
<td>Chief Officer, NCCG</td>
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<td>Dr Liam Staines</td>
<td>Chair of Great Yarmouth and Waveney CCG</td>
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<td>Nurse is Deputy Manager for Children and Young People's Services at NSFT Trustee for Lowestoft DIAL.</td>
<td>Indirect</td>
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<td>Dr John Webster</td>
<td>Chair, West Norfolk CCG</td>
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<tr>
<td>Ms Tracy Williams</td>
<td>Nurse Member Chair of NCCG Governing Body</td>
<td>Nurse practitioner Leslie Partnership (employed) Employed as Lead Nurse for City Reach Health Services Norwich, hosted by Norfolk Community Health and Care. Elected Member of NCCG Governing Body. Elected Chair of NCCG Governing Body. Member of Queen's Nurse Homeless advisory group. Member of the Faculty for Homelessness &amp; health inclusion - National Body. Queen's Nurse. Member of the QNI Vice Chair of Health and Wellbeing Group (from March 2018).</td>
<td>Direct</td>
<td>Current</td>
<td>All potential conflicts are declared at each meeting. For any related items, individual would not participate in discussions, voting, procurements etc. For items relating to NCH&amp;C's City Reach service, individual would not participate in discussions voting procurement.</td>
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Unconfirmed Minutes of the Joint Strategic Commissioning Committee meeting

Tuesday 16th April 2019
14:00-16:00

The Willow Centre, Cringleford

Present:
Dr Anoop Dhesi (AD), Chair, NHS North Norfolk CCG (Chair)
Tracy Williams (TW), Chair, NHS Norwich CCG
Jo Smithson (JS), Chief Officer, NHS Norwich CCG
John Ingham (JI), Chief Finance Officer, NHS Norwich CCG
Melanie Craig (MC), Chief Officer, NHS Great Yarmouth & Waveney CCG & STP Executive Lead
John Plaskett (JP), Lay Member for Audit and Governance, NHS Great Yarmouth and Waveney CCG
Frank Sims, (FS), Chief Officer, NHS North and South Norfolk CCGs
Peter Franzen (PF), Lay Member, North Norfolk CCG
Stephen Griffe (SG), Lay Member for Patient Participation and Engagement, NHS South Norfolk CCG
Liam Stevens (LS), Chair, NHS Great Yarmouth & Waveney CCG
Dr Hilary Byrne (HB), Chair, NHS South Norfolk CCG
Paul Williams (PW), Chair, West Norfolk CCG
Sue Hayter (SH), Nurse Member, Governing Body, West Norfolk CCG

In attendance:
Cath Byford (CB), Deputy Chief Officer and Director of Commissioning GYWCCG (Item 10)
Gary Heathcote, Director of Commissioning, Adult Services, Norfolk County Council
Suzanne Meredith, Public Health, Norfolk County Council
Tim Curtis (TC), Head of Communications
Chris Dent (CD) Item 11
Alison Leather (AL) Items 12(a), 12(b) & 16
Heather Farley (HF), Assistant Director - Corporate Services, NHS West Norfolk CCG
Jane Bacon, Executive Assistant, Norwich CCG (Minute Taker)

1. Welcome and Apologies

Formal introductions were made.

Apologies were noted from:
Louise Smith, Sara Tough, John Webster, James Bullion, Robert Mallinson

2. Items exempt under the Freedom of Information Act

No items declared as exempt under FOI

3. Declarations of Conflicts of Interest

The Chair and members of this meeting are reminded to declare any conflicts of interests in relation to the business to be transacted, including any gifts or hospitality, as soon as practicable after the commencement of the meeting. Interests can be financial, non-financial personal or professional, or indirect. Members may be asked not take part in the consideration, discussion, or voting, as appropriate.

None declared.

4. Minutes & Action Log from the meeting held on 19th February 2019
The minutes of the meeting held on the 19th February 2019 were agreed as an accurate record and signed by the chair.

The action log was reviewed and updated.

5. Chair’s Actions

There were no chair’s actions.

6. Action Log

The action log was reviewed and updated.

Matters Arising

There were not matters arising.

Question from the Public

AD reported that some questions had been received by email on the 15th April which relate to ME.

MC responded that we have been in conversations with the author of the questions for many months and repeat the offer to meet in person to discuss their concerns. ME/CFS isn’t on the agenda today and there are no plans to respond to the questions sent by email in the meeting today as they don’t relate to any agenda items. However, the offer is repeated to meet to discuss further the concerns with the author. The Chair responded that some detailed questions were received yesterday and considerable time has been spent at previous meetings on questions relating to ME and that he didn’t propose to take them today.

Operational


JI presented the JCCE report and reported that key areas of discussion at the April meeting were:

- Acute Services Integration – review of the proposed Memorandum of Understanding (MoU)
- Updates on 2019/20 contract planning and negotiations, including a focus on mental health;
- Review of the procurement pipeline and proposals for improving the joint infrastructure to support procurements;
- Reprocurement of Musculoskeletal (MSK) Physiotherapy services;
- Agreement on the re-commissioning of a Minor Eye Conditions Service (MECS);
- A regular report from the Joint Commissioning Programme Board (JCPB) on the joint QIPP programme;
- Approval of business cases relating to children’s services;
- Agreement on a commissioning approach for assisted fertility services;
- Review of issues relating to Termination of Pregnancy services.

One issue identified for escalation to JSCC related to the extension of contracts for community-based minor surgical work. At the March JSCC meeting, it was agreed to extend the current N2S contract to 30th September 2019 to facilitate a procurement exercise. JCCE has since reviewed other community-based contracts and concluded that it would be preferable to synchronise all current contracts and conduct a single procurement process across Norfolk & Waveney, with new arrangements to commence from 1 April 2020 and would therefore need a tender waiver to extend until 1st April 2020.

Agreed:
The committee discussed the proposal and agreed for the extension tender waiver until 1st April 2020.

JP raised a question on the TOPS service and asked for assurance that the provider was providing a good service and meeting its KPI's given that the contract had been extended for a further 2 years. JI responded that no issues have been raised.

JP asked if a lead had been identified for the referral to treatment (RTT) work and JI reported that conversations were ongoing.

The report was discussed and noted.

8. Systems Finance Report

JI presented the Month 11 System Finance report and highlighted the following:

- For 2018/19 the STP forecast outturn remains £32.4m adverse to plan, with some outstanding risks at the time of writing
- For 2019/20 all organisations are planning to deliver their control totals except for the Queen Elizabeth Hospital NHS FT (QEH). There is therefore £23m of Provider Support Funding (PSF) at risk as this is linked to acceptance and delivery of the QEH control total.
- Contracts have now been agreed with all providers for 2019/20.

JSCC should note that since the preparation of the report, system-wide discussions have taken place in respect of the creation of a STP risk reserve to support the QEH in planning to deliver their control total, which in turn would safeguard the £23m of external resource. Further work is needed in order to confirm the source of funding for this reserve and the methodology through which the funds would be accessed, but this system intent was strongly supported by the STP chairs.

In 2019/20 the planned system deficit is £16m, with CCG plans showing a combined surplus of £5m and providers a planned deficit of £21m (after external support funding).

PF raised a question regarding the governance behind the financial systems and the support to help others in the system to deliver their control totals and a discussion took place on this.

JP raised concern over the QEHKL position and a discussion took place on solutions to the situation. It was noted that PWC Auditors are currently working with the QEHKL to develop programmes and West Norfolk CCG is linking in with the work taking place.

The Committee asked for a detailed feedback to be included in the Finance report regarding the QEHKL to the next meeting in June.

Action: JI to include detailed item re QEHKL in next finance report.

The report was discussed and noted.

9. RightCare Benchmarking

JI reported on the RightCare benchmarking data and highlighted the following:

This was a joint initiative between NHS England (NHSE) and NHS Improvement within the Midlands & East region to bring together benchmarking information from RightCare, Getting It Right First Time (GIRFT) and Model Hospital to highlight material areas of opportunity for productivity improvement at a STP level. It shows how we compare with comparators around the Country and highlights areas to focus on.
The STP has for some time had established programmes of work focusing on Cancer and Circulation, in response to previous RightCare information.

JP asked if we would get feedback to the committee on any new ideas that we come across and JI responded that it would be included in future reporting.

The report was discussed and noted.

10. **Drugs & Therapeutics Commissioning Group – Commissioning Recommendations**

CB presented the recommendations from the TAG & D&T group for approval:

LS raised question on the Xonvea treatment for Nausea and the lack of information regarding the safety of the drug to manage nausea in pregnancy.

**Action:** CG to raise with the committees and obstetricians concerns from the committee and to see whether they had taken it in to consideration.

AD raised question on how the decisions from JSCC were communicated back to the relevant groups and what the process is.

CB responded that the process is that decisions go back to the CSU lead pharmacist and then are feedback to the membership.

**Action:** CB to check the process for feeding back recommendations so that all the relevant people/groups are notified.

TW raised a question on Risperidone for the short term management of severely aggressive behaviour in young people, for short term use. In the paper it states Long term use and there was concern that patients would be on the drug longer than necessary.

CB responded that this had been raised at the meeting and this item will be managed as part of a wider STP led pathway review and has been removed from TAG’s agenda until commissioning arrangements for the patient group were clarified.

**Agreed:**

The committee discussed and ratified the Norfolk and Waveney TAG recommendations and D&TC commissioning decisions.

11. **Clinical Policy Development Group – Updated and New Policies**

CD presented the following revised policies for approval:

a) Lipoma (surgical revision of)
   Question raised on the Lipoma policy and it was felt that it needs to be clear in the policy that once a lipoma reaches 5cm it can be removed.

b) Corneal Cross Linking for Keratoconus

c) Hysterectomy for Heavy Menstrual Bleeding

d) Aesthetic/Cosmetic Breast Surgery V4

e) Steroidal Epidural Injections

f) Epiphora

g) Patella Resurfacing

h) D&C (now IFR status not Threshold)

The above policies have all been updated and fit with current practice.
The following policy was developed and agreed by CPDG as outlined in the NHS Evidence Based Interventions Guidance – November 2018):

a) Shoulder Decompression

The review date for the policies below was due and were reviewed by CPDG and no changes were made.

b) Buttock Lift
c) Calf Implant
d) Hallux Valgus
e) Abdominoplasty/Apronectomy
f) Cataract Surgery
g) Eyelid Ectropion
e) Eyelid Ptosis

CD brought to the attention of the committee the Aesthetic/Cosmetic Breast Surgery policy and reported that it was an old policy was not routinely funded. Guidance suggested a less stringent approach with certain categories of patients. The primary aspect was that patients with a body mass index of 27 or less could access the surgery within the perimeters and this will have a cost implication for the CCG’s.

A discussion took place on the policy and approved it in principle but would like further information on the cost implications/impact on IFR panel and benchmarking against other areas on numbers.

**Action:** Further information on Aesthetic/Cosmetic Breast Surgery to be circulated to members.

**Approved:**

All the above policies were discussed and approved with the exception of the Aesthetic/Cosmetic Breast Surgery policy which was approved in principle pending further information on numbers and costing implications.

12. **Quality Issues**

AL attended the meeting and gave an update on the following:

12a) **NSFT**

NSFT continues to be subject to Special Measures and while the new Executive team is making progress in the delivery of its Quality Improvement Plan it recognise there is a significant amount of work left to do.

The Trust has now appointed a new ‘top team’ including a new Chair and Chief Executive. The current Medical Director has also stood down and a new appointment has been made. NSFT are also currently undergoing a significant recruitment exercise into key leadership posts across the Trust. The level of assurance has improved and confidence in the ability of the new Executive team is increasing. The Trust has made significant progress and the trust recognises that there is still further work to do. The CCG has been working closely with NSFT on clinical harm reviews to make sure that the patients who are on waiting lists won’t harm, whilst waiting an appointment. An audit process has been agreed and will be embedded as part of the quality schedule.

The update was discussed and noted

12b) **N&N**

The must do’s and should do’s within their Quality improvement plan is now showing as 40 actions completed overall equating to 54%. There has been a slight increase in red
actions at 24% and the CCG is assured that they are putting actions in place to focus on these areas. The main focus of attention from a quality assurance perspective has been around emergency department with two section 29a notifications served on them. These were mainly around governance and needed to improve their systems and processes within the department. A new governance process has been put in place in conjunction with the Winter Room director. The mental health care and Dols continues to cause some concern regarding the systems and process requirements and the NNUH recognise there is more work to do. There were a lot of issues with infection and control within the Emergency department and these are being supported by the CCG Infection and control team in getting processes in place. The NNUH are keen to get the Section 29a lifted and are looking to invite the CQC team earlier than the planned inspection date.

The CCG attends oversight and assurance groups on a monthly basis to gain assurance on the work that they are doing and provide scrutiny.

The update was discussed and noted.

12c) QEH
HM reported that following the CQC inspection in May 2018 a section 29a was imposed on the QEH. A lot of work has taken place within their action plan to address the issues and a re-inspection took place in March 2019 and the CCG is awaiting the outcome from the visit.

JI raised question on whether there was any shared learning between the Acute trusts.

It was recognised that this was a gap in the system and something to take forward in the future.

The position was discussed and noted.

13. System Continuing Healthcare Update
NCCP Operational Management Group

JS presented the NCCP report and highlighted the following:

Norwich CCG, as the host CCG, established the Operational Management Group (OMG) to oversee the operational activities of NCCP on behalf of all CCGs covered – North Norfolk, Norwich, South Norfolk and West Norfolk. NHS Great Yarmouth and Waveney CCG have operated an in-house CHC model since 2013 and the NCCP and NHS GYW CCG NHS Continuing Healthcare teams work very closely together with the reports providing a brief summary of overall performance and assurance to the committee.

JP stated that it would be helpful if the two papers could cover some of the same issues and JS responded that we would strive for that for future reporting.

The report was discussed and noted.

14. Terms of Reference

HF presented the Terms of reference for review following the imminent changes and the move to a single structure.

The focus is around four areas, membership, remit, decision making and quoracy summarised below:
**Section 2 – Membership** – changed to reflect the Joint Accountable Officer and Chief Financial Officer. With a proposed temporary membership until recruitment to the single management team is complete and a proposal for when it is fully in place.

It was agreed that given the changes taking place that the membership should be discussed and explored outside the meeting before presenting to the committee.

**Section 3 – Remit and Responsibility** – 3.1 Addition of strategic commissioning of primary care.

Agreed to add addition of strategic commissioning of primary care.

**Section 3 – Remit and Responsibility** – 3.2 Clarification of the sum delegated by governing bodies to the JSCC. This will require in depth review by the JSCC to agree whether the £0.5m delegated amount from each CCG is per year or contract. Addition of a specified delegated limit for individual funding requests and clinical threshold policies and managing drugs and treatments.

It was agreed that it should be per year.

Other amendments to section 3 are following advice from the Internal auditors.

The proposed amendments to section 4 are to tidy up the governance processes for the committee.

A discussion took place on the proposals and further discussions is to take place on the proposed changes outside of the meeting. Following revisions a revised draft is to be presented to next public meeting in June 2019 for agreement.

**Action:** Revised ToR to June 2019 meeting.

**Transformational Items**

**15. STP Mental Health Strategy**

FS presented the revised Mental Health Strategy and highlighted the following:

The paper had been presented to JSCC in February 2019 and since then the CCG has been working in co-production phase with providers, users and public to draft the strategy which reflects the feedback from service users. The document has been approved in principle by the STP Mental Health (MH) forum at their 19th March meeting, and by the Co-production Advisory and Assurance Group at their meeting on the 12th March and both groups are recommending the strategy to JSCC and STP Executive members respectively for definitive sign-off and approval.

Each of the commitment areas has a clear programme of work as proposed by the overarching strategy. This has translated into 5 working groups with a defined core membership of key partners including service users and carers. These groups are meeting monthly and are currently developing implementation plans (‘plans’) which will form standalone documents in their own right. The plans will have project initiation documents (PIDs) sitting underneath them focusing on priority areas, with associated timelines, milestones and metrics for delivery.

The co-production working group will continue and be part of the implementation plans and timeline and oversight will take place through the working groups.

**Agreed:** The JSCC discussed and approved the strategy
16. Transforming Care

AL gave an update on Transforming Care and highlighted the following:

Norfolk and Great Yarmouth & Waveney CCG are one of 48 Transforming Care Partnerships (TCPs) formed in December 2015, who are working together to improve outcomes for people with Learning Disabilities and/or Challenging Behaviours who are in long term hospital inpatient settings.

The Transforming Care agenda is broad and includes development of suitable alternative housing in community settings including access to crisis accommodation. There was a national commitment to reduce the number of people in inpatient settings by 35 to 50%, by April 2019. Nationally this has not been achieved and the Programme has now been extended to March 2020. The local TCP has a revised trajectory for 2019/20 of 15 CCG commissioned inpatient and 15 NHS E Specialist Commissioning Group (SCG) commissioned beds by the end of March 2020.

The TCP trajectory for 2018/19 was 12 CCG commissioned inpatients. The TCP ended the year at 22 CCG commissioned inpatients. The TCP is subject to monthly assurance meetings with NHS E and have been requested to submit a Recovery Plan. A recovery plan has been put in place with a focus on admission avoidance and Norfolk County Council are strengthening their resources to support.

The update was discussed and noted.

17. Questions from the public on matters relating to the agenda

No questions received relating to the agenda.

Date and time of the next meeting

Tuesday 18th June 2019 Meeting room 3, GT Yarmouth & Waveney CCG, Beccles – meeting in public
<table>
<thead>
<tr>
<th>No.</th>
<th>Date Raised</th>
<th>Agenda Item</th>
<th>Action Title</th>
<th>Action</th>
<th>Owner</th>
<th>Target Date</th>
<th>Date Closed</th>
<th>Action update</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td>16/04/2019</td>
<td>8 Systems Finance Report</td>
<td>Following discussion on the QEHKL, JI to include a detailed item on the QEHKL in next meeting.</td>
<td>JI</td>
<td>18/06/2019</td>
<td></td>
<td></td>
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<tr>
<td>20</td>
<td>16/04/2019</td>
<td>10 Drugs &amp; Therapeutics Recommendation</td>
<td>Concern raised in non-financial meeting and JI to take back to the committees and discuss and ensure that there would be reviewed. BCP to raise in meeting.</td>
<td>CB</td>
<td>18/06/2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>16/04/2019</td>
<td>11 Clinical Policies</td>
<td>Discussion took place on Aesthetic/Cosmetic Breast Surgery Policy and approved and in principle, but would like further information on the financial implications. CD to circulate information.</td>
<td>CD</td>
<td>03/06/2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>16/04/2019</td>
<td>10 Drugs &amp; Therapeutics Recommendation</td>
<td>Discussion took place on Xonvea treatment and CB to raise with the committees and obstetricians concerns from the committee to see whether this had been taken into consideration.</td>
<td>CB</td>
<td>18/06/2019</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>16/04/2019</td>
<td>14 Terms of Reference</td>
<td>Following discussion, revisions to be made to the ToR to be presented to next meeting for approval.</td>
<td>HF</td>
<td>18/06/2019</td>
<td></td>
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</tbody>
</table>

Joint Strategic Commissioning Committee (JSCC)
Action Log - 16th April 2019
Updated for JSCC 18th June 2019

N:\MEETINGS - External\Joint Strategic Commissioning Committee\2019 Meetings in Public\(6) - June 2019\06.06.19 JSCC 180619
**Subject:** Joint Commissioning & Contracting Executive (JCCE) Report

**Presented By:** John Ingham, CFO, Norfolk & Waveney CCGs (chair of JCCE)

**Prepared By:** John Ingham, CFO, Norfolk & Waveney CCGs (chair of JCCE)

**JSCC Sponsor:** John Ingham, CFO, Norfolk & Waveney CCGs

**Submitted To:** JSCC 18th June 2019

**Purpose of Paper:** For information

**Summary:**

A key part of the supporting infrastructure for JSCC has been the role of the Joint Commissioning & Contracting Executive (JCCE) to cover most of the operational ("business as usual") elements of the JSCC work programme.

The JCCE last met on 3rd June 2019, and this report outlines the key areas that were discussed and decisions made by JCCE members. It should be noted that whilst the JCCE meeting in itself has no delegated authority, collective decisions are able to be made where they sit within the delegated authority given by CCGs to individual members of JCCE.

Key areas of discussion at the June JCCE meeting were:
- Updates on key contract issues
- Updates on procurement projects and discussion of the procurement pipeline
- Feedback from the Joint Commissioning Programme Board
- Miscellaneous commissioning queries

The future role of JCCE is to be reviewed as part of the process of transition to the single management team across the five CCGs, as issues are increasingly being referred to the interim Senior Management Team for decision (as reflected in the reduced number of issues on the JCCE agenda in June).

**Recommendation:**

JSCC is asked to note the update from the June meeting of the JCCE and comment on any issues raised.
1. **Introduction**

1.1 A key part of the supporting infrastructure for JSCC has been the role of the Joint Commissioning & Contracting Executive (JCCE) to cover most of the operational (“business as usual”) elements of the JSCC work programme.

1.2 JCCE meets monthly, and consists of CCG Associate Chief Finance Officers (CFOs), Chief Operating Officers (COOs), the Director of Children’s Commissioning from Great Yarmouth & Waveney (GYW) CCG, a representative of the Directors of Nursing & Quality, and contracting and finance leads from Arden GEM Commissioning Support Unit (CSU). The JCCE chair is the Norfolk & Waveney CCGs’ CFO, who provides a monthly highlight report to JSCC.

1.3 This report outlines the issues discussed at the JCCE meeting on 3rd June 2019. The next meeting is due to take place on Monday 1st July.

2. **Report from June 2019 JCCE Meeting**

2.1 Key items discussed were as follows:

**Contracting, performance & procurement issues:**

- **Contract updates** – the CSU contract lead provided an update on key performance issues with the main providers. This included discussion on A&E performance, Referral to Treatment (RTT) times, and key mental health issues.

- **Procurement issues** – the Arden GEM CSU Senior Procurement Manager presented an update on on-going procurements and the future procurement pipeline. It was noted that a workshop had been held to scope a procurement strategy for the CCGs, and that a new group had been established with representatives from CCGs and the CSU to provide more detailed oversight of procurements. This group will ensure a more proactive approach to contract planning to minimise the number of tender waiver requests.

**Commissioning issues**

- **Joint Commissioning Programme Board (JCPB) update** – Howard Martin (West Norfolk CCG Associate CFO) provided an update on the May meeting of the JCPB. Particular issues noted were:
  - work is progressing in lining up the QIPP summary reporting/forecasting across the 5 CCGs to ensure it is consistent, and was due to be completed by mid-June;
  - Peer reviews of individual CCG QIPP schemes have been completed. A full summary with actions will be presented at the June JCPB meeting and reported back to JCCE in July;
  - The Project Initiation Document (PID) for the extension of the Clinical Assessment Service (CAS) was discussed, and will be brought for approval in July following modifications. Options for this extension are to be presented to the interim Senior Management Team for agreement in respect of the financial investment required.
  - The PID for Ophthalmology was presented and will be updated for the JCPB meeting in June.
• **Diabetes Strategy implementation** – it was noted that the Norfolk & Waveney STP has received funding for implementation of Diabetes improvements, and was proposed that a plan for spending this funding is developed for approval by JSCC.

• **Foot & Ankle pathway** – JCCE received a paper requesting approval of a business case and funding for the redesign of the Foot and Ankle pathway in central Norfolk. The proposal would support RTT delivery within Orthopaedics and has potential to reduce the level of acute activity (hence delivering savings), but had a gross cost of £185k per year and a potential net cost (after savings) of £82k. JCCE requested further information to understand the likely impact on waiting lists and to support the potential savings.
### Agenda Item: 8
John Ingham, CFO
JSCC 18th June 2019

<table>
<thead>
<tr>
<th>Subject:</th>
<th>Norfolk &amp; Waveney Sustainability &amp; Transformation Partnership (STP) Finance Report as at April 2019 (month 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presented By:</td>
<td>John Ingham, CFO, Norfolk &amp; Waveney CCGs</td>
</tr>
</tbody>
</table>
| Prepared By:             | John Hennessey, Chief Finance Officer, Norfolk & Waveney STP  
                          Julie Cave, Interim Chief Operating Officer, Norfolk & Waveney STP  
                          John Ingham, CFO, Norfolk & Waveney CCGs                                                                   |
| JSCC Sponsor:            | John Ingham, CFO, Norfolk & Waveney CCGs                                                                   |
| Submitted To:            | JSCC 18th June 2019 – In Public                                                                            |
| Purpose of Paper:        | For information and discussion                                                                             |

### Summary

In June 2019 the Sustainability & Transformation Partnership (STP) Chairs’ Oversight Group received an update on the financial position across the Norfolk & Waveney STP. This report, which is attached at Appendix A, highlights the STP’s financial position as at April 2019 (month 1), and outlines the plans to produce a 5 year financial plan for the STP.

Key points within the report are that:
- The month 1 position for the STP is an adverse variance to plan of £1.1m, relating to the Norfolk & Norwich University Hospitals NHS FT (NNUH) and the Queen Elizabeth Hospital NHS FT (QEH).
- The 2019/20 forecast outturn position remains in line with submitted plans.

#### 2019/20 system support

Within CCG financial plans for 2019/20 are included two levels of broader system support:

1. **Support to the Queen Elizabeth Hospital NHS FT (QEH)**

   Within the Norfolk & Waveney STP, partners agreed a request from the QEH for £6m financial support from the STP in 2019/20 in order for the QEH to accept their control total. This in turn released the availability of £23m external support funding for the QEH linked to the Provider Sustainability Fund and Financial Recovery Fund.

   The STP is therefore establishing a Risk Reserve of £6m, which is consistent with the approach outlined in the draft Memorandum of Understanding (MoU) document produced early in 2019 following the Aspirant Integrated Care System (ICS) workshops in 2018. This document stated that:

   “Risk reserves will be established and held by CCGs and distributed as required across the STP as recommended by the STP Executive and approved by CCG Governing bodies.”

   The £6m will be released to the QEH in two tranches: £2m in October 2019, provided the QEH is achieving its financial plan for the first 6 months of the year, and the final £4m in March 2020 if the QEH is remaining on track to deliver its plan. It is intended that this support would be repayable by the QEH to STP partners in future years. In the event that it is clear the Trust
cannot deliver its financial plan, none of the £6m supporting funding will be made available; decisions on how this funding will otherwise be utilised in that circumstance will be at the discretion of the Norfolk and Waveney CCGs.

All of these aspects of the operation of the STP risk reserve require confirmation in a formal Memorandum of Understanding between the STP partners, and are also encapsulated in a contract variation with the QEH.

2. Support to the Cambridgeshire & Peterborough (C&P) STP

As noted in Section 3 of the attached report, the Norfolk & Waveney STP agreed to the request from NHS England & Improvement to provide £5m of non-recurrent financial support for the C&P system, which is anticipated to be repaid within 3 years. The contribution from the 5 CCGs totals £2.9m.

The impact of these two areas of system support is to increase the CCGs' combined QIPP (Quality, Innovation, Productivity, Prevention) target for 2019/20 from £60m (3.8% of allocation) to £69m (4.3%). Work is on-going to identify a full picture of CCG risks, including this increased QIPP requirement, and potential mitigations available to enable the CCGs to deliver their financial plans for 2019/20.

**Recommendation:**

JSCC is asked to:
- note the attached STP Finance Report as at month 1 2019/20, and to discuss its contents;
- note the system support provided in 2019/20 and the resultant increase in CCGs' combined QIPP requirement from £60m to £69m.
Main body of report

Financial Position: Month 1

1. The month one financial position, as reported at organisational level to NHSI/E is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Month 1 Actual</th>
<th>FOT</th>
<th>Variance</th>
<th>Month 1 Plan</th>
<th>FOT</th>
<th>Variance</th>
<th>CT</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NNUH</td>
<td>-</td>
<td>8,210</td>
<td>-</td>
<td>7,560</td>
<td>-</td>
<td>650</td>
<td>54,340</td>
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<tr>
<td>QEH</td>
<td>-</td>
<td>3,424</td>
<td>-</td>
<td>3,024</td>
<td>-</td>
<td>400</td>
<td>25,589</td>
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<tr>
<td>JPUH</td>
<td>-</td>
<td>1,510</td>
<td>-</td>
<td>1,510</td>
<td>-</td>
<td>-</td>
<td>6,081</td>
<td>6,081</td>
</tr>
<tr>
<td>NCH&amp;C</td>
<td>-</td>
<td>507</td>
<td>-</td>
<td>507</td>
<td>-</td>
<td>-</td>
<td>2,475</td>
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</tr>
</tbody>
</table>

Subtotal Providers: - 14,491 - 13,441 - 1,050 - 91,802 - 91,802 - - 91,802 - 93,911 - 2,109

<table>
<thead>
<tr>
<th></th>
<th>Month 1 Actual</th>
<th>FOT</th>
<th>Variance</th>
<th>Month 1 Plan</th>
<th>FOT</th>
<th>Variance</th>
<th>CT</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Norfolk CCG</td>
<td>49</td>
<td>49</td>
<td>-</td>
<td>600</td>
<td>600</td>
<td>-</td>
<td>600</td>
<td>600</td>
</tr>
<tr>
<td>Norwich CCG</td>
<td>57</td>
<td>57</td>
<td>-</td>
<td>700</td>
<td>700</td>
<td>-</td>
<td>700</td>
<td>700</td>
</tr>
<tr>
<td>South Norfolk CCG</td>
<td>202</td>
<td>202</td>
<td>-</td>
<td>2,420</td>
<td>2,420</td>
<td>-</td>
<td>2,420</td>
<td>2,100</td>
</tr>
<tr>
<td>GY&amp;W CCG</td>
<td>182</td>
<td>182</td>
<td>-</td>
<td>2,880</td>
<td>2,880</td>
<td>-</td>
<td>2,880</td>
<td>2,200</td>
</tr>
<tr>
<td>West Norfolk</td>
<td>29</td>
<td>29</td>
<td>-</td>
<td>340</td>
<td>340</td>
<td>-</td>
<td>340</td>
<td>300</td>
</tr>
<tr>
<td>Subtotal CCGs</td>
<td>519</td>
<td>519</td>
<td>-</td>
<td>6,940</td>
<td>6,940</td>
<td>-</td>
<td>6,940</td>
<td>4,000</td>
</tr>
<tr>
<td>TOTAL STP</td>
<td>- 13,972</td>
<td>12,922</td>
<td>- 1,050</td>
<td>84,862</td>
<td>84,862</td>
<td>-</td>
<td>84,862</td>
<td>89,911</td>
</tr>
</tbody>
</table>

Plan figures as per final 15th May regulatory submissions.
Month 1 actuals/FOT from ‘heads up’ updates received from organisations, or PRM data where available (formal data collection not undertaken for Month 1)

2. The table shows that the NNUH and the QEH are behind plan by £0.6m and £0.4m respectively for April. Forecasts remain on plan for the year.

Cambridgeshire and Peterborough STP

3. Further to previous discussions on the requested support to the Cambridgeshire and Peterborough STP we have now agreed £5m support from our health system. This is non-recurrent and we have been told that this is repayable in the next 3 years. Of this
sum £4m has been provided from our organisations and £1m support from NHSI/E to our system.

**Five Year Financial Plans**

4. As part of our Financial Recovery Plan and Long Term Plan (which is required to be submitted to NHSI/E in the autumn), we are preparing five year plans at organisational level for consolidation and review by the STP. The deadline for draft plans is 30 June.

5. The consolidation of organisational plans will allow us to determine the system-wide position and the need to deliver system-wide financial savings and efficiencies. This includes the significant potential for back office consolidation (including HR, Finance, IT, Estates), procurement, outpatient transformation where progress has been slow. Freeing up resource to lead on these schemes is key but progress has been made with the recent appointment to senior finance and programme posts.
Agenda Item: 9
Norfolk & Waveney DTC,
JSCC 18th June 2019

Subject: Norfolk and Waveney Drug & Therapeutics Committee (D&TC) commissioning recommendations

Presented by: Cath Byford, Deputy Chief Officer, Director of Commissioning GYWCCG

Prepared by: Fiona Marshall, TAG Lead Pharmacist, Arden & GEM CSU

Submitted to: JSCC 18th June 2019 – Meeting in Public

Purpose of Paper: For Agreement

Executive Summary:

All NICE drugs and devices documents are routinely submitted to the Norfolk & Waveney CCGs’ Area Prescribing Committee, the Therapeutics Advisory Group (TAG), along with any locally developed business cases and prescribing guidance. The purpose of TAG is to ensure clinical oversight and to take forward recommendations for a commissioning decision or impact.

Subsequently, the Norfolk & Waveney CCGs’ Drugs & Therapeutics Committee (D&TC) will turn the clinical recommendation of TAG into a commissioning recommendation in relation to drugs used in primary and secondary care, however this group does not have the authority to make the final commissioning decision since the local governance process requires that all recommendations must be submitted to JSCC for approval.

It is recognised that funding for NICE technology appraisal guidance must be available within NHSE’s mandated timeframe (usually 3 months however some do come through on a fast track basis), however some recommendations made by the TAG and the D&TC are not mandated and the clinical, financial and strategic impact should be used to inform final commissioning decisions.

The attached document sets out a summary of the recommendations of TAG and D&TC from May 2019.

Recommendations:
JSCC is asked to:

- Ratify the Norfolk and Waveney TAG recommendations and D&TC commissioning decisions

Supporting Papers are attached:

1. Recommendations of the Norfolk & Waveney Therapeutics Advisory Group (TAG) and related Commissioning Decision Recommendations by the Norfolk & Waveney CCGs’ Drugs & Therapeutics Committee (D&TC) – May 2019
Recommendations of the *Norfolk & Waveney Therapeutics Advisory Group (TAG)* and the Norfolk & Waveney CCGs’ Drugs & Therapeutics Committee (D&TC) (May 2019) for consideration by the JSCC – June 2019

<table>
<thead>
<tr>
<th>Recommending Body</th>
<th>Drug / Product</th>
<th>Indication for Use</th>
<th>TAG Clinical Recommendation</th>
<th>N&amp;W CCGs’ D&amp;TC Commissioning Recommendation to the CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NICE Guidance: CCG commissioning responsibility</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>NICE TA 568 (March 2019)</strong>&lt;br&gt;(terminated appraisal)</td>
<td>Abatacept (Orencia®)</td>
<td>For treating psoriatic arthritis after DMARDs</td>
<td>The TAG acknowledged <em>NICE TA 568 (March 2019)</em> and confirmed a traffic light classification of <strong>Double Red (Not recommended for routine use)</strong></td>
<td>Noted and supported by the D&amp;TC – to be forwarded to the JSCC for ratification.</td>
</tr>
<tr>
<td><strong>NICE TA 572 (March 2019)</strong>&lt;br&gt;Ertugliflozin (Steglatro®) as monotherapy or with metformin for treating type 2 diabetes</td>
<td>Ertugliflozin (Steglatro®) (as monotherapy or with metformin)</td>
<td>1.1 Ertugliflozin monotherapy is recommended as an option for treating type 2 diabetes in adults for whom metformin is contraindicated or not tolerated and when diet and exercise alone do not provide adequate glycaemic control, only if: • a dipeptidyl peptidase 4 (DPP-4) inhibitor would otherwise be prescribed and</td>
<td>The TAG acknowledged <em>NICE TA 572 (March 2019)</em> and recommended a traffic light classification of <strong>Green - GP prescribable at the request of a Specialist or Consultant</strong>, in line with other NICE-recommended SGLT2 inhibitors</td>
<td>Noted and supported by the D&amp;TC – to be forwarded to the JSCC for ratification.</td>
</tr>
<tr>
<td>Recommending Body</td>
<td>Drug / Product</td>
<td>Indication for Use</td>
<td>TAG Clinical Recommendation</td>
<td>N&amp;W CCGs’ D&amp;TC Commissioning Recommendation to the CCGs</td>
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</tr>
<tr>
<td><strong>NICE TA 574 April 2019</strong>&lt;br&gt;• a sulfonylurea or pioglitazone is not appropriate.&lt;br&gt;1.2 Ertugliflozin in combination with metformin is recommended as an option for treating type 2 diabetes, only if:&lt;br&gt;• a sulfonylurea is contraindicated or not tolerated or&lt;br&gt;• the person is at significant risk of hypoglycaemia or its consequences.&lt;br&gt;1.3 If patients and their clinicians consider ertugliflozin to be one of a range of suitable treatments including canagliflozin, dapagliflozin and empagliflozin, the least expensive should be chosen.</td>
<td>Certolizumab pegol (Cimzia®)&lt;br&gt;For treating moderate to severe plaque psoriasis in adults, only if:&lt;br&gt;1.1 Recommended by NICE as an option for plaque psoriasis in adults, only if:&lt;br&gt;• the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and&lt;br&gt;• the disease has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated and&lt;br&gt;• the lowest maintenance dosage of certolizumab pegol is used (200mg every 2 weeks) after the loading dosage and</td>
<td>The TAG acknowledged NICE TA 574 April 2019 and recommended a traffic light classification of Red (Hospital / Specialist use only) in line with the Joint CSU / Trusts Business Application which was also considered by the TAG; the revised specialist treatment pathway for psoriasis to be brought to the July 2019 TAG meeting.</td>
<td>Noted and supported by the D&amp;TC in line with the joint CSU / Acute Trusts business application – see further entry below (p13-14).</td>
<td></td>
</tr>
<tr>
<td>Recommending Body</td>
<td>Drug / Product</td>
<td>Indication for Use</td>
<td>TAG Clinical Recommendation</td>
<td>N&amp;W CCGs’ D&amp;TC Commissioning Recommendation to the CCGs</td>
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</tbody>
</table>
| **NICE TA 575 April 2019** | Tildrakizumab (Ilumetri®) | For treating moderate to severe plaque psoriasis in adults, only if:  
1.1 Recommended by NICE as an option for plaque psoriasis in adults, only if:  
• the disease is severe, as defined by a total Psoriasis Area and Severity Index (PASI) of 10 or more and a Dermatology Life Quality Index (DLQI) of more than 10 and  
• the disease has not responded to other systemic treatments, including ciclosporin, methotrexate and phototherapy, or these options are contraindicated or not tolerated and  
• the company provides the drug according to the commercial arrangement.  
1.2 Consider stopping tildrakizumab between 12 weeks and 28 weeks if there has not been at least a 50% reduction in the PASI score from when treatment started. | The TAG acknowledged [NICE TA 575 April 2019](https://www.nice.org.uk/guidance/ta575) and recommended a traffic light classification of Red (Hospital / Specialist use only) in line with the Joint CSU / Trusts Business Application which was also considered by the TAG; the revised specialist treatment pathway for psoriasis to be brought to the July 2019 TAG meeting. | Noted and supported by the D&Tc in line with the joint CSU / Acute Trusts business application – see further entry below (p13-14) |

- the company provides the drug according to the commercial arrangement.

1.2 Stop certolizumab pegol at 16 weeks if the psoriasis has not responded adequately. An adequate response is defined as:
- a 75% reduction in the PASI score (PASI75) from when treatment started or
- a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.
<table>
<thead>
<tr>
<th>Recommending Body</th>
<th>Drug / Product</th>
<th>Indication for Use</th>
<th>TAG Clinical Recommendation</th>
<th>N&amp;W CCGs’ D&amp;TC Commissioning Recommendation to the CCGs</th>
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<tr>
<td><strong>1.3 Stop tildrakizumab at 28 weeks if the psoriasis has not responded adequately. An adequate response is defined as:</strong></td>
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<td>• a 75% reduction in the PASI score (PASI 75) from when treatment started or&lt;br&gt;• a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from when treatment started.</td>
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<tr>
<td><strong>NICE NG 121 (March 2019)</strong>&lt;br&gt;This guideline aims to improve experiences and outcomes for women and their babies.</td>
<td>Intrapartum care for women with existing medical conditions or obstetric complications and their babies</td>
<td>Includes recommendations on:&lt;br&gt;• heart disease, bleeding disorders and subarachnoid haemorrhage&lt;br&gt;• asthma, long-term systemic steroids and obesity&lt;br&gt;• acute kidney injury and chronic kidney disease&lt;br&gt;• sepsis and intrapartum haemorrhage&lt;br&gt;• previous caesarean section and labour after 42 weeks&lt;br&gt;• small-for-gestational-age baby and large-for-gestational-age baby&lt;br&gt;• no antenatal care</td>
<td>The TAG noted NICE NG 121 (March 2019)&lt;br&gt;Noted by the D&amp;TC</td>
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<tr>
<td><strong>NICE NG 122 (March 2019)</strong>&lt;br&gt;NICE has made new recommendations supplement the existing ones on diagnosis, treatment for non-small-cell and small-cell lung cancer</td>
<td>Lung cancer: diagnosis and management:</td>
<td>NICE reviewed the evidence and made new recommendations on:&lt;br&gt;• intrathoracic lymph node assessment&lt;br&gt;• brain imaging for people with non-small-cell lung cancer&lt;br&gt;• radical radiotherapy (including stereotactic ablative radiotherapy [SABR]) for people with non-small-cell lung cancer</td>
<td>The TAG noted NICE NG 122 (March 2019)&lt;br&gt;Noted by the D&amp;TC</td>
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<td>Recommending Body</td>
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<td>cancer and palliative care.</td>
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<td><strong>NICE NG 123 (April 2019)</strong></td>
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<td>This guideline covers assessing and managing urinary incontinence and pelvic organ prolapse in women aged 18 and over. It also covers complications associated with mesh surgery for these conditions. At the time of publication, the high vigilance restriction period regarding mesh surgery had been extended and, until it ends, professionals should continue to follow its requirements.</td>
<td>Urinary incontinence and pelvic organ prolapse in women: management</td>
<td>Includes recommendations on:</td>
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<td>• organisation of specialist services</td>
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<td>• collecting data on surgery and surgical complications</td>
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<td>• urodynamic testing to assess urinary incontinence</td>
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<td>• pelvic floor muscle training and absorbent containment products for urinary incontinence</td>
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<td>• medicines and botulinum toxin type A injections for overactive bladder</td>
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<td>• surgical management of stress urinary incontinence</td>
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<td>• assessing pelvic organ prolapse</td>
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<td>• non-surgical and surgical management of pelvic organ prolapse</td>
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<td>• surgery for women with both stress urinary incontinence and pelvic organ prolapse</td>
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<td>• assessing and managing complications associated with mesh surgery</td>
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<td>The TAG noted NICE NG 123 (April 2019) and acknowledged that the guidance does not specify the type of pelvic floor muscle training. The TAG recommended that the Prescribing Reference Group be requested to consider the place of different devices promoted for pelvic floor muscle training as listed in the Drug Tariff.</td>
<td></td>
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<td>Noted by the D&amp;TC</td>
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<td><strong>NICE NG 124 (April 2019)</strong></td>
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<td>- covers specific aspects of respiratory support (for example, Specialist neonatal respiratory care for babies born preterm)</td>
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<td>Includes recommendations on:</td>
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<td>• risk factors for bronchopulmonary dysplasia</td>
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<td>• respiratory support for preterm babies</td>
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<td>• managing respiratory disorders</td>
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<td>The TAG noted NICE NG 124 (April 2019)</td>
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<td>Noted by the D&amp;TC</td>
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<td>Recommending Body</td>
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<td><strong>oxygen supplementation, assisted ventilation, treatment of some respiratory disorders, and aspects of monitoring) for preterm babies in hospital.</strong></td>
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<tr>
<td><strong>NICE NG 125 (April 2019)</strong></td>
<td>Surgical site infections: prevention and treatment</td>
<td>Includes recommendations on:</td>
<td>The TAG noted <strong>NICE NG 125 (April 2019)</strong></td>
<td>Noted by the D&amp;TC</td>
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<td></td>
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<td>- nasal decolonisation before surgery</td>
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<td>- antiseptic skin preparation during surgery</td>
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<td>- antiseptics and antibiotics before wound closure</td>
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<td>- methods of wound closure</td>
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<td><strong>NICE NG 126 (April 2019)</strong></td>
<td>Ectopic pregnancy and miscarriage: diagnosis and initial management</td>
<td>Includes new &amp; updated recommendations:</td>
<td>The TAG noted <strong>NICE NG 126 (April 2019)</strong></td>
<td>Noted by the D&amp;TC</td>
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<tr>
<td></td>
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<td>- using ultrasound scans for diagnosis of tubal ectopic pregnancy</td>
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<td>- expectant management</td>
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<td>Also includes recommendations on:</td>
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<td>- support and information giving</td>
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<td>- early pregnancy assessment services</td>
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<td>- symptoms and signs of ectopic pregnancy</td>
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<td>- diagnosis of viable intrauterine pregnancy and ectopic pregnancy</td>
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<td>- management of miscarriage</td>
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<td>- management of ectopic pregnancy</td>
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| **Medtech innovation briefings:** | **Medtech innovation briefings - NICE MIB 170 (January 2019)** | **Path Finder for freezing of gait in people with Parkinson’s disease**  
- The Path Finder laser shoe attachment is a walking aid designed to help prevent freezing of gait in people with Parkinson's disease.  
- It is currently the only hands-free visual-cueing device for people with Parkinson's disease available in the UK.  
- The intended place in therapy would be in place of other visual-cue walking aids but together with a reduced number of physiotherapy sessions, depending on the individuals' disease stage and personal preference.  
- It would be used by the patient in their home or in the physiotherapy clinic. It may also be used in physiotherapy as a training tool for people with early stages of Parkinson's disease.  
- Available evidence is from 1 case report and 2 observational pilot studies involving a total of 21 adults with Parkinson's disease and freezing of gait symptoms. They show that Path Finder has the potential to reduce freezing of gait and the risk of falls in patients with Parkinson's disease.  
- Key uncertainties are that available evidence is limited in quantity and quality, based on a small number of patients and lacking in evidence from an NHS healthcare setting.  
- The cost is £395 per unit (exclusive of VAT). The resource impact would be an additional upfront cost to current practice. However, the use of the technology may be resource releasing if it can reduce the incidence of falls and emergency visits.  

The TAG noted NICE MIB 170 (January 2019) and recommended a traffic light classification of **Double Red (Not recommended for routine use)** until a local business application for use is supported for this technology. | The D&TC was advised that the CCGs' Clinical Policy Development Group may have future involvement in reviewing the use of such devices.  
Otherwise noted and supported by the D&TC.  
**Not recommended for commissioning, pending the submission of a local business application which is supported for commissioning by the CCGs**  
-- to be forwarded to the JSCC for ratification. |
| **Medtech innovation briefings:** | **iQoro for stroke-related dysphagia** | **iQoro** is a neuromuscular training device for stimulating the nerves and strengthening the muscles in the face, mouth, throat, oesophagus, and diaphragm.  
Swallowing therapy is the usual treatment for dysphagia (difficulty starting to swallow) after a stroke. The company claims swallowing exercises can be more accurately and effectively done using **iQoro**. No similar technologies are currently recommended in care guidelines. | The D&TC was advised that the CCGs' Clinical Policy Development Group may have future involvement in reviewing the use of such devices. |
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<tr>
<td><strong>TAG</strong></td>
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<td>Otherwise noted and supported by the D&amp;TC.</td>
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<td><strong>N&amp;W CCGs’ D&amp;TC</strong></td>
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<td>Not recommended for commissioning, pending the submission of a local business application which is supported for commissioning by the CCGs – to be forwarded to the JSCC for ratification.</td>
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**IQoro for hiatus hernia**

- IQoro is a neuromuscular training device used for improving symptoms related to hiatus hernia by strengthening the oesophagus and diaphragm. It is initially used daily for 3 to 6 months, with follow up maintenance use dependent upon individual need.
- IQoro is the only device available for treating hiatus hernia with oral, neuromuscular training and an exercise regime.
- The intended place in therapy would be as an alternative to long-term proton pump inhibitor (PPI) treatment or laparoscopic fundoplication surgery in people with hiatus hernia.
- Available evidence is from 3 non-comparative, observational studies including 148 adults in Swedish ear, nose and throat clinics. They show that IQoro may improve symptoms related to hiatus hernia when used for 6 to 8 months in people with long-term hiatus hernia.
- Key uncertainties around the evidence are that it is limited in quantity and quality. The effect of IQoro may be overestimated because of a lack of a control group. A study comparing IQoro with standard NHS care would help address this.

Medtech innovation briefings:
NICE MIB 176 (March 2019)

The D&T was advised that the CCGs’ Clinical Policy Development Group may have future involvement in reviewing the use of such devices.

Otherwise noted and supported by the D&TC.

Not recommended for commissioning, pending the submission of a local business application which is supported for commissioning by the CCGs – to be forwarded to the JSCC for ratification.
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<td>• The <strong>cost</strong> of IQoro is £116 per unit (exclusive of VAT). The <strong>resource impact</strong> would be greater than standard care, but costs may be offset by reducing long-term PPI maintenance. The TAG noted <a href="https://www.nice.org.uk/guidance/mib176">NICE MIB 176 (March 2019)</a> and recommended a traffic light classification of <strong>Double Red (Not recommended for routine use)</strong> until a local business application for use is supported for this technology.</td>
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| **Medtech innovation briefings:** [NICE MIB 178 (March 2019)](https://www.nice.org.uk/guidance/mib178) | **PredictSure-IBD for inflammatory bowel disease prognosis** | • PredictSure-IBD. It is used as a prognostic tool to identify patients who will go on to have severe, relapsing Crohn's disease and ulcerative colitis and who might benefit from early aggressive (biological) therapy.  
• It is designed to predict clinical prognosis when Crohn's disease or ulcerative colitis are diagnosed, using a combination of existing assays based on polymerase chain reaction technology.  
• The intended **place in therapy** would be to help the gastroenterologist's choice of treatment for people who have been recently diagnosed with Crohn's disease or ulcerative colitis.  
• Available **evidence** is from 2 biochemical studies and 1 prospective cohort study with 248 adult patients in a UK NHS secondary care outpatient setting. They show that PredictSure-IBD can accurately show which patients are likely to have severe relapsing disease. Evidence suggests an improved disease response when treatment with tumour necrosis factor (TNF) inhibitors is started early.  
• **Key uncertainties** around the evidence or technology are that the test has only been validated in biochemical studies.  
• The **cost** is £1,250 per unit (exclusive of VAT). The **resource impact** could be much lower than the current standard of care if starting anti-TNF therapy early leads to disease remission and prevents disease flare-ups but this is uncertain because it depends on the positive predictive value of the test, which is not yet determined. | The D&TC was advised that the CCGs’ Clinical Policy Development Group may have future involvement in reviewing the use of such devices. Otherwise noted and supported by the D&TC. **Not recommended for commissioning,** pending the submission of a local business application which is supported for commissioning by the CCGs – to be forwarded to the JSCC for ratification. |
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<td><strong>NHS England / NHS Clinical Commissioners items:</strong></td>
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<td><strong>NHS England:</strong></td>
<td>Flash Glucose Monitoring: National arrangements for funding of relevant diabetes patients (March 2019)</td>
<td><strong>For information</strong> <a href="#">Link</a></td>
<td>Noted by the TAG.</td>
<td>Noted by the D&amp;TC</td>
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<td><strong>Regional Medicines Optimisation Committees (RMOCs):</strong></td>
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<td><strong>London RMOC:</strong></td>
<td>Heparinised saline for central venous catheter lock in adults (February 2019)</td>
<td><strong>March 2019:</strong> The TAG noted that the RMOC’s guidance referred to routine use of heparinised saline and that some examples of exceptional use were given. TAG Trust representatives requested that the guidance is first circulated in Trust for a view before recommending traffic light classification. <strong>May 2019:</strong> The TAG was advised that the NNUH had reviewed its PGDs regarding management of central venous catheters and did not see a place for use of heparinised saline. The QEH agreed that the RMOC’s recommendations would not cause any issues for the Trusts. The TAG members therefore agreed to recommend a traffic light classification of Double Red (Not recommended for routine use) for use of heparinised saline for central venous catheter lock in adults, in line with the RMOC guidance.</td>
<td>Noted and supported by the D&amp;TC. Recommended as Double Red (Not recommended for routine use) / Not Commissioned regarding use of heparinised saline for central venous catheter lock in adults, in line with the RMOC guidance – to be forwarded to the JSCC for ratification.</td>
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<td><strong>East of England Priorities Advisory Committee (PAC) / PrescQIPP Guidance:</strong></td>
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<td><strong>East of England Priorities Advisory Committee (PAC):</strong> <a href="#">Draft Interim PAC Recommendations: v7</a></td>
<td>Doxylamine succinate 10mg plus pyridoxine hydrochloride 10mg delayed-release (Xonvea®) for the</td>
<td>The PAC’s draft interim recommendations v7 now state: • Prescribing of doxylamine plus pyridoxine (Xonvea®) for nausea and vomiting in pregnancy is NOT recommended in primary care.</td>
<td>March 2019: The TAG was advised that the PAC had met a few days before the TAG meeting and has since issued another draft of their guidance which</td>
<td>March 2019: The D&amp;TC noted the TAG’s recommendations and decided to apply an interim traffic light classification of Double</td>
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Summary of recommendations of the Therapeutics Advisory Group (TAG) and the Norfolk and Waveney Drugs & Therapeutics Committee (D&TC) for JSCC – June 2019

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|                   | treatment of nausea and vomiting in pregnancy | • There is insufficient information relating to efficacy, safety and cost-effectiveness of doxylamine and pyridoxine in comparison with other recognised non-pharmacological and pharmacological ways to manage nausea and vomiting in pregnancy and hyperemesis gravidarum.  
• Patients presenting with nausea and vomiting in pregnancy should be managed in line with current Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.  
• These recommendations will be reviewed in the light of new evidence and/or national guidance (including from Royal College of Obstetricians and Gynaecologists and Regional Medicines Optimisation Committees).  
For information & possible local adoption | clarified that national guidance would also include a steer from an RMOC.  
It was noted that the PAC has experienced significant pressure from the manufacturer regarding the issue that Xonvea® is the sole licensed option in the UK for this indication.  
The TAG acknowledged that there is long term experience of using other medicines off-label for this condition.  
The TAG deferred making any recommendation for this product until the PAC issues its final interim guidance. | Red (Not recommended for routine use) / Not commissioned for use of Doxylamine succinate 10mg plus pyridoxine hydrochloride 10mg delayed-release (Xonvea®) for the treatment of nausea and vomiting in pregnancy. |

March 2019:  
The D&TC decided to apply an interim traffic light classification of Double Red (Not recommended for routine use) / Not commissioned  

May 2019:  
Local (NNUH) specialists have commented on the draft version 6, citing varying support for use on the treatment of nausea and vomiting in pregnancy.  

May 2019:  
Noted and supported by the D&TC. The DTC confirmed that the current interim traffic light
### Norfolk & Waveney Therapeutics Advisory Group (TAG) recommendations regarding Matters Arising, New Applications from local stakeholders, and review of previous guidance:

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<td><strong>Therapeutics Advisory Group:</strong>&lt;br&gt;<strong>QEH Application:</strong>&lt;br&gt;Currently classified as <strong>Double Red / Not commissioned</strong> until a local business application for its use is submitted and supported.</td>
<td><strong>Jorveza</strong>® (Budesonide)&lt;br&gt;1mg orodispersible tablets for treatment of eosinophilic oesophagitis in adults older than 18 years of age</td>
<td>March 2019:&lt;br&gt;The TAG noted that <strong>Jorveza</strong>® is a newly licensed option for a rare condition that occurs in a small number of people, which has been treated to date using budesonide nebulisers, off-label, mixed to form a slurry to coat the oesophagus. The Trusts consider that it is necessary to use a licensed product, where available. The TAG considered that the evidence presented indicated that <strong>Jorveza</strong>® was as effective as the current treatment option and debated whether a more expensive licensed option should necessarily be used. It was noted that there are occasions where treatments of lower cost and equivalent effectiveness have continued to be used off-label instead of a more expensive licensed option. The TAG acknowledged that the evidence provided indicated higher patient preference for using <strong>Jorveza</strong>® compared with the slurry prepared from the nebulisers.</td>
<td>March 2019:&lt;br&gt;The D&amp;TC acknowledged that the proposed treatment schedule would mean that GPs would be asked to prescribe only a single (follow-up) 6-week treatment course per patient, for a very small number of cases. The D&amp;TC therefore requested sight of the QEH Trust’s planned GP communication letter regarding use of <strong>Jorveza</strong>® before agreeing</td>
<td>classification of <strong>Double Red (Not recommended for routine use) / Not commissioned</strong> is maintained – to be forwarded to the JSCC for ratification.</td>
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The latest draft PAC guidance indicates possible use in secondary care but not primary care. Final PAC guidance not yet available (at the time of writing the TAG’s agenda) – further feedback from the PAC to be returned to the TAG in July 2019.

The licensed product. Draft v7 since circulated for final support.
The TAG also debated how the 6-week treatment course for Jorveza® might be managed if an additional 6-week course was deemed necessary as confirmed by histology. In order to avoid patients having to return to hospital, the TAG agreed it was reasonable to recommend a traffic light classification of Red (Hospital/Specialist use only) for the first six weeks of treatment, and Green (GP prescribing following Specialist initiation/recommendation) if an additional six weeks of treatment is required. This would be a one-off, acute prescription from the GP.

The TAG noted the price differential between the current and the proposed treatment options.

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<td>Therapeutics Advisory Group:</td>
<td>Certolizumab pegol (Cimzia®)</td>
<td>For treatment of moderate to severe plaque psoriasis – as per NICE TA 574</td>
<td>The TAG agreed to support the application and recommended a traffic light classification of Red (Hospital/Specialist use only) for the first six weeks of treatment, and Green (GP prescribing following Specialist initiation/recommendation) if an additional six weeks of treatment is required. This would be a one-off, acute prescription from the GP.</td>
<td>to recommend that it is commissioned as per the TAG’s recommendations. Once approved the letter would have to be used across all the Acute Trusts to ensure a consistent approach. May 2018: The D&amp;TC considered the QEH’s proposed template letter and agreed to support its use. The recommended classifications of Red (Hospital/Specialist use only) for the first six weeks of treatment, and Green (GP prescribing following Specialist initiation/recommendation) if an additional six weeks of treatment is required - This would be a one-off, acute prescription from the GP – to be forwarded to the JSCC for ratification. Both business applications, which relate</td>
</tr>
<tr>
<td>Recommending Body</td>
<td>Drug / Product</td>
<td>Indication for Use</td>
<td>TAG Clinical Recommendation</td>
<td>N&amp;W CCGs’ D&amp;TC Commissioning Recommendation to the CCGs</td>
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<tr>
<td>Joint Acute Trusts/CSU Application:</td>
<td>Tildrakizumab (Ilumetri®)</td>
<td>For moderate to severe adult plaque psoriasis – as per NICE TA 575</td>
<td>The TAG agreed to support the application and recommended a traffic light classification of Red (Hospital/Specialist use only). The revised specialist treatment pathway for psoriasis to returned to the July 2019 TAG meeting.</td>
<td>Patients numbers across the STP area are estimated as &lt;10 per year. Prices are commercial in confidence. As an option of several products for treatment, locally Trusts use the most cost-effective therapies first line, and use of higher cost non-biosimilars is expected to be limited. Use will be monitored in line with pathway and through BluTeq. – to be forwarded to the JSCC for ratification.</td>
</tr>
<tr>
<td>Therapeutics Advisory Group: Joint Acute Trusts/CSU Application:</td>
<td>Oral Anticoagulant Therapy in Atrial Fibrillation</td>
<td>Stroke prevention in Atrial Fibrillation</td>
<td>Updated in consultation with STP AF review group –</td>
<td>The D&amp;TC noted the further amendments to the pathway and supported</td>
</tr>
<tr>
<td>Recommending Body</td>
<td>Drug / Product</td>
<td>Indication for Use</td>
<td>TAG Clinical Recommendation</td>
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<tr>
<td>Treatment Pathway – Review</td>
<td></td>
<td></td>
<td>proposed changes in Amber text</td>
<td>the publication of this version of the document. - <a href="#">Link</a> – to be forwarded to the JSCC for ratification.</td>
</tr>
<tr>
<td><strong>Norfolk &amp; Waveney Prescribing Reference Group (PRG): Recommendations</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>Prescribing Reference Group:</strong> Formulary recommendation</td>
<td>GLP-1 agonist Semaglutide (<em>Ozempic®</em>) for once-weekly subcutaneous injection</td>
<td>Indicated for adults with insufficiently controlled type 2 diabetes mellitus as adjunct to diet and exercise: • as monotherapy when metformin is considered inappropriate due to intolerance or contraindications • in addition to other medicinal products for the treatment of diabetes The TAG was requested to acknowledge the PRG’s recommendation to have this once-weekly product available on formulary as a 3rd line add-on treatment option.</td>
<td>The TAG acknowledged the PRG’s recommendation and agreed to apply a traffic light classification of Green (suitable for GPs to prescribe following specialist recommendation)</td>
<td>The PRG’s and the TAG’s recommendations were noted and supported by the D&amp;TC – to be forwarded to the JSCC for ratification.</td>
</tr>
<tr>
<td><strong>Prescribing Reference Group:</strong></td>
<td>Mexiletine</td>
<td>Licensed new High Cost Drug (<em>Namuscla®</em>) for non-dystrophic myotonic disorders (NDMD) • Unlicensed (in the UK) imported products in use for VT / NDMD The TAG was requested to consider the PRG’s recommendation to apply a Double Red (Not recommended for routine)</td>
<td>The TAG acknowledged the PRG’s recommendation and after consideration of the wider issues agreed to apply the following traffic light classifications:</td>
<td>The TAG’s recommendations were noted and supported by the D&amp;TC. The TAG’s recommended classifications for the licensed and unlicensed</td>
</tr>
<tr>
<td>Recommending Body</td>
<td>Drug / Product</td>
<td>Indication for Use</td>
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|                   |               | classification for use of mexiletine for any indication for new patients and takes a view on whether patients currently on unlicensed mexiletine should be reviewed. | Regarding use of the licensed High Cost Drug (*Namuscla*®):  
Red (Hospital/Specialist use only) for the symptomatic treatment of myotonia in adult patients with non-dystrophic myotonic disorders – as per NHSE commissioning policy.  
**Double Red (Not recommended for routine use/Not commissioned)** for all other indications (including migraine and neuropathic pain for which local use has been identified)  
Regarding use of Unlicensed (in the UK) imported mexiletine:  
Red (Hospital/Specialist use only) for ventricular tachycardia  
**Double Red (Not recommended for routine use / Not commissioned)** for all other indications (including migraine and neuropathic pain for which local use has been identified) | mexiletine products for different indications were supported.  
It was estimated that there are currently a small number of patients taking mexiletine across the Norfolk and Waveney area, for a variety of indications.  
– to be forwarded to the JSCC for ratification. |
<table>
<thead>
<tr>
<th>Recommending Body</th>
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</thead>
<tbody>
<tr>
<td>Prescribing Reference Group:</td>
<td>Primary Care Formularies:</td>
<td>updated and published</td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
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<tr>
<td>• Formulary: Analgesics</td>
<td></td>
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<tr>
<td>“Key Message” Bulletins - Updates</td>
<td>• Key Message Bulletin 14: Use of Opioids in Chronic Pain</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
</tr>
<tr>
<td></td>
<td>• Key Message Bulletin 15: Tapering Opioids in Chronic Pain</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
</tr>
<tr>
<td></td>
<td>• Key Message Bulletin 35: Chronic Pain (adults)</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
</tr>
<tr>
<td></td>
<td>• Key Message Bulletin 44: Management of Dry Eyes - New</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
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<tr>
<td>Primary Care Guidance: - Updates for information</td>
<td>• Pain Management Pathway</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
</tr>
<tr>
<td></td>
<td>• Reducing Opioids Patient Leaflet -Opioid Treatment Patient-GP Agreement</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
</tr>
<tr>
<td></td>
<td>• Dry Eye Pathway for Tear Film Disorder in Primary Care</td>
<td></td>
<td>Noted and supported by the TAG?</td>
<td>Noted and supported by the D&amp;TC</td>
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<tr>
<td></td>
<td>• Vitamin D Deficiency in Adults: Primary Care Management</td>
<td></td>
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<tr>
<td>MHRA/CHM Drug Safety Update March to April 2019</td>
<td>• Medicines with teratogenic potential: what is effective contraception and how often is pregnancy testing needed?</td>
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<td></td>
<td>• Onivyde (irinotecan, liposomal formulations): reports of serious and fatal thromboembolic events</td>
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<td></td>
<td>• Fluoroquinolone antibiotics: new restrictions and precautions for use due to very rare reports of disabling and potentially long-lasting or irreversible side effects</td>
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<td></td>
<td>• Elvitegravir boosted with cobicistat: avoid use in pregnancy due to risk of treatment failure and maternal-to-child transmission of HIV-1</td>
<td></td>
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<td></td>
<td>• Pregabalin (Lyrica), gabapentin (Neurontin) and risk of abuse and dependence: new scheduling requirements from 1 April</td>
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<td></td>
<td>• Belimumab (Benlysta▼): increased risk of serious psychiatric events seen in clinical trials</td>
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<td></td>
<td>• Valproate medicines and serious harms in pregnancy: new Annual Risk Acknowledgement Form and clinical guidance from professional bodies to support compliance with the Pregnancy Prevention Programme</td>
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</tr>
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<tr>
<td>• Yellow fever vaccine (Stamaril) and fatal adverse reactions:</td>
<td>extreme caution needed in people who may be immunosuppressed and those 60 years and older</td>
<td>The TAG noted the Drug Safety Updates</td>
<td>Noted by the D&amp;TC</td>
<td></td>
</tr>
</tbody>
</table>
The purpose of the paper is to request ratification of the attached reviewed clinical policies and to approve the revised IFR Policy document.

The process remains unchanged for IFR, however the policy has been amalgamated into one document to include a FAQ section and now reads as a controlled paper with audit tracking being incorporated.

Previously, all the Clinical Policies were sent to each CCG for ratification. This process has now changed and all policies agreed by the Clinical Policy Development Group will be submitted to the JSCC for ratification. Following JSCC ratification, the policies will then be uploaded to Knowledge Anglia for use by both Primary and Secondary care clinicians when considering patient referrals.

This request for ratification is in line with JSCC delegated authority.

The review dates for the following policies were due and therefore reviewed by CPDG. These policies have been approved by CPDG and remain unchanged:

- a) Cholecystectomy for Asymptomatic Gallstones
- b) Laser Treatment of Myopia
- c) Removal of Redundant Fat or Skin
- d) Rhinoplasty
- e) Scars and Keloids
- f) Spinal Fusion
- g) Surgical Discectomy (for Lumbar Disc Prolapse)
- h) Thigh/Arm Contouring

**Recommendation:**

JSCC is asked to:-

- Ratify the attached reviewed policies
- Approve IFR Policy (Item 11i)
Norfolk and Waveney Clinical Policy Development Group

Title: Cholecystectomy for Asymptomatic Gallstones

Date (approved by CPDG): 09/05/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website [http://nww.knowledgeanglia.nhs.uk/](http://nww.knowledgeanglia.nhs.uk/) for the latest version of this policy.
## Title/topic:
Cholecystectomy for Asymptomatic Gallstones

## Status:
Individual Funding Request

This procedure is not routinely funded by Norfolk and Waveney Clinical Commissioning Groups.

Asymptomatic gallstones are usually diagnosed incidentally when they are seen on imaging which is carried out for unrelated reasons or discovered while surgery is underway for another condition. Removal of gallstones in these circumstances will not be funded.

### CASES FOR INDIVIDUAL CONSIDERATION

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

### CCG Variation:

<table>
<thead>
<tr>
<th>Clinical Codes for audit/monitoring</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J18.1</td>
<td>Total cholecystectomy and excision of surrounding tissue</td>
</tr>
<tr>
<td>J18.2</td>
<td>Total cholecystectomy and exploration of common bile duct</td>
</tr>
<tr>
<td>J18.3</td>
<td>Total cholecystectomy NEC</td>
</tr>
<tr>
<td>J18.4</td>
<td>Partial cholecystectomy and exploration of common bile duct</td>
</tr>
<tr>
<td>J18.5</td>
<td>Partial cholecystectomy NEC</td>
</tr>
<tr>
<td>J18.8</td>
<td>Other specified excision of gall bladder</td>
</tr>
<tr>
<td>J18.9</td>
<td>Unspecified excision of gall bladder</td>
</tr>
<tr>
<td>J21.1</td>
<td>Open removal of calculus from gall bladder</td>
</tr>
<tr>
<td>J21.8</td>
<td>Other specified incision of gall bladder</td>
</tr>
<tr>
<td>J21.9</td>
<td>Unspecified incision of gall bladder</td>
</tr>
</tbody>
</table>
Norfolk and Waveney Clinical Policy Development Group

Title: Laser Treatment of Myopia (Short Sightedness)

Date (reviewed and approved by CPDG): 11/04/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website http://nww.knowledgeanglia.nhs.uk/ for the latest version of this policy.
Title/topic: Laser Treatment of Myopia (Short Sightedness)
Status: IFR

This procedure is not routinely funded by the Norfolk and Waveney Clinical Commissioning Groups.

This procedure has been assessed as a low clinical priority by the Norfolk and Waveney CCGs and will not be funded unless there are exceptional clinical circumstances.

**CASES FOR INDIVIDUAL CONSIDERATION**

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

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Norfolk and Waveney Clinical Policy Development Group

Title: Removal of Redundant Fat or Skin

Date (reviewed and approved by CPDG): 11/04/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website http://nww.knowledgeanglia.nhs.uk/ for the latest version of this policy.
Removal of Redundant Fat or Skin

Individual Funding Request

This procedure is usually performed for cosmetic reasons and is not routinely funded by the Norfolk and Waveney Clinical Commissioning Groups.

This procedure has been assessed as a low clinical priority by the Norfolk and Waveney CCGs and will not be funded unless there are exceptional clinical circumstances.

CASES FOR INDIVIDUAL CONSIDERATION

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

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Norfolk and Waveney Clinical Policy Development Group

Clinical Threshold Policy

Title: Rhinoplasty

Date (approved by CPDG): 09/05/19

Date (approved by JSCC):

Please check the Knowledge Anglia website [http://nww.knowledgeanglia.nhs.uk/](http://nww.knowledgeanglia.nhs.uk/) for the latest version of this policy.
This procedure is not routinely funded on cosmetic grounds alone. This procedure will only be funded by Norfolk and Waveney Clinical Commissioning Groups if the following conditions apply:

- Patient is post traumatic

AND/OR

- Condition is affecting airways

CASES FOR INDIVIDUAL CONSIDERATION

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

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<thead>
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<th>CCG Variation:</th>
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<tbody>
<tr>
<td></td>
<td>E02.3 - Septorhinoplasty using implant</td>
</tr>
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<td>E02.4 - Septorhinoplasty using graft</td>
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<td></td>
<td>E02.5 - Reduction rhinoplasty</td>
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<td></td>
<td>E02.6 - Rhinoplasty NEC</td>
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<tr>
<td></td>
<td>E02.7 - Alar reconstruction with cartilage graft</td>
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<tr>
<td></td>
<td>E02.8 - Other Specified Plastic Operations on nose</td>
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<tr>
<td></td>
<td>E07.3 - Septorhinoplasty NEC</td>
</tr>
</tbody>
</table>
Norfolk and Waveney Clinical Policy Development Group

Title: Scars and Keloids

Date (reviewed and approved by CPDG): 11/04/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website http://nww.knowledgeanglia.nhs.uk/ for the latest version of this policy.
This procedure is not routinely funded by the Norfolk and Waveney Clinical Commissioning Groups.

This procedure has been assessed as a low clinical priority by the Norfolk and Waveney CCGs and will not be funded unless there are exceptional clinical circumstances

**Exemptions** – Scars interfering with function following burns/trauma, serious scarring of the face and severe post-surgical scarring are exempt from this policy.

**CASES FOR INDIVIDUAL CONSIDERATION**

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

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<tr>
<td>Clinical Codes for audit/monitoring</td>
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<tr>
<td>S60.4 - Refashioning of scar NEC</td>
</tr>
<tr>
<td>S53.2 - Injection of therapeutic substance into skin (injection of scar tissue with local anaesthetic) – this is not exclusively for scar coding so could be used for other scenarios</td>
</tr>
<tr>
<td>Y06.4 – Excision of scar tissue NOC</td>
</tr>
</tbody>
</table>
Norfolk and Waveney Clinical Policy Development Group

Clinical Threshold Policy

Title: Spinal Fusion

Date (approved by CPDG): 09/05/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website [http://nww.knowledgeanglia.nhs.uk/](http://nww.knowledgeanglia.nhs.uk/) for the latest version of this policy.
There is currently insufficient evidence of clinical/cost-effectiveness of surgical stabilisation over intensive rehabilitation in relieving patients of symptoms of chronic low back pain. Fusion surgery may be considered in selected patients.

Norfolk and Waveney Clinical Commissioning Groups will only fund this procedure if the following criteria can be met:

- Patient is suffering from degenerative spondylolisthesis

OR

- Degenerative Scoliosis

**CASES FOR INDIVIDUAL CONSIDERATION**

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

**CCG Variation:**

<table>
<thead>
<tr>
<th>Clinical Codes for audit/monitoring</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>V37.1 – Posterior fusion of atlantoaxial joint NEC</td>
<td></td>
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<tr>
<td>V37.2 – Posterior fusion of joint of cervical spine NEC</td>
<td></td>
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<tr>
<td>V37.3 – Transoral fusion of atlantoaxial joint</td>
<td></td>
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<tr>
<td>V37.4 – Fusion of atlanto-occipital joint</td>
<td></td>
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<tr>
<td>V37.5 – Posterior fusion of atlantoaxial joint using transarticular screw</td>
<td></td>
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<tr>
<td>V37.6 – Posterior fusion of atlantoaxial joint using pedicle screw</td>
<td></td>
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<tr>
<td>V37.7 – Fusion of occipitocervical junction NEC</td>
<td></td>
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<tr>
<td>V37.8 – Other specified primary fusion of joint of cervical spine</td>
<td></td>
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<tr>
<td>V37.9 – Unspecified primary fusion of joint of cervical spine</td>
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<tr>
<td>V38.1 – Primary fusion of joint of thoracic spine</td>
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<tr>
<td>V38.2 – Primary posterior interlaminar fusion of joint of lumbar spine</td>
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<tr>
<td>V38.3 – Primary posterior fusion of joint of lumbar spine NEC</td>
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<tr>
<td>V38.4 – Primary intertransverse fusion of joint of lumbar spine NEC</td>
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<tr>
<td>V38.5 – Primary posterior interbody fusion of joint of lumbar spine</td>
<td></td>
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<tr>
<td>V38.6 – Primary transforaminal interbody fusion of joint of lumbar spine</td>
<td></td>
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<tr>
<td>V38.8 – Other specified primary fusion of other joint of spine</td>
<td></td>
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<tr>
<td>V38.9 – Unspecified primary fusion of other joint of spine</td>
<td></td>
</tr>
<tr>
<td>V39.1 – Revisional fusion of joint of cervical spine NEC</td>
<td></td>
</tr>
<tr>
<td>V39.2 – Revisional fusion of joint of thoracic spine</td>
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<tr>
<td>V39.3 – Revisional posterior interlaminar fusion of joint of lumbar spine</td>
<td></td>
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<td>V39.4 – Revisional posterior fusion of joint of lumbar spine NEC</td>
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<tr>
<td>V39.5 – Revisional intertransverse fusion of joint of lumbar spine NEC</td>
<td></td>
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<tr>
<td>V39.6 – Revisional posterior interbody fusion of joint of lumbar spine</td>
<td></td>
</tr>
<tr>
<td>V39.7 – Revisional transforaminal interbody fusion of joint of lumbar spine</td>
<td></td>
</tr>
<tr>
<td>V39.8 – Other specified revisional fusion of joint of spine</td>
<td></td>
</tr>
<tr>
<td>V39.9 – Unspecified revisional fusion of joint of spine</td>
<td></td>
</tr>
<tr>
<td>V66.1 – Revisional fusion of occipitocervical junction</td>
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<tr>
<td>Code</td>
<td>Description</td>
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</tr>
<tr>
<td>V66.2</td>
<td>Revisional posterior fusion of atlantoaxial joint using transarticular screw</td>
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<tr>
<td>V66.3</td>
<td>Revisional posterior fusion of atlantoaxial joint using pedicle screw</td>
</tr>
<tr>
<td>V66.4</td>
<td>Revisional posterior fusion of atlantoaxial joint NEC</td>
</tr>
<tr>
<td>V66.8</td>
<td>Other specified other revisional fusion of joint of spine</td>
</tr>
<tr>
<td>V66.9</td>
<td>Unspecified other revisional fusion of joint of spine</td>
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</tbody>
</table>
Norfolk and Waveney Clinical Policy Development Group

Clinical Threshold Policy

Title: Surgical Discectomy (for Lumbar Disc Prolapse)

Date (approved by CPDG): 09/05/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website http://nww.knowledgeanglia.nhs.uk/ for the latest version of this policy.
This procedure will be funded by Norfolk and Waveney Clinical Commissioning Groups if the following criteria can be met:

- The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms

**AND**

- The patient has a corresponding neurologic deficit (asymmetrical depressed reflex, decreased sensation in a dermatomal distribution, or weakness in a myotomal distribution, altered bowel or bladder function)

**OR**

- The patient has radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement

**OR**

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise - positive between 30° and 70° or positive femoral tension sign)

**AND**

- Symptoms persist despite conservative management for at least 6 weeks e.g. physiotherapy, analgesics.

**AND**

- The patient must be 18 years or older - Adult Service only

**Exemptions:** Patients with severe symptoms requiring emergency admission and those patients with recent neurological deficit e.g. foot drop and equine cauda will be exempt from the threshold criteria.
## CASES FOR INDIVIDUAL CONSIDERATION

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

<table>
<thead>
<tr>
<th>CCG Variation:</th>
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<tr>
<td></td>
<td>V33.1 - Primary laminectomy excision of lumbar intervertebral disc</td>
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<td>V33.4 - Primary anterior excision of lumbar intervertebral disc NEC</td>
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<td>V33.6 - Primary anterior excision of lumbar intervertebral disc and posterior instrumentation of lumbar spine</td>
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<td>V33.7 - Primary microdiscectomy of lumbar intervertebral disc</td>
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<td>V33.8 - Other specified</td>
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<td>V33.9 - Unspecified</td>
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</table>
Norfolk and Waveney Clinical Policy Development Group

Title: Thigh/Arm Contouring

Date (reviewed and approved by CPDG): 11/04/2019

Date (approved by JSCC):

Please check the Knowledge Anglia website http://nww.knowledgeanglia.nhs.uk/ for the latest version of this policy.
Title/topic: Thigh/Arm Contouring
Status: IFR

This procedure is usually performed for cosmetic reasons and is not routinely commissioned or funded by the Norfolk and Waveney Clinical Commissioning Groups.

This procedure has been assessed as a low clinical priority by the Norfolk and Waveney CCGs and will not be funded unless there are exceptional clinical circumstances

CASES FOR INDIVIDUAL CONSIDERATION

On a case to case basis, patients might be eligible for surgical intervention, in consideration of their exceptionality. The requesting clinician must provide information to support the case for being considered an exception, by submitting an individual funding request.

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<tr>
<td>S03.2 – Thigh lift</td>
</tr>
<tr>
<td>S03.3 – Excision of redundant skin or fat of arm</td>
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## INDIVIDUAL FUNDING REQUEST
### POLICY AND PROCEDURE

<table>
<thead>
<tr>
<th><strong>Author</strong></th>
<th>Ruth Spencer</th>
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<td><strong>Review Date:</strong></td>
<td>June 2020</td>
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<tr>
<td><strong>Version Number:</strong></td>
<td>5.0</td>
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Version History

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

<table>
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<th>Version Number</th>
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<td>Annual update</td>
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GLOSSARY

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1. Introduction

The NHS Norfolk & Waveney Clinical Commissioning Groups (N&W CCGs) wish to operate a policy for decision making in respect of non-drug Individual Funding Requests (IFR). This document sets out the operating policy.

Like any other organisation, the NHS has limited resources, and N&W CCG duty to manage them to a robust process.

Clinicians, on behalf of their patients, are entitled to make an individual IFR application to the IFR Panel for treatment to be funded by the N&W CCGs that is not normally commissioned by the N&W CCGs under defined conditions. Namely:

The request does not constitute a service development

AND

The patient is suffering from a medical condition for which the N&W CCGs have a policy but where the patient’s particular clinical circumstances fall outside the criteria set out in the existing commissioning policy for funding the requested treatment – a request for exceptional funding

OR

The patient is suffering from a medical condition, or requesting a treatment, for which the N&W CCGs have no policy – a request for individual funding

OR

The patient has a rare clinical circumstance, rendering it impossible to carry out clinical trials, and for whom the clinician wishes to use an existing treatment on an experimental basis.

2. Equality Statement

The N&W CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as outlined in the Health and Social Care Act 2012. The N&W CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), marriage and civil partnership, pregnancy and maternity, race, religion or belief or sexual orientation. In carrying out its functions, the N&W CCGs will have due regard of the Equality Act 2010, the NHS Constitution and the Human Rights Act 1998.

3. Information Governance

All individual funding requests will be reviewed by Arden and Gem (AGEM) Commissioning Support Unit (CSU) on behalf of the N&W CCGs as the statutory body responsible for funding decisions. The individual funding request form and any other supporting information supplied may therefore be shared with the N&W CCGs or other trusted organisations legitimately acting on behalf of the N&W CCGs. IFR panel meeting minutes, will not be made available in the public domain. Personal information may be retained only for the purposes of the IFR application and, in some cases, may be used for invoicing and payment reconciliation.
Patient’s medical records may be used for the purposes of quality audit which will be completed by a Health professional. Anonymised information may also be shared as part of the N&W CCGs reporting processes.

4. Clinical Exceptionality

The responsibility is on the clinical applicant to set out the grounds clearly for the panel on which it is said that the patient is exceptional. The grounds will usually arise out of exceptional clinical manifestations of the medical condition, as compared to the general population of patients with the medical condition which the patient has. These grounds must set out on the form provided by N&W CCGs and should clearly set out any factors which the clinician invites the panel to consider as constituting a case of exceptional clinical circumstances.

Exceptional in IFR terms means a person to whom the general rule should not apply. This implies that there is likely to be something about their clinical situation which was not considered when formulating the general rule. Very few patients have clinical circumstances which are genuinely exceptional.

The fact that a treatment is likely to be efficacious for a patient, is not in itself a basis for exceptionality.

If a patient’s clinical condition matches the ‘accepted indicators’ for a treatment that is not funded, their circumstances are not by definition, exceptional.

5. Policy

5.1 – Consultation Process
All affected Providers, Primary Care and other appropriate stakeholders will be given the opportunity to engage in the policy development process via the Clinical Policy Development Group. The Clinical Policy Development Group will consider all feedback received and where appropriate, are willing to make amendments as suggested.

5.2 – Acute Contract
Revisions are to be agreed using the contract variation in the National Contract. Once agreement is reached between the Provider and the Commissioner, at every amended/new phase, a contract variation proposal to the NHS Standard Acute Contract will be made detailing the changes, updated policy and timescales for implementation in line with relevant contract clauses.

5.3 – Clinical Thresholds Policy
Once the procedures and thresholds for any new or existing phase are decided the Clinical Thresholds Policy will be amended, uploaded on to Knowledge Anglia and disseminated out to appropriate Providers and stakeholders.

5.4 – Knowledge Anglia
The IFR policy and the IFR template can be found on the Knowledge Anglia website available for downloading at: Great Yarmouth and Waveney; North Norfolk; Norwich; South Norfolk; West Norfolk
6. Roles & Responsibilities

6.1 – Individual Funding Request Process – Providers, Including General Practice

Providers, including General Practice, are to ensure the following:

The Clinical Thresholds Policy, IFR form and other associated documentation is shared and communicated internally with all relevant staff to ensure compliance with the Policy.

Clinicians will take the N&W CCGs, clinical threshold policies into account in the advice and guidance given to patients prior to making the decision to request an IFR. The IFR process is discussed with the patient in clinic to ensure the patient understands the process regarding funding requirements and consent to share information. The IFR leaflet should be given to the patient to assist with this discussion.

An IFR form must be completed by the relevant supporting clinician for the patient. The request forms are available on the Knowledge Anglia website at; http://nww.knowledgeanglia.nhs.uk/KMS.aspx or via email request nw.ifr@nhs.net

The completed IFR form should be submitted to AGEM CSU using the agreed template.

The IFR form must be completed to indicate patient consent. If this is not confirmed, the form will be returned to the supporting clinician by the IFR Team.

Once a request has been submitted for funding, the clinician will respond to queries and/or requests for further information by AGEM CSU or the designated N&W CCG in a timely manner.

All communication with the patient is the responsibility of the requesting clinician. The requesting clinician is responsible for informing the patient of the ultimate decision.

If an IFR is returned to the referring clinician approved, the patient should be referred or listed for the requested procedure and the relevant authorisation number recorded by the hospital according to their local policies and procedures.

If an IFR is declined, it will be returned to the referring clinician, the patient should not be referred or listed for the procedure.

6.2 – Individual Funding Request Process – AGEM CSU

Please see attached Appendix A for a flowchart of the AGEM CSU IFR process. In summary;

IFR Panels will be administered by AGEM Commissioning Support Unit.

IFR Panels will be held on a monthly basis.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Time Frame</th>
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<tbody>
<tr>
<td>Acknowledgement letter sent to referring clinician</td>
<td>AGEM CSU to complete within 5 working days of receipt</td>
</tr>
<tr>
<td>Admin Triage - To ascertain if further information is required</td>
<td>AGEM CSU to complete within 15 working days of receipt</td>
</tr>
<tr>
<td>Panel papers circulated to panel members</td>
<td>AGEM CSU to administrate within 5 working days of monthly panel meeting</td>
</tr>
<tr>
<td>Decision communicated to referring clinician</td>
<td>AGEM CSU to administrate within <strong>5 working days</strong> after panel</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Urgent Requests</td>
<td>IFR panel members to provide a decision. AGEM CSU to administrate within <strong>5 working days</strong></td>
</tr>
<tr>
<td>If any further information requested by IFR team fails to be submitted the IFR case will be lapsed and referrer will be notified with the option to re-submit.</td>
<td>Cases to be processed by AGEM CSU within <strong>40 working days</strong> of receipt</td>
</tr>
</tbody>
</table>

The IFR Team at the AGEM CSU will process requests from receipt to decision letter within 40 working days (this timeframe will be subject to any requested information awaited from the referrer/clinician/patient).

**6.3 – Individual Funding Request Process N&W CCG**
Norfolk & Waveney CCGs will ensure the following;

The N&W CCGs will appoint a chair for the IFR (non-drugs) Panel.

The N&W CCGs will ensure there is a clinical representative from their respective organisations at each IFR Panel meeting. The N&W CCG’s representative will have delegated authority to make decisions on behalf of their individual N&W CCG.

Norfolk County Council will provide Public Health advice on the IFR Panel as part of the Core Offer to N&W CCGs.

**6.4 - IFR Re-consideration Panel**
Where the IFR Panel has declined a request or has approved treatment subject to conditions, the patient shall be entitled to ask that the decision of the IFR Panel be re-considered. Requests for re-consideration must be submitted within 6 months of decision. The referring clinician must clearly outline the reasons for the re-consideration and/or the clinician requesting the re-consideration must submit new clinical evidence to the panel.

Re-consideration would be considered on one of the following grounds only;

- That further evidence can be provided by the referring clinician and is duly submitted; and/or

  - It was in the clinician’s opinion a decision which no reasonable IFR Panel would have reached.

**6.5 - IFR Appeals Panel**
Where all relevant information was available to the IFR Panel when the decision was made, but the referring clinician remains dissatisfied with the decision, the referring clinician may request that the case is reviewed by an Appeals Panel. Submission for a case to appeal must be submitted within 6 months of notification of reconsideration decision.
An appeals panel would consist of a designated chairperson supported by a minimum of two other clinical panel members, who are not members of non-drugs IFR panel. The appeals process remains the responsibility of the N&W CCGs.

Appeals process would be considered on one of the following grounds only;

- Due process was not followed;

Or

- The IFR panel failed to give a clear rationale for its decision.

The IFR Team will arrange for either an IFR Re-consideration or IFR Appeals Panel to be set up following receipt of a formal request, within the appropriate timeframes and guidelines.

7. Urgent Requests

IFR requests marked as urgent, the IFR Panel will aim to make a decision within 5 working days of receipt. An urgent request is one which requires urgent consideration and a decision because the patient faces a substantial risk of death or significant harm if a decision is not made before the next scheduled meeting of the IFR Panel. If the referring clinician considers that treatment cannot be delayed and decides to treat immediately then the cost of such treatment is incurred at the risk of the Provider.

The N&W CCGs recognise that there will be occasions when an urgent decision needs to be made to consider approving funding for treatment for an individual patient outside the N&W CCG’s normal policies. In such circumstances the N&W CCGs recognise that an urgent decision may have to be made before a panel can be convened. The following provisions apply to such a situation.

- Urgency under this policy cannot arise as the result of a failure by the Clinical Team expeditiously to seek funding through the appropriate route and/or where the patient’s legitimate expectations have been raised by a commitment being given by the provider trust to provide a specific treatment to the patient. In such circumstances the N&W CCGs expect the provider trust to proceed with treatment and for the provider to fund the treatment.

- In situations of clinical urgency, the decision will be made by a clinical lead delegated by the N&W CCG’s to make an urgent decision as set out in the N&W CCG’s Standard Operational Procedures (SOP) for the Management of Individual Funding Requests.

- The clinical lead will as far as possible within the constraints of the urgent situation, follow the policy set out above in making the decision. The clinical lead shall consider the nature and severity of the patient’s clinical condition and the time period within which the decision needs to be taken. As much information about both the patient’s illness and the treatment should be provided as is feasible in the time available and this shall be considered for funding in accordance with relevant existing commissioning policies.
The clinical lead shall be entitled to reach the view that the decision is not of sufficient urgency or of sufficient importance that a decision needs to be made outside of the usual process.

The IFR administrative team will submit anonymised urgent requests via e-mail to N& W CCGs IFR panel members.

The IFR Panel will aim to make a decision within 5 working days of receipt of the request. Trusts should treat all urgent and life-threatening situations based on the clinical need.

Urgent requests will also be discussed at the next available panel meeting and a record added to the minutes.

8. Q & A Section

8.1 - What is a service development?
A service development is any aspect of healthcare which the N&W CCGs has not historically agreed to fund, and which will require additional and predictable recurrent funding.

All individual funding requests submitted to N&W CCGs will be subject to screening by the IFR Panel and N&W CCGs, to determine whether the request represents a service development. Service developments include, but are not restricted to:

- New services
- New treatments including medicines, surgical procedures and medical devices.
- Developments to existing treatments including medicines, surgical procedures and medical devices.
- New diagnostic tests and investigations.
- Quality improvements.
- Requests to alter existing policy (called a policy variation). The proposed change could involve adding in an indication for treatment, expanding access to a different patient sub-group or lowering the threshold for treatment.
- Requests to fund a number of patients to enter a clinical trial and the commissioning of a clinical trial are considered as service developments in this context as they represent a need for additional investment in a specific service area.

A request for a treatment should be classified as a request for a service development if there are likely to be a cohort of similar patients who are:

- In the same or similar clinical circumstances as the requesting patient whose clinical condition means that they could make a like request (regardless as to whether such a request has been made) AND
- Who could reasonably be expected to benefit from the requested treatment to the same or a similar degree.
It is common for clinicians to request an individual funding request for a patient where the request is properly analysed, the first patient of a group of patients wanting a particular treatment. Any individual funding request which is representative of this group represents a service development. As such it is difficult to envisage circumstances in which the patient can properly be classified to have exceptional clinical circumstances. Accordingly, the individual funding request route is usually an inappropriate route to seek funding for such treatments as they constitute service developments.

8.2 - What is a “cohort of similar patients”?
A cohort of similar patients for the purposes of this policy has been defined as the number of requests received or likely to be received per year which will require consideration of a commissioning policy. In these circumstances, the IFR route to funding may only be considered if the patient is clinically exceptional to the cohort.

8.3 - When should consideration of a commissioning policy be given?
The N&W CCGs have set the level at which cases will require consideration of a commissioning policy. Once this number of requests is met, the IFR route to funding may only be considered if the patient is clinically exceptional to the cohort.

The N&W CCGs will consider the development of a clinical commissioning policy where:

- The numbers of patients for whom the treatment will be requested per year is likely to be 5 or more patients in the population served by N&W CCGs. Upon receipt of the fifth request for funding a business case/clinical commissioning policy will be requested. (The IFR Panel will continue to have the right to make decisions on any further similar applications for funding whilst a policy is in the process of being produced.)
  
  OR

- The cost of funding the requested treatment for an individual is likely to result in expenditure to the N&W CCGs in excess of £50,000.

If the number of patients for whom the treatment is requested is likely to be below 5 per year, the IFR Panel will consider the request for funding.

The IFR Panel is not entitled to make policy decisions for N&W CCGs. It follows that where a request has been classified as a service development for a cohort of patients, the IFR Panel is not the correct body to make a decision about funding the request. In such circumstances the individual funding request should not and will not be presented to the IFR Panel but will be dealt with in the same way as other requests for a service development through N&W CCGs due processes (the IFR Panel will continue to have the right to make decisions on further similar applications whilst a policy is in the process of being developed).

Where an IFR has been classified as a service development for a cohort of patients, the options open to the IFR Panel include:

- To refuse funding and request the provider prioritises the service development internally within the provider organisation that made the request and, if supported, to invite the provider to submit a business case as part of the annual commissioning round for the requested service development
• To refuse funding and initiate an assessment of the clinical importance of the service development within the N&W CCGs with a view to developing a policy and determining its priority for funding in the next financial year

• To refer the request for funding for immediate workup of the service development as a potential candidate for in year service development.

In practice, all requests for funding for an individual patient have been called Individual Funding Requests (IFRs) but these sub-categories of request should be recognised.

The broad types of request that may be received are;

• Representing a service development for a cohort of patients
• On grounds of clinical exceptionality where there are commissioning arrangements in place
• On grounds of rarity and no commissioning arrangements exist
• For a new intervention or for use of an intervention for a new indication, where no commissioning arrangements exist

There can be no exhaustive definition of the conditions which are likely to come within the definition of an exceptional individual case. The word ‘exception’ means;

‘a person, thing or case to which the general rule is not applicable’.

To meet the definition of ‘exceptional clinical circumstances’ there must be a N&W CCG policy in place that describes the availability of the requested intervention and the patient (or their clinician must demonstrate that they are both):

• Significantly different clinically to the group of patients with the condition in question and at the same stage of progression of the condition
  AND
• Likely to gain significantly more clinical benefit than others in the group of patients with the condition in question and at the same stage of progression of the condition

8.4 - What are non-clinical factors?
The N&W CCGs do not discriminate on grounds of social factors (for example, but not limited to: age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors). Social factors will not be taken into account in determining whether exceptionality has been established.

The N&W CCGs will seek to commission treatment based on the presenting clinical condition of the patient and not based on the patient’s non-clinical circumstances.

In reaching a decision as to whether a patient’s circumstances are exceptional, the panel is required to follow the principles that non-clinical factors including social value judgements about the underlying medical condition or the patient’s circumstances are not relevant.
Clinicians are asked to bear this policy in mind and not refer to non-clinical factors to seek to support the application for individual funding.

8.5 - How do you prove the patient’s circumstances are exceptional?
The responsibility is on the clinical applicant to set out the grounds clearly for the panel on which it is said that this patient is exceptional.

The grounds will usually arise out of exceptional clinical manifestations of the medical condition, as compared to the general population of patients with the medical condition which the patient has. These grounds must be set out on the form provided by the N&W CCG’s and should clearly set out any factors which the clinician invites the panel to consider as constituting a case of exceptional clinical circumstances. If a clear case as to why the patient’s clinical circumstances are said to be exceptional is not made out, then the panel can do no other than refuse the application.

The panel recognises that the patient’s referring clinician and the patient together are usually in the best position to provide information about the patient’s clinical condition as compared to a subset of patients with that condition.

The referring clinician is advised to set out the evidence in detail because the panel will contain a range of individuals with a variety of skills and experiences but may well not contain clinicians of that speciality. The N&W CCGs therefore requires the referring clinician, as part of their duty of care to the patient, to explain why the patient’s clinical circumstances are said to be exceptional.

There may be cases where clinicians and/or patients seek to rely on multiple grounds to show their case is exceptional. In such cases the panel should look at each factor individually to determine;

(a) whether the factor was capable of making the case exceptional and
(b) whether it did in fact make the patient’s case exceptional

The panel may conclude, for example, that a factor was incapable of supporting a case of exceptionality and should therefore be ignored. That is a judgment within the discretion of the panel.

If the panel is of the view that none of the individual factors on their own make the patient’s clinical circumstance exceptional, the panel should then look at the combined effect of those factors which are, in the panel’s judgement, capable of supporting a possible finding of exceptionality. The panel should consider whether, in the round, these combined factors demonstrate that the patient’s clinical circumstances are exceptional. In reaching that decision the panel should remind itself of the difference between individual distinct circumstances and exceptional clinical circumstances.

8.6 - What is rarity in an IFR?
The assessment of these funding requests should be distinguished from requests on the grounds of exceptionality.

A set of criteria need to be applied when a patient’s medical condition is so rare or their condition is so unusual that the clinician wishes to use an existing treatment in an experimental
way. This exception does not routinely apply to rare disorders or small subgroups of patients within a more common disorder because here it would be normal to have a trial involving sufficient patients formally to evaluate the proposed treatment in a trial.

In assessing these cases the panel should consider the following;

- Can this treatment be studied properly using any other established method? If so then funding should be refused.
- Is the treatment likely to be clinically effective?
- In addition, the usual considerations are included. Whether the treatment is cost effective, and what is this patient’s priority compared to patients whose care has not been funded.

8.7 - What is Triage?
Requests are subject to a triage process to determine whether the request has sufficient clinical and other information for the individual funding request to be considered fully by the IFR Panel.

All requests will be triaged prior to presenting at the IFR Panel. Triage will consider the information provided in the request against any relevant commissioning policies and make recommendations for the panel to consider. Recommendations include;

- Approved
- Declined
- Further clinical debate required at panel

Sometimes, triage will determine that more information is required to progress the request and the referrer will be contacted.

8.8 - What happens with IFRs which have passed triage?
An exceptionality request can be made in relation to a medical condition where the N&W CCGs have a Commissioning Policy but the patient’s clinical circumstances or the requested treatment falls outside the N&W CCGs Policy. These exceptionality requests should be completed by the clinician with reference to the relevant generic and/or treatment specific commissioning policy.

The IFR Panel shall be entitled to approve funding if the patient has exceptional clinical circumstances. In considering whether to fund a patient on grounds of exceptional clinical circumstances, in this situation, the IFR Panel will act as follows:

- The IFR Panel will use the information provided by the requester to compare the patient to other patients with the same presenting medical condition at the same stage of progression. Specifically, the panel may consider, based upon the evidence provided to it, whether the patient has demonstrated exceptional clinical circumstances which lead the panel to believe that the patient would benefit significantly more from the treatment than the other patients not meeting funding criteria.
- When making their decision, the IFR Panel is required to restrict itself to considering only the patient’s presenting medical condition and the likely benefits which have been
demonstrated by the evidence to be likely to accrue to the patient from the proposed treatment.

- The IFR Panel shall seek to make decisions in accordance with the NHS ethical framework & principles, including the requirement to have due regard to the obligations of the Equality Act 2010 save where a difference in treatment is based on objectively justifiable factors and is a justified and proportionate response to the needs of different groups of patients.

- The IFR Panel shall seek to make decisions in accordance with the 1998 Human Rights Act.

- The IFR Panel will not make decisions for treatments available to individual patients, or other clinically similar patients, on the basis of non-clinical factors.

The IFR Panel shall be entitled to approve funding an experimental treatment for patients with rare clinical conditions or clinical circumstances.

In considering whether to agree to fund the treatment the IFR Panel's consideration shall include the following factors:

- The potential benefit and risks of the treatment

- The biological plausibility of anticipated benefit for the patient based on evidence of this treatment in other similar disease states

- Value for money

- Where the request is in respect of more than one patient or it is clear from the nature of the request that there is likely to be more than one patient, then the IFR Panel should consider whether the request is a service development or trial.

8.9 – Retrospective payments for funding?

Individual Funding Requests will not be accepted where the request is for retrospective funding e.g. requests from clinicians or providers made after a period of care has commenced or request from patients for reimbursement of the costs of a treatment which has been purchased privately. Treatments that are undertaken, without funding approval or agreement, will be at the risk of the provider.

8.10 - What information is submitted to the IFR Panel?

All applications must be accompanied by written support and evidence provided by the clinical team treating the patient. It is the clinician’s responsibility to ensure that the appropriate information is provided to the N&W CCG according to the type of request being made, in a timely fashion consistent with the urgency of the request. If relevant information is not submitted, then the referring clinician will bear responsibility for any delay that this causes.

All clinical teams submitting IFR requests must be aware that information that is immaterial to the decision will not be considered by the IFR Panel. This may include information about non-
clinical factors relating to the patient or information which does not have a direct connection to the patient's clinical circumstances.

An electronic request form must be completed by the referring clinician. The request forms are available on the Knowledge Anglia website at; 
http://nww.knowledgeanglia.nhs.uk/KMS.aspx or via email request nw.ifr@nhs.net
Requests for patients covered by NHS England’s responsibilities should be sent directly to them.

If further information is required to prepare the case for consideration by the IFR Panel this may delay presentation to the IFR Panel. All required information from the provider hospital trust/clinician must be sent to the IFR Administrator at least 10 working days before the scheduled date of the IFR Panel at which the case is to be considered.

All applications must be accompanied by written support and evidence provided by the clinical team treating the patient explaining:

- Whether the request for funding is an individual request or an exceptional request.
- The clinical circumstance of the patient. The Clinical Team is required to present a full report to the IFR Panel which sets out a comprehensive and balanced clinical picture of the history and present state of the patient’s medical condition, the nature of the treatment requested and the anticipated benefits of the treatment.
- The planned treatment and the expected benefits and risks of treatment. The Clinical Team shall describe the anticipated clinical outcomes for the individual patient of the proposed treatment and the degree of confidence of the Clinical Team that the outcomes will be delivered for this particular patient.
- The evidence on which the clinical opinion is based. The clinician shall refer to, and include, copies of any clinical research material which supports, questions or undermines the case that is being made that the treatment is likely to be clinically effective in the case of the individual patient.
- The Clinical Team shall set out the full attributable costs of and connected to the treatment.
- Whether or not there are likely to be similar patients either within the N&W CCGs or across the region. For exceptionality requests the clinician must also provide the case for treating this patient and no other apparently similar patients.

8.11 - How does the IFR Panel approve requests?
The IFR Panel shall be entitled to approve requests for funding for treatment for individual patients where all the following conditions are met:

- The IFR Panel is satisfied that there is no cohort of similar patients. If there is a cohort of similar patients the IFR Panel shall decline to make a decision because the application is required to be treated as a request for a service development. (The IFR Panel will continue to have the right to make decisions on any further similar applications for funding whilst a policy is in the process of being produced.)
• The request does not constitute a service development.

• The patient is suffering from a medical condition for which the N&W CCGs has a policy but where the patient’s particular clinical circumstances fall outside the criteria set out in the existing commissioning policy for funding the requested treatment.

• The patient is suffering from a medical condition, or requesting a treatment, for which the N&W CCG has no policy.

• The patient has a rare clinical circumstance, this rendering it impossible to carry out clinical trials, and for whom the clinician wishes to use an existing treatment on an experimental basis.

• Exceptional circumstances apply where there is sufficient evidence to show that, for the individual patient, the proposed treatment is likely to be clinically and cost effective or that the clinical trial has sufficient merit to warrant NHS funding.

The IFR Panel is not required to accept the views expressed by the patient or the clinical team concerning the likely outcomes for the individual patient of the proposed treatment, but it is entitled to reach its own views on:

• The likely clinical outcomes for the individual patient of the proposed treatment;

  AND

• The quality of the evidence presented to support the request and/or the degree of confidence that the IFR Panel has about the likelihood of the proposed treatment delivering the proposed clinical outcomes for the individual patient.

The IFR Panel may make such approval contingent on the fulfilment of such conditions as it considers fit.

Very occasionally an individual funding request presents a new issue which needs a substantial piece of work before the N&W CCGs can reach a conclusion upon its position. This may include wide consultation. Where this occurs the IFR Panel may adjourn a decision on an individual case until that work has been completed.

8.12 - How are IFR Panel decisions communicated?
The referring clinician making the request will be informed of the IFR Panel’s decision as soon as practicable via email within 5 working days. Patient confidentiality will be maintained at all times.

8.13 - Will the IFR Panel give reasons as to why a decision has been made?
The NHS Constitution requires NHS organisations to make decisions ‘rationally following a proper consideration of the evidence’ and be clear about the reasons for their decisions. The N&W CCGs will give reasons for its decisions.
The purpose of a duty to give reasons is to tell the patient in general terms why the N&W CCGs reached the decision it did and the factors that it considered in reaching the decision.

Where a public body is required to give reasons for its decision, it is required to give reasons which are proper, adequate, and intelligible and enable the person affected to know why they have been approved or declined. These can be expressed in a few sentences, but they need to go into sufficient detail so that the patient knows that the main aspects of their case have been properly considered.

Whether the N&W CCG’s IFR Panel has or has not discharged the duty to give reasons will all depend on the individual circumstances. There will be simple cases where a single sentence is sufficient and there will be more complex cases where a full paragraph or two is needed to explain the thinking of the IFR Panel, and the rationale for the panel’s decision.

The duty will usually mean that the decision letter should explain:

- Whether the panel reached the view that the patient did or did not demonstrate exceptional clinical circumstances, and the basis for that decision. If the panel felt that the patient’s clinical circumstances were broadly in line with the clinical circumstances of those in the cohort of other patients in the same clinical condition, then this should be stated.

- If the patient put forward specific factors which were said to support his or her claim to be in exceptional clinical circumstances, the letter should explain (by reference to the main factors) why the panel did not consider that these amounted to exceptional clinical circumstances.

### 8.14 - Can the IFR Panel decision be reviewed?

Where the IFR Panel has declined a request or has approved the treatment subject to conditions, the patient shall be entitled to ask that the decision of the IFR Panel be reviewed. All requests for a review must be supported by the senior treating clinician in writing to the IFR Administrator within 6 months from the date of notification of the date of the IFR Panel’s decision. The clinician must clearly outline the reasons as to why a review is requested. It will be either:

- That further evidence can be provided by the referrer and is duly submitted; and/or

- It was in the clinician’s opinion a decision which no reasonable IFR Panel would have reached.

The IFR Administrator will prepare the additionally submitted evidence for discussion at the next available panel meeting. The IFR Panel will then review its initial decision based on any additional information received. The result of the review will be communicated to the referring clinician who must then notify the patient of the panel’s decision.

Should the referring clinician or patient remain dissatisfied with the IFR Panel decision, the matter may be pursued through the NHS Complaints Procedure. This can be done by contacting: snccg.complaintsservice@nhs.net or by telephone 01063 595857.

### 8.15 - Can the IFR Panel decision be appealed against?

Where all the relevant information was available to the IFR Panel when the decision was
made, but the referring clinician remains dissatisfied with the decision, they may request that it be reviewed by an IFR Appeals Panel on one of the following grounds only:

a) Due process was not followed  
OR  
b) The IFR Panel failed to give a clear rationale for its decision

In the case of failure to follow due process or an inadequate rationale for the IFR Panel decision, the referring clinician may request an IFR Appeals Panel review by making a formal request in writing to the IFR Administrator within 6 months of the date of the IFR Panel’s decision.

The IFR Administrator will arrange for an IFR Appeals Panel to be set up. This will normally be the next available IFR Drugs Panel.

The IFR Appeals Panel will review the process followed by the IFR Panel. The IFR Appeals Panel will reach a decision within 30 working days of the IFR Administrator referring the case to them.

The role of the IFR Appeals Panel is to determine whether the IFR Panel has followed its own procedures, has properly considered the evidence presented to it and has come to a reasonable decision upon the evidence.

In the event that the IFR Appeals Panel considers that the IFR Panel has:

- Failed in a material way to follow its own procedures; and/or
- Failed in a material way properly to consider the evidence presented to it (e.g. by taking account of an immaterial fact or by failing to take account of a material fact); and/or
- Failed to give a clear rationale for its decision;

The IFR Appeals Panel shall uphold the patient’s appeal and shall refer the case for reconsideration by the IFR Panel.

The IFR Appeals Panel shall not have power to authorise funding for the requested treatment but shall have the right to make recommendations to the IFR Panel.

The IFR Appeals Panel will set out its decision and the reasons for it as soon as practicable in writing via e-mail or letter to the IFR Panel and the referring clinician. It is the responsibility of the referring clinician to notify the patient in a timely manner of the IFR Appeals Panel decision.

Should the referring clinician or patient remain dissatisfied with the IFR Appeals Panel decision, the matter may be pursued through the NHS Complaints Procedure. This can be done by contacting: snccg.complaintsservice@nhs.net or telephone: 01063 595857.

8.16 – Decisions on Funding

The IFR panel is committed to ensuring that decision making is transparent, fair and equitable. At all times, decision to fund treatments will be based upon both national and local guidance. Where there is no guidance available, or to be ratified, the panel will make decisions based upon rational and supporting evidence submitted to support the IFR application.
The standard policy is available on N&W CCG website and is accessible to all.
Glossary

**Appeal** refers to the process where the referring clinician can request that the IFR Panel decision is assessed, either on the basis that due process was not followed by the IFR Panel or that the IFR Panel failed to give a clear rationale for its decision.

**Clinical circumstances** means a full history of the patient’s medical condition, a full description of the patient’s present medical condition and as comprehensive an assessment of the patient’s future medical condition and prognosis as the Clinical Team treating the patient is able to provide.

**Clinical Commissioning Group** is a statutory organisation responsible for purchasing health and care services for patients.

**Cohort** of similar patients for the purposes of this policy has been defined as the number of requests received or likely to be received per year which will require consideration of a commissioning policy.

**Exceptional clinical circumstances** refers to a patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients with the same medical condition and at the same stage of progression as the patient.

**IFR Panel** is the committee of CCG clinicians who have been given authority by CCG Governing Bodies to make individual funding request decisions on its behalf in line with the legal duties of CCGs set out in The Health & Social Care Act 2012.

**Individual funding request** is a request received from a clinician which seeks funding for a single identified patient for a specific treatment.

**NHS Constitution** refers to the established principles and values of the NHS in England.

**NICE** refers to the National Institute for Health & Care Excellence. They provide national guidance and advice to improve health and social care.

**Policy** refers to a written document determining whether or not a particular treatment is commissioned.

**Policy variation** occurs when an existing policy is changed. When there is a proposal which would result in increased access to a treatment (for example by lowering the threshold for treatment or adding a new indication for treatment) the policy variation is a service development and will be treated as such.

**Rarity** refers to a patient whose medical condition is so rare, or their condition is so unusual that the clinician wishes to use an existing treatment in an experimental way.

**Review** refers to the process where the referring clinician can request the IFR Panel decision is reviewed, either on the basis that further evidence can be provided in support of the IFR or
that the decision, in the clinician’s opinion, was one which no reasonable IFR Panel would have reached.

**Service Development** refers to any aspect of healthcare which the CCG has not historically agreed to fund, and which will require additional and predictable recurrent funding.

**Social factors** are, for example, (but not limited to) age, gender, ethnicity, employment status, parental status, marital status, religious/cultural factors.

**Treatment** means any form of healthcare intervention which has been proposed by a clinician and is proposed to be administered as part of NHS commissioned and funded healthcare.

**Triage** is a process to determine whether the request has sufficient clinical and other information in order for it to be fully considered by the IFR Panel.

**Urgent request** requires urgent consideration and a decision because the patient faces a substantial risk of death or significant harm.
<table>
<thead>
<tr>
<th>Subject:</th>
<th>Norfolk and Waveney CCGs 360° Survey Results</th>
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<tbody>
<tr>
<td>Presented By:</td>
<td>Melanie Craig - Chief Officer – Norfolk &amp; Waveney CCGs</td>
</tr>
<tr>
<td>Prepared By:</td>
<td>Heather Farley – Assistant Director – Corporate Services – WNCCG</td>
</tr>
<tr>
<td>JSCC Sponsor:</td>
<td>Melanie Craig - Chief Officer – Norfolk &amp; Waveney CCGs</td>
</tr>
<tr>
<td>Submitted To:</td>
<td>Norfolk JSCC – 18th June 2019 – Meeting in Public</td>
</tr>
<tr>
<td>Purpose of Paper:</td>
<td>Information</td>
</tr>
</tbody>
</table>

**Summary:**

The CCG 360° Stakeholder Survey is conducted on a yearly basis by Ipsos Mori on behalf of NHS England. The survey assesses how stakeholders perceive the CCGs and the results contribute to NHS England’s statutory annual assessment of CCGs. CCGs can invite a range of stakeholders to take part including Member Practices, other CCGs, Health and Wellbeing Boards, Healthwatch, voluntary sector organisations and acute and community providers.

The process for gathering information for this year’s survey began last November and CCGs were asked to compile and upload lists of stakeholders to an online portal by 30 November 2018. The survey period took place between 14 January 2019 and 22 February 2019. Final reports were published on 1 April 2019. The results are published on CCG websites.

The results are an average of the individual results for each of the five CCGs. This is the first time Ipsos Mori have been asked to present an amalgamated data and therefore there are no trends available. However national and regional benchmarking is shown.

CCGs are reviewing the document and agreeing actions to improve their results.

**Summary of key results**

- **Red** results are those where the Norfolk and Waveney CCGs’ results are at least 5% less positive than the national result.

**Overall engagement**

- Effectiveness of working with the CCG - 87% rate as very good or fairly good (88% national)
- Effectiveness as local system leader (i.e. as part of ICS/STP) - 72% rate as very effective or fairly effective (national 74%)

**Leadership and partnership working in the local health and care system**

- The CCGs consider the benefits to the whole health and care system when taking a decision – 74% strongly agree or tend to agree (79% national)
- The CCG actively avoids passing on problems to another system partner – 65% strongly agree or tend to agree (64% national)
- The CCG works collaboratively with other system partners on the vision to improve the future health of the population across the whole system – 80% strongly agree or tend to agree (82% national)
Core functions
- Improvement health outcomes for its population – 68% rate as very effective or fairly effective (76% national)
- Reducing health inequalities – 54% rate as very effective or fairly effective (63% national)
- Delivering value for money – 66% rate as very effective or fairly effective (65% national)
- Improving the quality of local health services – 71% rate as very effective or fairly effective (74% national)

Commissioning/decommissioning services
- The CCG involves the right individuals and organisations when commissioning/decommissioning services – 68% strongly agree or tend to agree (66% national)
- The CCG asks the right questions at the right time when commissioning services – 58% strongly agree or tend to agree (58% national)
- The CCG engages effectively with patients and the public, including those groups within the local population who are at risk of experiencing poorer health outcomes when commissioning services – 52% strongly agree or tend to agree (62% national)
- The CCG demonstrates that it has considered the views of patients and the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care, when it is commissioning/decommissioning services – 58% strongly agree or tend to agree (62% national)

Participants

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>No of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
</tr>
<tr>
<td>Health and wellbeing boards</td>
<td>9</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
</tr>
</tbody>
</table>

Response Rates

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Average response rate across the CCGs within the STP</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices (one from every member practice)</td>
<td>75%</td>
</tr>
<tr>
<td>Health and wellbeing boards (up to two per HWB)</td>
<td>95%</td>
</tr>
<tr>
<td>Local Healthwatch (up to three per local Healthwatch)</td>
<td>70%</td>
</tr>
<tr>
<td>Other patient groups and voluntary sector organisations or representatives (up to eight)</td>
<td>69%</td>
</tr>
<tr>
<td>NHS providers (up to two from each acute, mental health and community health providers)</td>
<td>66%</td>
</tr>
<tr>
<td>Other CCGs (up to five)</td>
<td>90%</td>
</tr>
<tr>
<td>Upper tier/unitary LA (up to five per local authority)</td>
<td>30%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>73%</td>
</tr>
<tr>
<td>All stakeholders</td>
<td>70%</td>
</tr>
</tbody>
</table>

Note:
Following further scrutiny of the report sent to West Norfolk CCG, it became evident that it contained a number of errors. The CCG notified Ipsos Mori and NHS England and were informed that a “processing error” had resulted in 13 out of 56 stakeholders not being invited to complete the survey as they should have been. Ipsos Mori has apologised and had omitted 13 stakeholders who were
therefore not invited to take part in the survey. Whilst IPSOS Mori updated the report there will still
concerns over accuracy and so the report has been made invalid, not published and will not be taken
into account by NHS England assessment.

**Recommendation:**

JSCC is asked to note the outcome of the Norfolk and Waveney CCGs 360° Survey Results.
Findings for CCGs in Norfolk and Waveney Health & Care Partnership STP

CCG 360° Stakeholder Survey 2018-19
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Summary

The following charts show the summary findings for the following CCGs (Great Yarmouth and Waveney CCG, North Norfolk CCG, Norwich CCG, South Norfolk CCG, West Norfolk CCG) in Norfolk and Waveney Health & Care Partnership STP, indicating the percentage of stakeholders responding positively to the key survey questions.

Please note that sampling occurred at CCG level, thus the question wording relates to individual CCGs. The results presented here for Norfolk and Waveney Health & Care Partnership STP are an average of the results for all the individual CCGs within the STP. As this analysis has been done for the first time this year, no trends are available at STP level.

Overall Engagement

Overall, how would you rate the effectiveness of your working relationship with the CCG?

% very good/fairly good

Overall, how would you rate (the CCG’s) effectiveness as a local system leader, i.e. as part of an Integrated Care System (ICS)/Sustainable Transformation partnership (STP)?

% very effective/fairly effective

Leadership and partnership working in the local health and care system

To what extent do you agree or disagree with EACH of the following statements:

% strongly agree/tend to agree

The CCG considers the benefits to the whole health and care system when taking a decision.

The CCG actively avoids passing on problems to another system partner.

The CCG works collaboratively with other system partners on the vision to improve the future health of the population across the whole system.

Norfolk and Waveney Health & Care Partnership STP

Base = all stakeholders 159
How would you rate the effectiveness of the CCG at doing EACH of the following:

- Improving health outcomes for its population: 68%
- Reducing health inequalities: 54%
- Delivering value for money: 66%
- Improving the quality of local health services: 71%

To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

- The CCG involves the right individuals and organisations when commissioning/decommissioning services: 68%
- The CCG asks the right questions at the right time when commissioning/decommissioning services: 58%
- The CCG engages effectively with patients and the public, including those groups within the local population who are at risk of experiencing poorer health outcomes when commissioning/decommissioning services: 52%
- The CCG demonstrates that it has considered the views of patients and the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care, when it is commissioning/decommissioning services: 58%
Background and objectives

Clinical Commissioning Groups (CCGs) need to have strong relationships with a range of stakeholders in order to be successful commissioners within their local health and care systems. These relationships provide CCGs with valuable intelligence to help them make the effective commissioning decisions for their local populations.

The CCG 360° Stakeholder Survey, which has been conducted since 2013/14, enables stakeholders to provide feedback about their CCGs. The results of the survey serve two purposes:

1. Provide CCGs with insight into key areas for improvements in their relationships with stakeholders and provide information on how stakeholders’ views have changed over time.

2. Contribute towards NHS England’s statutory responsibility to conduct an annual assessment of each CCG, through the CCG Improvement and Assessment Framework.

Due to changes within the health system and the way in which services are being commissioned, this year, individual CCG results are being combined at an STP level. This allows STPs to determine where there is variation between CCGs within the STP, and to look at areas that may be a priority across the STP footprint.
Interpreting the numerical data

• For each question, the response to each answer is presented as both a percentage (%) and as a number (n). The total number of stakeholders who answered each question (the base size) is also stated at the bottom of each chart and in every table. For questions with fewer than 30 stakeholders answering, we strongly recommend that you look at the number of stakeholders giving each response rather than the percentage, as the percentage can be misleading when based on so few stakeholders.

• Please note that sampling occurred at CCG level, thus question wording relates to individual CCGs, and the results for Norfolk and Waveney Health & Care Partnership STP are an average of the results for the individual CCGs in the STP.

• Where results do not sum to 100%, or where individual responses (e.g. tend to agree; strongly agree) do not sum to combined responses (e.g. strongly/tend to agree) this is due to rounding.

• There have been significant changes to the survey this year, such as the removal, rewording and reordering of several questions (including the answer codes). Additionally, the online format of the survey has changed this year and the ability for stakeholders to answer the questionnaire on behalf of multiple CCGs at the same time is a new feature, introduced to make participation easier and less time-consuming. These changes mean that we are unable to report on trend data. Please see slides 39 and 40 for more information on the methodology.
Using the numerical data

• The following slides show the results for each question, with a breakdown also shown for each of the core stakeholder groups where relevant, as well as regional comparisons.

• There are also charts to show the data for each individual CCG within an STP, so that comparisons can be made. For each open-ended question in the survey, there is also a chart to show the top ten coded themes from the verbatim comments.

• The comparisons are included to provide an indication of differences only and should be treated with caution due to the low numbers of respondents and differences in CCG stakeholder lists.

• Any differences are not necessarily statistically significant differences; a higher score for one CCG compared to another does not always equate to ‘better’ performance.

• The comparisons offer a starting point to inform wider discussions about the relationships of STP’s constituent CCGs with stakeholders. For example, they may indicate areas in which stakeholders think some CCGs are performing less well than others, for the STP to discuss to identify what improvements can be made in this area, if any.
Interpreting and using the themes from the verbatim comments

• This year, for the first time, the verbatim comments provided by stakeholders were coded, allowing for general themes to be identified across all of the CCGs within the STP.

• Each and every verbatim comment was reviewed and grouped together by common themes to create a “codeframe”.

• Where possible, the codes within the codeframe use the language of stakeholders providing feedback, in order to accurately reflect their views. This means that the wording of some codes is very detailed while that of others is more general.

• The themes show the main areas across all of the CCGs within the STP where it may be helpful for the constituent CCGs to focus their stakeholder work. For more detail, it will be important for each CCG to examine the actual comments which have already been reported to them directly (these are not published); these comments will show the specific areas of good practice or areas for improvement for individual CCGs as identified by their stakeholders.
Q1. Overall, how would you rate the effectiveness of your working relationship with the CCG? (Average across all CCGs in the STP)

**All stakeholders**

- **Very good**: 56%
- **Fairly good**: 31%
- **Fairly poor**: 11%
- **Very poor**: 2%

**By stakeholder group**

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Very good/Fairly good</th>
<th>Fairly poor/Very poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>82%</td>
<td>18%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>100%</td>
<td>0%</td>
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<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>93%</td>
<td>7%</td>
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<td>NHS providers</td>
<td>14</td>
<td>95%</td>
<td>5%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>97%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Regional comparisons**

- **STP**: 87%
- **Regional**: 87%
- **National**: 88%

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
Q1. Overall, how would you rate the effectiveness of your working relationship with the CCG? (Average across all CCGs in the STP)

Percentage of stakeholders saying very good/fairly good

- North Norfolk CCG
- Great Yarmouth and Waveney CCG
- Norwich CCG
- South Norfolk CCG
- Norfolk and Waveney Health & Care Partnership STP
- West Norfolk CCG

Base = all stakeholders 159
Q2. Please provide further comments, including identifying existing good practice and making suggestions for how, if necessary, your working relationship with the CCG could be improved. (Average across all CCGs in the STP)

This chart shows the top ten coded verbatim comments from this open-ended question.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More / better engagement with patients / patient participation groups /</td>
<td>12%</td>
</tr>
<tr>
<td>carers</td>
<td></td>
</tr>
<tr>
<td>Working relationship is good / has improved</td>
<td>12%</td>
</tr>
<tr>
<td>Need to listen to / involve / include / consult with us</td>
<td>10%</td>
</tr>
<tr>
<td>Insufficient alignment / more joined up working / goals needed</td>
<td>10%</td>
</tr>
<tr>
<td>Communication is good / improved</td>
<td>10%</td>
</tr>
<tr>
<td>The CCG is helpful / supportive / offers guidance</td>
<td>9%</td>
</tr>
<tr>
<td>Communication is frequent / timely / responsive</td>
<td>8%</td>
</tr>
<tr>
<td>Meetings / briefings occur frequently / regularly / are accessible</td>
<td>7%</td>
</tr>
<tr>
<td>Generally happy / fine as it is / keep it up / CCG doing a good job</td>
<td>7%</td>
</tr>
<tr>
<td>commissioning health services for population</td>
<td></td>
</tr>
<tr>
<td>Communication needs to be more frequent / timely / responsive</td>
<td>7%</td>
</tr>
</tbody>
</table>

Number of participants: 137
Q3. Overall, how would you rate the CCG’s effectiveness as a local system leader, i.e. as part of an Integrated Care System (ICS)/Sustainable Transformation Partnership (STP)? (Average across all CCGs in the STP)
Q3. Overall, how would you rate the CCG’s effectiveness as a local system leader, i.e. as part of an Integrated Care System (ICS)/Sustainable Transformation Partnership (STP)? (Average across all CCGs in the STP)

CCG range in STP

Percentage of stakeholders saying very good/fairly good

- Great Yarmouth and Waveney CCG
- Norwich CCG
- North Norfolk CCG
- Norfolk and Waveney Health & Care Partnership STP
- South Norfolk CCG
- West Norfolk CCG

Base = all stakeholders 159
Q4. Please provide further comments, including identifying existing good practice and making suggestions for how, if necessary, the CCG could improve its effectiveness as a local system leader. (Average across all CCGs in the STP)

This chart shows the top ten coded verbatim comments from this open-ended question.

<table>
<thead>
<tr>
<th>Comment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good alignment / joined up working / goals</td>
<td>12%</td>
</tr>
<tr>
<td>Insufficient alignment / more joined up working / goals needed</td>
<td>11%</td>
</tr>
<tr>
<td>Communication needs to be better / clearer</td>
<td>8%</td>
</tr>
<tr>
<td>Leadership is good / strong</td>
<td>7%</td>
</tr>
<tr>
<td>Good teamwork / collaboration / cooperation</td>
<td>6%</td>
</tr>
<tr>
<td>Insufficient power / CCGs cannot control outcomes / there are higher powers / external factors</td>
<td>6%</td>
</tr>
<tr>
<td>Improvements are ongoing / it’s a work in progress / there is more to do / room for improvement</td>
<td>6%</td>
</tr>
<tr>
<td>Need to listen to / involve / include / consult with us</td>
<td>6%</td>
</tr>
<tr>
<td>More / better engagement with the public</td>
<td>5%</td>
</tr>
<tr>
<td>Good / improved engagement</td>
<td>4%</td>
</tr>
</tbody>
</table>

Number of participants: 125
To what extent do you agree or disagree with EACH of the following statements?

Q5a. “The CCG considers the benefits to the whole health and care system when taking a decision.” (Average across all CCGs in the STP)

By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>74%</td>
<td>21%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>71%</td>
<td>25%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>68%</td>
<td>27%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>82%</td>
<td>13%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>71%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Regional comparisons

<table>
<thead>
<tr>
<th>STP</th>
<th>Percentage of stakeholders saying strongly agree/tend to agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest Performing</td>
<td>62%</td>
</tr>
<tr>
<td>Highest Performing</td>
<td>86%</td>
</tr>
<tr>
<td>Regional</td>
<td>78%</td>
</tr>
<tr>
<td>National</td>
<td>79%</td>
</tr>
</tbody>
</table>

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
To what extent do you agree or disagree with EACH of the following statements?

Q5a. “The CCG considers the benefits to the whole health and care system when taking a decision.” (Average across all CCGs in the STP)

CCG range in STP

Percentage of stakeholders saying very good/fairly good

Norfolk and Waveney Health & Care Partnership STP

Base = all stakeholders 159
Q5b. “The CCG actively avoids passing on problems to another system partner.” (Average across all CCGs in the STP)

To what extent do you agree or disagree with EACH of the following statements?

### By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>59%</td>
<td>26%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>64%</td>
<td>15%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>68%</td>
<td>32%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>57%</td>
<td>37%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>74%</td>
<td>12%</td>
</tr>
</tbody>
</table>

### Regional comparisons

<table>
<thead>
<tr>
<th>STP</th>
<th>Regional</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td>65%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td>64%</td>
<td></td>
</tr>
</tbody>
</table>

Percentage of stakeholders saying strongly agree/tend to agree

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
Q5b. “The CCG actively avoids passing on problems to another system partner.” (Average across all CCGs in the STP)
Q5c. “The CCG works collaboratively with other system partners on the vision to improve the future health of the population across the whole system.” (Average across all CCGs in the STP)

By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>73%</td>
<td>19%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>93%</td>
<td>7%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>84%</td>
<td>12%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>90%</td>
<td>10%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>73%</td>
<td>13%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
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<td>0%</td>
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<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>95%</td>
<td>5%</td>
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</table>

Regional comparisons

<table>
<thead>
<tr>
<th>STP</th>
<th>Percentage of stakeholders saying strongly agree/tend to agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>79%</td>
</tr>
<tr>
<td>National</td>
<td>82%</td>
</tr>
</tbody>
</table>

Lowest Performing: 65%

Highest Performing: 88%

CCG bases range from 37 to 28

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
Q5c. “The CCG works collaboratively with other system partners on the vision to improve the future health of the population across the whole system.” (Average across all CCGs in the STP)

To what extent do you agree or disagree with EACH of the following statements?

CCGs
- North Norfolk CCG
- Great Yarmouth and Waveney CCG
- Norwich CCG
- Norfolk and Waveney Health & Care Partnership STP
- South Norfolk CCG
- West Norfolk CCG

Percentage of stakeholders saying very good/fairly good

Base = all stakeholders 159
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6a. “Improving health outcomes for its population.” (Average across all CCGs in the STP)

### CCG range in STP

Percentage of stakeholders very effective/fairly effective

- Lowest Performing: 57%
- Highest Performing: 79%

CCG bases range from 37 to 28

### By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Very effective/fairly effective</th>
<th>Not very effective/Not at all effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>66%</td>
<td>27%</td>
</tr>
<tr>
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<td>9</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>67%</td>
<td>19%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>50%</td>
<td>17%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>62%</td>
<td>13%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>82%</td>
<td>12%</td>
</tr>
</tbody>
</table>

### Regional comparisons

Percentage of stakeholders saying very effective/fairly effective

- Regional: 68%
- National: 76%

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6a. “Improving health outcomes for its population.” (Average across all CCGs in the STP)

CCG range in STP

Percentage of stakeholders saying very effective/fairly effective

Norwich CCG
North Norfolk CCG
Great Yarmouth and Waveney CCG
Norfolk and Waveney Health & Care Partnership STP
South Norfolk CCG
West Norfolk CCG

Base = all stakeholders 159
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6b. “Reducing health inequalities.” (Average across all CCGs in the STP)

### All stakeholders

- **Very effective**: 50%
- **Fairly effective**: 28%
- **Not very effective**: 17%
- **Not at all effective**: 4%
- **Don’t know**: 0%

### By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Very effective/ Fairly effective</th>
<th>Not very effective/Not at all effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>57%</td>
<td>32%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>37%</td>
<td>56%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>23%</td>
<td>17%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>55%</td>
<td>13%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>62%</td>
<td>25%</td>
</tr>
</tbody>
</table>

### Regional comparisons

- **STP**: 54%
- **Regional**: 62%
- **National**: 63%

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6b. “Reducing health inequalities.” (Average across all CCGs in the STP)

**CCG range in STP**

Percentage of stakeholders saying very effective/fairly effective

![Chart showing the effectiveness of CCGs in reducing health inequalities across different regions within the STP. The chart includes data from various CCGs and compares them with the national average.](chart.png)

*Base = all stakeholders 159*
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6c. “Improving the quality of the local health services” (Average across all CCGs in the STP)

**All stakeholders**

- **Very effective**: 59%
- **Fairly effective**: 12%
- **Not very effective**: 19%
- **Not at all effective**: 5%
- **Don’t know**: 5%

**CCG range in STP**

- **Lowest Performing**: 54%
- **Highest Performing**: 86%

CCG bases range from 37 to 28

**By stakeholder group**

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Very effective/Fairly effective</th>
<th>Not very effective/Not at all effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>63%</td>
<td>32%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
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<td>73%</td>
<td>27%</td>
</tr>
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<td>Healthwatch and voluntary/patient groups</td>
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<td>91%</td>
<td>5%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>78%</td>
<td>17%</td>
</tr>
<tr>
<td>Other CCGs</td>
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<td>27%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>78%</td>
<td>15%</td>
</tr>
</tbody>
</table>

**Regional comparisons**

- **STP**: 71%
- **Regional**: 73%
- **National**: 74%

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6c. “Improving the quality of the local health services” (Average across all CCGs in the STP)
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6d. “Delivering value for money” (Average across all CCGs in the STP)

### All stakeholders

- **Very effective**: 52%
- **Fairly effective**: 14%
- **Not very effective**: 11%
- **Not at all effective**: 5%
- **Don't know**: 19%

### By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Very effective/Fairly effective</th>
<th>Not very effective/Not at all effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>68%</td>
<td>22%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
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<td>33%</td>
<td>0%</td>
</tr>
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<td>62%</td>
<td>33%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>71%</td>
<td>8%</td>
</tr>
</tbody>
</table>

### Regional comparisons

- **STP**: 66%
- **Regional**: 65%
- **National**: 65%

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
How would you rate the effectiveness of the CCG at doing EACH of the following?

Q6d. “Delivering value for money” (Average across all CCGs in the STP)

CCG range in STP

Percentage of stakeholders saying very effective/fairly effective

Norfolk and Waveney Health & Care Partnership STP

Base = all stakeholders 159
Q7. Please provide further comments, including identifying existing good practice and making suggestions for how, if necessary, the CCG could improve its effectiveness. (Average across all CCGs in the STP)

This chart shows the top ten coded verbatim comments from this open-ended question.

- More focus needed on health services / patients / primary care: 20%
- Insufficient power / CCGs cannot control outcomes / there are higher powers / external factors: 10%
- Generally happy / fine as it is / keep it up / CCG doing a good job commissioning health services for population: 10%
- More funding needed / lack of funding / investment: 10%
- More / better teamwork / collaboration / cooperation: 7%
- Improvements are ongoing / it’s a work in progress / there is more to do / room for improvement: 6%
- More / better engagement needed: 6%
- Need to listen to / involve / include / consult with us: 6%
- More accountability / ownership: 5%
- More focus on social prescribing / prevention and lifestyle changes: 5%

Number of participants: 97
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8a. “The CCG involves the right individuals and organisations when commissioning/decommissioning services.” (Average across all CCGs in the STP)

By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
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</tr>
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<td>13%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>48%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Stakeholder group

- GP member practices: 76 participants, 64% strongly agree/tend to agree, 25% strongly disagree/tend to disagree
- Health & wellbeing boards: 9 participants, 80% strongly agree/tend to agree, 20% strongly disagree/tend to disagree
- Healthwatch and voluntary/patient groups: 23 participants, 60% strongly agree/tend to agree, 26% strongly disagree/tend to disagree
- NHS providers: 14 participants, 90% strongly agree/tend to agree, 5% strongly disagree/tend to disagree
- Other CCGs: 16 participants, 80% strongly agree/tend to agree, 13% strongly disagree/tend to disagree
- Upper tier/unitary LA: 2 participants, 50% strongly agree/tend to agree, 0% strongly disagree/tend to disagree
- Wider stakeholders: 19 participants, 48% strongly agree/tend to agree, 35% strongly disagree/tend to disagree

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

**Q8a. “The CCG involves the right individuals and organisations when commissioning/decommissioning services.” (Average across all CCGs in the STP)**

### CCG range in STP

**Percentage of stakeholders saying strongly agree/tend to agree**

![Bar chart showing the percentage of stakeholders agreeing with the statement across different CCGs.](chart.png)

- **Norwich CCG**
- **Great Yarmouth and Waveney CCG**
- **North Norfolk CCG**
- **Norfolk and Waveney Health & Care Partnership STP**
- **South Norfolk CCG**
- **West Norfolk CCG**

**Base = all stakeholders 159**
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8b. “The CCG asks the right questions at the right time when commissioning/decommissioning services.” (Average across all CCGs in the STP)

### By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
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<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>56%</td>
<td>30%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>32%</td>
<td>54%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>90%</td>
<td>5%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>62%</td>
<td>13%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>50%</td>
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</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>48%</td>
<td>38%</td>
</tr>
</tbody>
</table>

### Regional comparisons

<table>
<thead>
<tr>
<th>STP</th>
<th>Percentage of stakeholders saying strongly agree/tend to agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>STP</td>
<td>58%</td>
</tr>
<tr>
<td>Regional</td>
<td>58%</td>
</tr>
<tr>
<td>National</td>
<td>58%</td>
</tr>
</tbody>
</table>

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8b. “The CCG asks the right questions at the right time when commissioning/decommissioning services.” (Average across all CCGs in the STP)
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8c. “The CCG engages effectively with patients and the public, including those groups within the local population who are at risk of experiencing poorer health outcomes when commissioning/decommissioning services.” (Average across all CCGs in the STP)

### All stakeholders

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Tend to agree</th>
<th>Tend to disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>24%</td>
<td>16%</td>
<td>9%</td>
<td>43%</td>
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</tbody>
</table>

### By stakeholder group

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>51%</td>
<td>22%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
<td>9</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>40%</td>
<td>55%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>52%</td>
<td>22%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>68%</td>
<td>7%</td>
</tr>
<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>46%</td>
<td>37%</td>
</tr>
</tbody>
</table>

### CCG range in STP

- **Percentage of stakeholders saying strongly agree/tend to agree**
  - **Lowest Performing**: 34%
  - **Highest Performing**: 64%

CCG bases range from 37 to 28

### Regional comparisons

- **STP**: 52%
- **Regional**: 60%
- **National**: 62%

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8c. “The CCG engages effectively with patients and the public, including those groups within the local population who are at risk of experiencing poorer health outcomes when commissioning/decommissioning services.” (Average across all CCGs in the STP)

CCG range in STP

Percentage of stakeholders saying strongly agree/tend to agree

Norwich CCG
Great Yarmouth and Waveney CCG
North Norfolk CCG
Norfolk and Waveney Health & Care Partnership STP
West Norfolk CCG
South Norfolk CCG

Base = all stakeholders 159
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8d. “The CCG demonstrates that it has considered the views of patients and the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care, when it is commissioning/decommissioning services.” (Average across all CCGs in the STP)

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>No. of participants</th>
<th>Strongly agree/Tend to agree</th>
<th>Strongly disagree/Tend to disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices</td>
<td>76</td>
<td>58%</td>
<td>22%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards</td>
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<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Healthwatch and voluntary/patient groups</td>
<td>23</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>NHS providers</td>
<td>14</td>
<td>52%</td>
<td>22%</td>
</tr>
<tr>
<td>Other CCGs</td>
<td>16</td>
<td>62%</td>
<td>13%</td>
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<tr>
<td>Upper tier/unitary LA</td>
<td>2</td>
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<td>50%</td>
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<tr>
<td>Wider stakeholders</td>
<td>19</td>
<td>68%</td>
<td>28%</td>
</tr>
</tbody>
</table>

Number of participants: Norfolk and Waveney Health & Care Partnership STP (159), Regional (817), National (7682).
To what extent do you agree or disagree with EACH of the following statements about the way in which the CCG commissions/decommissions services?

Q8d. “The CCG demonstrates that it has considered the views of patients and the public, including those groups which experience poorer health outcomes and/or barriers to accessing health and care, when it is commissioning/decommissioning services.” (Average across all CCGs in the STP)

Norwich CCG
Great Yarmouth and Waveney CCG
North Norfolk CCG
Norfolk and Waveney Health & Care Partnership STP
West Norfolk CCG
South Norfolk CCG

Base = all stakeholders 159
Q9. Please provide further comments, including identifying existing good practice and making suggestions for how, if necessary, the CCG could improve the way it commissions/decommissions services. (Average across all CCGs in the STP)

This chart shows the top ten coded verbatim comments from this open-ended question.

- **Need to listen to / involve / include / consult with us**: 13%
- **Good alignment / joined up working / goals**: 11%
- **More / better engagement needed**: 11%
- **More focus needed on health services / patients / primary care**: 10%
- **Generally happy / fine as it is / keep it up / CCG doing a good job commissioning health services for population**: 7%
- **Good teamwork / collaboration / cooperation**: 7%
- **Insufficient alignment / more joined up working / goals needed**: 6%
- **Poor decisions / improve decision making process**: 6%
- **The teams are good / strong / good / experienced staff**: 6%
- **Working relationship is good / has improved**: 5%

Number of participants: 104
Appendix: methodology and technical details

• It was the responsibility of each CCG to provide the list of stakeholders to invite to take part in the CCG 360° stakeholder survey. CCGs proposing to merge in April 2019 collaborated with each other to produce and submit a single stakeholder list across the merging CCGs. Results for the STP were generated by averaging the scores of the CCGs within the STP.

• CCGs were provided with a specification of core stakeholder organisations to be included in their stakeholder list. Beyond this, however, CCGs had the flexibility to determine which individual within each organisation was the most appropriate to nominate. CCGs were also given the opportunity to add up to ten additional stakeholders they wanted to include locally (they are referred to in this report as ‘wider stakeholders’).

• Stakeholders who have been nominated by more than one CCG or to represent more than one organisation had the opportunity to complete the questionnaire in ‘grid’ format. They could choose to give the same responses for each CCG that asked them to take part and the organisations they represent, or to give different answers for each CCG and each organisation.

• Stakeholders were sent an email inviting them to complete the survey online. Stakeholders who did not respond to the email invitation, and stakeholders for whom an email address was not provided, were telephoned by an Ipsos MORI interviewer who encouraged response and offered the opportunity to complete the survey by telephone. Non-responding stakeholders were sent reminder emails and telephone calls to encourage participation.
Appendix: methodology and technical details

- Within the survey, stakeholders were asked a series of questions about their working relationship with the CCGs that sit within the STP. Stakeholders were all asked the same questions in this year’s survey, with no bespoke questions.

- Fieldwork was conducted between 14th January and 28th February 2019.

- The average response rate across the CCGs within the STP was 70%. This varied across the stakeholder groups as shown in the table opposite. Please note that the number of stakeholders allowed per group apply to the CCG level and not the STP level.

### Survey response rates for Norfolk and Waveney Health & Care Partnership

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Average response rate across the CCGs within the STP</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP member practices One from every member practice*</td>
<td>75%</td>
</tr>
<tr>
<td>Health &amp; wellbeing boards Up to two per HWB*</td>
<td>95%</td>
</tr>
<tr>
<td>Local Healthwatch Up to three per local Healthwatch*</td>
<td>70%</td>
</tr>
<tr>
<td>Other patient groups and voluntary sector organisations or representatives Up to eight*</td>
<td>69%</td>
</tr>
<tr>
<td>NHS providers Up to two from each acute, mental health and community health providers*</td>
<td>66%</td>
</tr>
<tr>
<td>Other CCGs Up to five*</td>
<td>90%</td>
</tr>
<tr>
<td>Upper tier or unitary local authorities Up to five per local authority*</td>
<td>30%</td>
</tr>
<tr>
<td>Wider stakeholders</td>
<td>73%</td>
</tr>
<tr>
<td>All stakeholders</td>
<td>70%</td>
</tr>
</tbody>
</table>

*Specification from the core stakeholder framework

Norfolk and Waveney Health & Care Partnership STP
For more information

ccg360stakeholder@ipsos-mori.com
Subject: Transformation of Mental Health Services for Children and Young People

Presented By: Jo Smithson, Norwich CCG

Prepared By: Andy Vowles, RETHINK Partners

JSCC Sponsor: Jo Smithson, Lead Director - Norwich CCG
Sara Tough, Executive Director, Children’s Services, Norfolk County Council

Submitted To: Joint Strategic Commissioning Committee (JSCC) - 18 June 2019 – Meeting in Public

Purpose of Paper: For decision

Summary:

This paper updates members of JSCC on the second phase of the programme to transform mental health services for children and young people across Norfolk and Waveney, and sets out a small number of key issues that require a decision before the programme can move to the next phase.

The paper sets out:

- A brief recap of the context to this work and the conclusions from the first phase;
- An overview of the work undertaken as part of the second phase
- The key issues that require a decision:
  - Endorsing the emerging service model and agreeing the proposed age range
  - Agreeing the recommended approach to sourcing
  - Agreeing the proposed new governance arrangements for Children and Young People’s Mental Health
  - Agreeing the proposed approach to expanding the Section 75 agreement
  - Noting the approach to communications and engagement
- The proposed next steps for the programme

1. Recap – context and conclusions from phase 1

In the autumn of 2018, the five CCGs in Norfolk and Waveney and Norfolk County Council (NCC) commissioned RETHINK Partners to conduct a wide-ranging review of children and young people’s mental health (CYPMH) services.

The first phase considered all aspects of planning, commissioning and provision of CYPMH. The review also included an insight workstream, as part of which the views of children and young people (both those receiving services and those who were not) were obtained.
The phase one report has been widely shared across the system. It was discussed by JSCC at its December meeting and has also been considered by each of the five CCG Governing Bodies, NCC Corporate Board, Suffolk CC Children’s directorate team and the STP Executive.

Almost everyone who participated in phase one agreed that the current way the system plans and delivers mental health services for CYP is not fit for purpose and needs to improve. There was a broad consensus over what things should look like, together with a willingness and appetite to make significant changes.

Some of the key areas for improvement identified in phase one were:

- there is not yet an integrated, whole system approach to the way services are planned and provided, and relationships are not always as strong as they need to be
- the siloed nature of the existing contracts and service provision can make support difficult to access, create gaps and overall tends to ‘pull’ children and young people into more specialist services, rather than focusing on promoting well-being and resilience
- governance and decision-making structures are complex and bureaucratic, which leads to confusion and a lack of accountability
- significant fragmentation within the system, including in the leadership of the children’s agenda, in the way service contracts are managed and in where planning/commissioning skills are located
- a lack of an agreed system financial envelope for CYP mental health or a forward plan for future investment
- a risk of short-term concerns about the expiry of some contracts resulting in a perpetuation of the existing fragmentation

2. Overview of phase two of the programme

In early 2019, the Norfolk & Waveney system agreed to develop a second phase of the programme to transform mental health services for children and young people (CYP), focused on mobilising a series of workstreams to address the shortcomings identified during the first phase. This phase of the work began in late January and runs until the end of June 2019.

Two groups have been established to oversee and drive this second phase: the Executive Sponsor Group, which steers the overall programme, includes senior representation from across the system and is chaired by the Executive Director of Children’s Services, NCC; and the Delivery Team, which has a much more operational focus and brings together all the phase two workstream leads (see below) from across the system. There is good representation from NHS/NCC commissioners and providers throughout the structure.

The phase two workstreams are organised into four main themes: future service model; future governance and capacity; enablers; and the wider children’s vision. The broad objectives of each workstream, together with the leads for each, are set out at Annex 1 of this paper.

The majority of the workstreams are now beginning to conclude their work. Before they can progress further, a small number of the workstreams require decisions on the direction of travel to be made by JSCC, NCC, Suffolk County Council (SCC) and, potentially, service providers. The key areas for decision are set out in the following section.

3. Key issues for decision by JSCC

Future service model

The service design workstream was established to look in detail at the current model of provision and to identify and assess options for change. The workstream’s clear conclusion is that the system
needs to move away from its current ‘tiered’ approach to services (where there are different contracts and services in place for each ‘level’ of service).

There is a broad consensus that this model is difficult for children and families (and professionals) to navigate, that it is not child or family centered and that it is ineffective in promoting prevention and in intervening early enough to meet children’s needs.

The alternative model that the workstream has developed and that the Executive Sponsor Group has endorsed is an approach known as ‘THRIVE’. An overview of this model, and how it is envisaged it might operate on Norfolk and Waveney, is attached at Annex 2.

Adopting the THRIVE model is a fundamental shift in the way that the system views the mental health and emotional wellbeing of children and young people. In particular:

- all children and young people in Norfolk & Waveney are viewed as being within the model at all times
- the purpose of the model is to move as many children and young people as possible into a place where they are thriving
- there will be a shift away from an illness mindset
- it promotes an approach that deescalates need and encourages early intervention
- it continues to respect the need for strong clinical and professional input
- this model suggests what is thriving for one child may not be the same as the other

There is strong support for this model from across the system, including among clinicians, practitioners and wider children’s services. The workstream are currently working up a more detailed map of what service delivery would look like at a local level.

The group has also been considering access to services. At present, there are multiple routes of entry, which can be confusing for children and families as well as professionals. The group are developing a model which has just three points of entry: single phone line/email; walk in; and digital. They are also considering how this might align with access points to other services (such as early help and the healthy child programme).

The group has also been seeking to clarify the age range of services for most CYPMH services. It has concluded that for almost all services the most appropriate range is 0-25 (meaning up to the 26th birthday); this broad proposed approach has been endorsed by the Executive Sponsor Group. The key exceptions to this approach - because both are all age pathways - are early intervention psychosis (EIP) and eating disorders.

This shift is in line with emerging national policy and is underpinned by several factors, including: a growing clinical evidence that the adult brain is only mature in the mid-twenties; a cut-off of 25 is better aligned with councils’ statutory duties; and evidence that this arrangement smooths transitions between CYPMH and adult services.

Sourcing

The sourcing workstream has assessed how the system might move from the current pattern of services and contracts to the recommended new model (THRIVE). This is a challenging issue, given the need to balance legal and competition issues with the clear desire to continue to develop a collaborative and inclusive approach.

The workstream, which included commissioners and procurement leads from across Norfolk and Waveney, conducted a comprehensive options appraisal. Their paper, which has been agreed by the Executive Sponsor Group, is attached at Annex 3 to this paper.
The workstream developed a long list of possible options and assessed these against an agreed set of criteria. This resulted in three possible approaches being shortlisted for more detailed scrutiny: prime provider; joint venture; and alliance contracting model.

The workstream is recommending that the system should adopt an alliance contracting approach. The rationale for this is that an alliance model:

- creates a model that enables providers to continue to collaborate and develop the THRIVE model;
- allows considerable flexibility to strengthen links with wider children’s services (such as healthy child programme);
- avoids the potential cost and distraction of a major procurement;
- is aligned with developments elsewhere, including in Suffolk; and
- is congruent with the development of the ICS.

In order to retain momentum, it is envisaged that a year of shadow operation as an alliance could operate from October 2019, with the aim becoming fully operational 12 months later.

**Governance**

One of the key challenges identified in the first phase of the programme was a lack of clarity over governance and decision making for CYPMH. This is a major issue for the system, as it clouds accountability and makes it difficult for stakeholders to understand how and where decisions are made.

The workstream set up to address this issue recommends establishing a single whole system ‘board’ for CYPMH that brings together senior commissioners and providers across Norfolk and Waveney. Alongside this development, a number of pre-existing CYPMH groups will be stood down.

It is proposed that this group will be chaired by the Executive Director of Children’s Services (NCC), and would be jointly accountable to JSCC and NCC. This model would fit well with the proposed alliance contracting approach (see above). The draft Terms of Reference for the proposed board are attached at Annex 4.

The proposed board would need to have explicit delegated authority from each of the relevant statutory bodies to take decisions (within a clear framework) on relevant CYPMH services, in order to avoid ‘double loop’ decision making where all key decisions have to come back to CCGs/JSCC/NCC.

The draft terms of reference provide a key aspect of this framework. However, in order to enable the new board to be – as intended - the system focal point for decision making on CYPMH this needs to be accompanied by an expanded Section 75 agreement. The current agreement (between the five CCGs and NCC) does not enable this, as it only encompasses a relatively small set of (tier 2) services and the joint commissioning team.

Therefore, a clear recommendation that is supported by the Executive Sponsor Group is to establish a revised Section 75 agreement between the five CCGs and NCC that encompasses all relevant CYPMH expenditure – primarily the existing tier 2 services (currently provided by Point 1), the existing tier 3 services (provided by NSFT) and the joint commissioning team.

Subject to approval of the recommended way forward, a revised Section 75 agreement will be drafted and brought back to JSCC the CCG Governing Bodies and NCC at the earliest opportunity.

**Finance**
One of the concerns noted in the first phase of the programme was a lack of clarity over the existing levels of expenditure by partners on relevant CYPMH services across Norfolk and Waveney.

The system finance workstream was established to address both of this issue. In determining the estimated baseline, a key issue for the workstream has been to identify and agree the current expenditure on services for the proposed revised age range of 0-25 as opposed to previous definitions which were generally 0-18.

The workstream has made good progress in establishing a clear financial baseline, working collaboratively across commissioners and providers. This includes close consideration of block contracts, which historically have not fully differentiated expenditure on CYPMH from other areas.

The final assessment of the level of CYPMH expenditure, and how this links to the scope of services, will inform the development of the revised Section 75 agreement that is proposed above.

**Communications and engagement**

All major change programmes have effective engagement and communication at their heart, and this programme is no exception. Key audiences for consideration include:

- children, young people and their families
- staff
- stakeholders
- media

As part of this programme, a detailed engagement and communication strategy has been developed and endorsed by the Executive Sponsor Group. Partners from all organisations have contributed to the strategy, which includes detailed stakeholder mapping, a detailed action plan for future phases and a clear communications protocol.

In addition, as the proposed service model could be considered to be a significant service change, it is possible that some form of public consultation may be required prior to October 2020. As a result, partners have begun early, informal conversations with Norfolk Overview and Scrutiny Committee as well as NHS England, who may require their service change assurance process to be completed prior to the commencement of any consultation.

### 4. Next steps

Subject to approval of the recommendations in this paper at the June meeting of JSCC (and parallel decisions at NCC’s Corporate Board), the programme will move into two further phases:

- 3(a) – Jul 19 to Oct 19: further development of service model; establishment of Alliance Board; revised Section 75 drafted; development of inter-provider Alliance Agreement
- 3(b) – Nov 19 to Oct 20 – finalisation and mobilisation of the revised service model, completion of supporting workstreams

A detailed implementation plan for both of these proposed phases is currently being drafted.

**Recommendations:**

JSCC is asked to:

- **endorse** the emerging service model (THRIVE) and **agree** the proposed age range for core CYPMH services (0-25)
- **agree** to develop an Alliance approach to commissioning and providing the future model of CYPMH
• agree to the establishment of the proposed CYPMH Alliance Board
• agree in principle to the development of an expanded Section 75 agreement encompassing all relevant CYPMH services for sign off by CCGs/NCC
• note the importance of effective engagement and communications to the programme, and the potential requirement for consultation on the service model
• note the proposed next steps for the programme
### Overview of Phase Two workstreams

<table>
<thead>
<tr>
<th>Area</th>
<th>Workstream</th>
<th>Lead</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Future service model</strong></td>
<td>Tiers 2/3 and access</td>
<td>Simon Paylor/ Karryn Dixon</td>
<td>To design the operating and professional model that delivers a whole system approach for an integrated tier 2/3 service, and the operating model for a single point of access, ensuring alignment with current Children's Services</td>
</tr>
<tr>
<td>Innovation and Research</td>
<td>James Wilson</td>
<td></td>
<td>To develop a collaborative approach to service innovation for CYPMH for Norfolk and Waveney</td>
</tr>
<tr>
<td>Insight</td>
<td>Carey Cake</td>
<td></td>
<td>Scope the development of a co-production, insight and engagement model for Norfolk &amp; Waveney</td>
</tr>
<tr>
<td>Outcomes and reporting</td>
<td>To be finalised</td>
<td></td>
<td>To develop and agree system outcomes for CYPMH and a single, integrated reporting mechanism</td>
</tr>
<tr>
<td>Workforce</td>
<td>To be finalised</td>
<td></td>
<td>Develop a system approach to planning the future CYPMH workforce, to underpin the new service model</td>
</tr>
<tr>
<td><strong>2. Future Governance and Capacity</strong></td>
<td>Governance</td>
<td>Jean Clark</td>
<td>To design revised system wide governance for CYPMH, including establishing a single decision making Board and standing down groups that are no longer required</td>
</tr>
<tr>
<td>CYPMH Team</td>
<td>Andy Vowles</td>
<td></td>
<td>To design and cost an integrated, whole system CYPMH development team, including development of a proposed change process</td>
</tr>
<tr>
<td>Contracting</td>
<td>Anne-Louise Schofield</td>
<td></td>
<td>To identify and implement quick wins for the 2019/20 NSFT contract, including disaggregation of CYPMH</td>
</tr>
<tr>
<td><strong>3. Enablers</strong></td>
<td>Finance</td>
<td>Ed Lambert</td>
<td>To identify the existing system baseline expenditure on relevant CYPMH services, and develop a framework for future investment</td>
</tr>
<tr>
<td>Comms and engagement</td>
<td>Irene Carson</td>
<td></td>
<td>Deliver a comprehensive approach to communications, ensuring stakeholders are aware of and involved in the transformation programme</td>
</tr>
<tr>
<td>Sourcing</td>
<td>Joan Murray</td>
<td></td>
<td>To recommend a preferred option for sourcing an integrated tier 2/3 service</td>
</tr>
<tr>
<td>Third Sector</td>
<td>Dan Mobbs</td>
<td></td>
<td>To develop a broader strategic approach to working with the 3rd sector joined up between NCC and CCG partners</td>
</tr>
<tr>
<td>Demand and Capacity</td>
<td>Ana Odhe</td>
<td></td>
<td>To develop a methodology and interactive model that projects likely future demand for CYMPH services and matches this with likely capacity, so that potential gaps are quantified</td>
</tr>
<tr>
<td><strong>4. Integrated vision</strong></td>
<td>Long-term system vision for CYP</td>
<td>Clare Morris</td>
<td>To develop a longer term vision for integrated children’s services for Norfolk and Waveney</td>
</tr>
</tbody>
</table>
An Emerging Mental Health Service Model for Children & Young People in Norfolk & Waveney

Clinicians, service managers and commissioners have worked together to respond to input gained over many months from children, young people, families and professionals. There is a shared view across Norfolk & Waveney that there are significant opportunities to improve Children & Young People’s mental health and wellbeing services for children, young people and young adults. The current system is:

- Too fragmented, complicated, and difficult to access;
- Too focused on diagnosis and ill-health, with not enough focus on early prevention;
- Not consistent across Norfolk & Waveney;

System leaders have heard this feedback and have made the following commitments:

1. **We are listening to children, young people, families and professionals and are transforming children’s mental health services, to improve access and focus on getting support to children earlier.**

2. **We are working together to ensure there are the right services for children and young people aged 0-25, moving away from a focus on illness and diagnosis towards young people’s health and emotional well-being.**

3. **All of those working across children’s services in Norfolk and Waveney are united in creating the best mental health services.**

4. **We appreciate the fantastic staff working across mental health services and we want to ensure that the right systems are in place to support them to do their job.**

We want to create a system based on the THRIVE framework, a nationally recognised best practice approach cited in the Government’s recent Green Paper*.

- Instead of a tiered system that creates gaps and exacerbates waiting times, a THRIVE-based system focuses on the needs of individual children, young people and young adults.
- All 0—25 year olds are considered to be ‘in’ the THRIVE framework. The majority will be ‘Thriving’. 1 in 8 are likely to need some kind of help, with the majority having needs met through ‘Getting Advice’.

* The THRIVE framework was developed by a collaboration of authors from the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust. National i-THRIVE Community of Practice sites are responsible for over 62% of the population of children and young people in England: www.implementingthrive.org/implementing-sites/i-thrive-community-of-practice
Instead of moving a child or young person around the system, we will move the system around the child or young person. Our new model will embrace some core principles:

- **0—25 yrs:** any child, young person or young adult up to their 26th birthday will be served by this model.
- **A focus on Thriving:** investing in early prevention and aiming to return those with difficulties to a Thriving state.
- **Working as a single system**, with shared case management, performance management and assessments across providers.
- **Clear access routes** for children, young people, young adults and professionals.
- **Community Based:** serving local communities and building community capacity.
- **Relationship focused:** reducing 'hand offs' and reducing the amount of times children and young people need to tell their story.
- **Multi-agency multi disciplinary teams** that provide support to families, professionals, and universal settings (especially schools).
- **Goal-Focused & Episodic Interventions:** involving children, young people and young adults in setting goals and making

### How will it work?

- **Initial Contact**
  
  A single phone number for comprehensive advice and signposting to help.
  
  A digital offer (website / app) that provides advice, guidance and self referral.

- **Community Bases**
  
  Community Bases are the heart of the new model: multi-agency multi-disciplinary teams based in local communities who serve as a resource for the area. Teams could consist of Mental Health, Early Help, Social Work and Third Sector practitioners who go out to serve the community in different settings according to need. However, community bases could be physical locations for drop in advice and support, or assessment and treatment.

  Whether a school staff member, youth worker, family worker or mental health practitioner, children and young people will be able to keep working with one or two people who journey with them to get the help they need. This key worker will be able to draw in support from the multi-agency team according to need.

- **One Stop Shops**
  
  A smaller number of drop in and treatment bases that focus on the needs of 16—25 year olds, based in four or five locations depending on need.

- **Specialist Support**
  
  There will still be specialist teams or services to serve those who need them. These county-wide teams will be drawn in to help children, young people and young adults wherever they are.
What difference will it make?

- If I’m 0—25 yrs old, this service is for me.
- No matter who I turn to for help, I’ll be able to get the help I need.
- No matter where I live in Norfolk & Waveney, I’ll be able to get help nearby if I need it.
- I can call a dedicated number, use a website / app, or meet someone face to face.
- We’ll focus on possibilities and strengths, setting goals and making choices.
- I won’t need to repeat my story too many times. I’ll be able to keep working with someone for as long as I need to.

For Children, Young People, Young Adults & Families

- Everyone in the system takes responsibility: no ‘referrals on’. Support will be ‘drawn in’ for any worker continuing key relationships as a ‘team around the professional’ from wherever in the system is required.
- If I’m not in a specialist service, I will be in a multi-agency multi-disciplinary team co-located in a Community Base, One Stop Shop, or universal setting. I’ll use community resources to resolve difficulties if possible, drawing in specialists as required.
- We will work as a whole system, with a single performance and quality framework, and a shared IT system for case management and reporting.
- Commissioning and decision making will take place through a single governance body.

For Mental Health Practitioners

- I will be able to get to know my local CYPMHS Team and work together in my locality to meet the needs of children, young people and young adults. Important information will be shared between us. Our aim will be to increase early intervention, build resilient communities, and help every child to thrive.
- I can call a dedicated number, access a digital platform, or liaise with my local CYPMHS Team for advice, guidance and support. It will be easier and quicker for children, young people and young adults to get the help they need.
- If I have a working relationship with a child, young person or young adult experiencing particular needs, I will receive support and input to continue that relationship.

For other professionals and key workers

This new model presents an exciting opportunity to not only address the problems many of us have identified, but also to deliver nationally recognised best practice services. However, it is reliant on some key assumptions:

- Sufficient capacity & resource,
- Sufficient and supported workforce,
- ‘Managing out’ the current waiting list,
- Rapid access to help for those who need it.

It also demands a significant culture change, and a very different set of behaviours from everyone in the system. Implementation will be complex. However, there is a high level of ownership of this vision across the system, and a strong acceptance of the need for change. We’ve also established very strong foundations of joint working between Children’s Services, commissioners, and providers in the last six months of Transformation work that we can build on.

What’s next?

Having completed the design phase, we’re now due to start the implementation phase of our Transformation work. We’ll start to answer detailed practical questions about how services will work in co-production with children, young people, young adults, families, and staff across the system.

We also intend to run a pilot in the Autumn to test our assumptions and shape our plans. We may need to change things gradually, and there will be a continuous process of learning and adapting, but we’re aiming to launch the new service in October 2020.
This report summarises options for the provision of children and young people’s mental health services in Norfolk and Waveney. The paper sets out options and makes recommendations for consideration by the Executive Sponsor Group.

RETHINK Partners
JUNE 2019
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Executive Summary

The local system has a drive towards an integrated model based on THRIVE. Within Norfolk and Waveney there is a strong vision for the future of mental health services for children and young people that breaks down traditional tiers, focuses on prevention and resilience and is driven by outcomes. At the core of this vision is an integrated delivery model, combining tier 2 and tier 3 services to enable the early intervention, continuity of care and a much more person-centered approach based on the THRIVE model.

A key recommendation of work conducted in Phase 1 of the programme was to consider sourcing options and to develop a roadmap for delivery, recognising that the longer-term end state will be more integrated and modelled towards an Integrated Care System (ICS). This paper summarises the output of work led by the Sourcing Workstream and sets out options and recommendations for consideration by the Executive Sponsor Group.

The current service is not considered to be sustainable or fit for purpose

In considering the way forward, the workstream took account of commissioners’ ambitious plans to further integrate children and young people’s services over time and the inter-dependencies of the current service provision with Suffolk. This, together with the agreed change in age profile of services to be delivered (0-25 age group), and the impact on adult provision, has required the workstream to focus on three key issues.

- The requirement and need for structural reform;
- The route and way of working to move towards an integrated model; and,
- The requirement for competencies and skills to deliver real service transformation.

The paper highlights the inter-dependencies of these issues and sets out the process and evaluation criteria used to inform decision making.

Considering structural options for change

An initial long list of structural options was developed (see section 8). Applying criteria, the analysis determined that three options failed to offer the degree of benefits required by the system, due either to their limited impact on reducing...
fragmentation, or the degree of complexity involved. As a result, the workstream focused on the three remaining options (section 9):

- an alliance contracting model;
- contracting joint venture; and
- a prime provider model.

The paper sets out the relative advantages and disadvantages and the applicability of each model to address challenges locally. The workstream concludes that although an ICS structure represents the optimal long-term solution, an alliance model is considered to be a practical option in the short-term as a staging post towards the future development of local children and young people’s services.

**Routes to change and ways of working as a system**

The paper also highlights the importance of determining the way of working as a system, to move towards a more integrated model and the impact of different approaches on both organisational and individual behaviours. Based on analysis the workstream’s assessment concludes that the system should adopt a collaborative approach, building on work to date between both commissioners and providers.

The requirement for core competencies and skills to deliver real change

To develop a more integrated model will require reform to core elements of the health and care system. Specifically, in the case of the CYPMH services there will need to be considerable work undertaken to:

- Bring together capabilities, skills and resources currently across many organisations into a single enterprise;
- Revise care pathways, building on best practice and the THRIVE model of care to better meet individual needs;
- Realign the activities of care professionals (including primary care, community, mental health, social and educational) around the THRIVE model and patient needs as opposed to being bound by organisational structures; and
- Transition towards an outcome based contracting model that incentivises prevention and proactive care and rewards outcomes rather than inputs.
The success of the overall programme will be dependent on the ability of the providers to deliver transformation. The workstream recommends that the system undertakes an assessment of its preparedness to implement complex change and to carry out a system ‘gap analysis’ to help inform decisions around potential parties to any future agreement.

Essentially, there needs to be a willingness on the part of existing providers to supplement existing capacity within organisations to address any capability and competency gaps. Based on work to date, there is a clear expectation that the leadership and infrastructure to support change will need to be strengthened.

Recommendation and way forward

The recommended option is that an alliance model offers a practical and feasible option for the next stage of developing CYPMH services in Norfolk and Waveney.

Although an alliance model is not considered to be the optimal end state, it does represent a significant stepping stone towards and ICS model and would allow commissioners to be part of any agreement. In summary, an alliance model offers the potential to:

- Achieve structural reform, subject to the willingness and commitment of providers to work together;
- Enable current providers to continue to work together to achieve a move towards THRIVE and integration of tiers 2 and 3 services;
- Align the interests of providers and commissioners, as a pragmatic first step towards an ICS model.
- Limit workforce disruption;
- Avoid distraction and cost of a lengthy procurement process;
- Pursue this option in parallel with the NHS assurance process leading to public consultation probably in spring 2020;
- Be compatible with the review of adult mental health services and the future determination of NSFT;
- Allow flexibility for NCC with Point 1 contract to manage procurement risks
- Further explore potential links with CCS and the healthy child programme; and
• Leverage additional capacity and capabilities to support service transformation at an alliance level, for example, appointment of an Alliance MD, Medical Director, etc.

**Requirement for structured programme**

Given the scale and pace of change required, the workstream recommends that there is a structured programme with defined check-points along the route to an alliance agreement. The report proposes a number of conditions would need to be attached to the proposed way forward including;

- Commissioners being party to the alliance agreement with clearly defined responsibilities and obligations; for example, commitment to service investment and leadership/transformational support
- Agreement and alignment of individual contracts to underpin new service model and outcomes
- Development of a clear road map and milestones to track progress and to hold all parties to account
- Agreement and commitment of providers to develop an alliance model, with draft heads of agreement prepared and signed off by September 2019, shadow operation for the alliance from October 2019 to drive transformation and to bed in new relationships and working arrangements and a go live start date in October 2020 (subject to NHS assurance and public consultation).

It also needs to be understood that if progress is not achieved, the default position would be for commissioners to revert to a market process.

**Requirement for legal advice and compliance with NHS assurance**

The adoption of an alliance model does not automatically negate the need to follow a procurement process. The paper highlights that under current Public Contract Regulations 2015 there is requirement to advertise services of this value and to undertake some competitive procurement process if required.

The report strongly advises that commissioners seek further procurement and legal advice on any options under consideration. It should also be noted that given the scale of transformation and the changes proposed, these are likely to be considered a substantial “development” or “variation”, raising the prospect that
there is a requirement for public consultation and for the system to navigate an NHS assurance process.

Next steps
To progress the report highlights the need for the system to confirm its chosen direction, seek consensus from key stakeholders and commence a phased programme of transformation. The following sets out the high-level next steps:

- Executive sponsors to consider final sourcing report and to confirm recommendations and onward governance (3rd May).
- Urgent discussions with providers to test appetite for an alliance model.
- Develop an early draft of an Alliance Heads of Terms to confirm parameters and approach; this must be developed collaboratively, but quickly and seek to achieve sign-up to key terms and arrangements for the proposed shadow operating period. It has been suggested that connecting with a system already operating alliance models would be very helpful and that some training and development on this topic for the system would also be useful and timely.
- Consult with regulators around emerging thinking and obtain clarification on any requirement for public consultation and associated assurance processes.
- Early engagement with HOSC (Norfolk and possibly also Suffolk)
- Develop critical path with clear timelines and milestones with clear gateways for critical decision points.
- Progress dialogue with provider partners and undertake an analysis of the system’s competencies and capabilities to progress system change with a view to identifying gaps.
- Based on a ‘gap analysis’, revalidate collaboration as preferred option and assess partner requirements for any future alliance model.
- Confirm partnering options with both regulators and commissioners.
- Finalise and agree Heads of Agreement by September 2019.
- Move to shadow operation from September and turn Heads of Agreement into formal contractual relationship.
- Consider resource / capability requirements to support and manage this process alongside achieving service transformation; in particular there is a need for strong commissioning leadership, strengthened provider leadership within the alliance, and finance / legal / OD support and programme management to manage the process of transition.
1. **Introduction**

This paper summarises the output of the Sourcing Workstream for the provision of Children and Young People’s Mental Health (CYPMH) services in Norfolk and Waveney. The paper sets out options and makes recommendations for consideration by the Executive Sponsor Group.

2. **Background**

Within Norfolk and Waveney there is a strong vision for the future of mental health services for children and young people that breaks down traditional tiers, focuses on prevention and resilience and is driven by outcomes. At the core of this vision is an integrated delivery model, combining tier 2 and tier 3 services to enable the early intervention, continuity of care and a much more person-centered approach based on the THRIVE model.

Despite a clear vision there has not been a consensus to date on how a new service model could be sourced or delivered. Whilst the ambition for a much more integrated approach is compelling and exciting, the ultimate end state/delivery vehicle and the route to achieve this is not straightforward and requires a number complex and often competing issues to be taken into consideration.

With this in mind, a key recommendation of work conducted in Phase 1 of the programme was to consider sourcing options and to develop a roadmap for delivery, recognising that the longer-term end state will be more integrated and modelled towards an Integrated Care System (ICS).

3. **Requirement for sourcing**

Fundamental to the delivery of this programme is the requirement to achieve significant change or transformation. Transformation of the scale required will need the system to deploy core competencies and capabilities to lead complex service redesign overtime. Ensuring these core competencies and capabilities, together with the requirement to integrate and procure services needs to be considered in the round.
For the purpose of this paper, the term sourcing relates to a number of processes including structural change, procurement and contracting models. Essentially a number of considerations (detailed below) will need to be factored into any decision on sourcing a new service.

Although shown below as a linear process (reflecting the structure of the document) in reality many of the factors considered in this paper have interdependencies and will need to be considered in the round when making any final decision.

4. **The context for service transformation and issues to be considered**

4.1 **The current model of service provision is not fit for purpose and requires significant transformation**

At the heart of the local vision for CYPMH services is an integrated delivery model based on THRIVE. National NHS policy supports this view, including combining tier 2 and tier 3 services into a single model.

Currently CYPMH services are delivered through a traditional tiered approach from different providers with different referral processes and access criteria. This often results in a confused and fragmented system which bounces children and young people between tiers and allows others to fall between different services.
The existing services are under pressure and long waits have developed in parts of the system. This, and the lack of integration, prevents young people from being able to seamlessly access different parts of the service as and when required. Taken together the existing services are not fit for purpose and require significant transformation.

4.2 Commissioners have ambitious plans to further integrate children and young people’s service over time.
In addition to integrating CYPMH services there is an exciting debate underway locally about the potential to further integrate wider children’s services and mental health. It will be important to consider this emerging direction as new revised arrangements for CYPMH are designed and implemented. Future proofing any proposed changes to accommodate further phases of transformation will be essential to ensuring future longer-term sustainability.

4.3 Interdependency of current service provision with Suffolk
Current tier 3 services and an element of tier 2 services are provided by Norfolk and Suffolk Foundations Trust (NSFT). Suffolk are pursuing their own redesign of CAMHS connected to their locality-based alliance models. Any structural change to Norfolk CAMHS will need to take account of the timing and plans emerging in Suffolk so as not to destabilise service provision.

4.4 Age profile of services to be delivered and the impact on adult provision
Work with system leaders has concluded that the default assumption is that CYPMH services will be provided to the 0-25 age group. Effectively this means the CYPMH services will be provided to young people up to their 26th birthday when care, if required, will be transitioned to adult mental health services. Norfolk and Waveney STP are undertaking a parallel review and transformation of adult mental health services. Changes to CAMHS will need to take account of this process and consider how the shift to a 0 to 25 age range is achieved.

4.5 Current provider landscape and contract status
Currently, the main provider of tier 2 services is Point 1, a consortium of Ormiston families, Mancroft Advice Project and NSFT. This contract is held by NCC and is for approximately £1.9m.

Tier 3 services are provided by NSFT and are embedded within a block contract which spans all mental health services. This contract is managed by South Norfolk
CCG, and the approximate value of these services are currently being validated and will be confirmed in the next couple of weeks.

4.6 System strategy and move towards an ICS
The system has clearly signaled its intent to move towards an Integrated Care System. This approach would apply to children’s health and care services as well as adult services. However, an ICS is not yet a legal entity – although the NHS has clearly signaled a desire for legislative change at a national level to facilitate this.

Those systems moving first towards ICS models have done so through the use of existing contractual and legal frameworks (such as alliance and lead provider contracts) and with the support and consensus of existing providers and commissioners. The arrangements to a large degree function on the basis of consensual arrangements; the legal framework binding ICS’s together remains thin.

For the purposes of this phase of the sourcing process we have therefore not included ICS as a separate option for evaluation because it does not yet exist. But it is taken as understood that this is the direction of travel for Norfolk and Waveney. However, the evaluation below should be undertaken in the light of the intention to move towards an ICS and the compatibility of the various options with this desired end state considered.

5. The scope and function of what is required to be delivered

5.1 Vision and proposed service model
The vision for children and young people’s mental health in Norfolk and Waveney is to create a system in which all children and young people are thriving.

This means:

- Our core Child and Adolescent Mental Health Services (CAMHS) will move towards the THRIVE1 model of delivery.

1 THRIVE is a recognised best practice approach to CAMHS services developed by the Anna Freud Institute
• We will strengthen how we work with and connect to other services within the health and care system including education.
• These services will operate at the heart of a stronger set of partnerships with other statutory, community and professionals involved in supporting children and young people to thrive.
• Our approach – within CAMHS services and across partnerships - will be focused on the needs and strengths of the child or young person and their family; we recognise both the expertise and contribution of families, and that they may also have needs requiring support and services. This needs to be joined up with our work.
• Our work will be based on strong evidence and delivered by skilled clinicians and professionals. To be truly focused on individual children and young people we will need to be flexible and adaptive.
• Services will be available for children and young people from birth until the age of 25 (up to their 26th birthday); for those who need on-going support beyond this age, transition into services for adults will begin earlier and be responsive to the needs and development of each young person.
• There will be a consistent and less complex service offer across Norfolk and Waveney that recognises the needs and context of local communities.
• Adopting the THRIVE model is a subtle but fundamental shift in the way that the system views the mental health and emotional wellbeing of children and young people.

5.2 Scope of services to be included
Given the scale of ambition and change required, it is essential that there is system agreement on which services should fall within the scope of a future integrated service model. Engagement with system leaders has identified 4 categories that existing services can be placed into:

• Services that are in scope for the new service model to be commissioned from October 2020 and will operate under the new governance arrangements being considered
• Services that are likely to be in scope in the future, but not until after the October 2020 and that fall under the revised governance arrangements
• Services that are not in scope, but that need to fall under the new governance arrangements
• Services that are not in scope, having separate governance but need to be aligned with CYPMH services.
At a workshop event on the 28th/29th March 2019, system leaders agreed which current services provided fall into which category, and this should now inform all future contractual discussions.

6. Creating a sustainable integrated model requires the system to consider structural reform

6.1 The requirement for structural reform
National policy is increasingly to move towards an Integrated Care System (ICS) and this is consistent with emerging local policy development and has framed recent sourcing discussions.

Against this policy background and due to a number of challenges facing the existing service (detailed in Phase 1 of the programme), the system leadership has determined that the current configuration of services is not sustainable, or fit for purpose. In particular, the system has identified the requirement to better integrate services in order to meet the needs of service users.

Given the emerging clarity on the proposed service model and the commitment to integrated provision, combined with the issues within the current services, it seems likely that structural reform is a necessary element of the desired change.

6.2 Structural reform should be seen as an enabler for transformation and not an end point in itself
Structural reform on its own does not ensure transformation. Only if done correctly and targeted to address a specific issue can it act as a catalyst for broader service improvement, that otherwise would not be realised. The system should be aware that structural change is not in itself an end point and a key objective throughout this process must be to ensure that the system creates the right environment, leadership, capabilities and capacity to transform the service.

6.3 Potential benefits of structural reform
Developing closer integration between all aspects of care (primary, community, mental health, social and education) will be essential to unlocking the benefits of service reform for CYPMHs. These benefits include:
• Improved collaboration - sharing best practice and duplicated costs etc.
• Improved clinical management – reduction in duplication of management activities at a specialty level and potential reduction in clinical support overheads.
• Corporate management – reduction in operational management costs (single management team).
• Reduced transaction costs – simplified or streamlined contractual arrangements could reduce both commissioning and provider costs.
• Integration – reductions in patient ‘hand-offs’ and reduced organisational boundaries resulting in improved patient experience and outcomes.

Regardless of these benefits any approach needs to ensure that it is adaptable and flexible to future policy developments. To progress, the system now needs to confirm its chosen direction, seek consensus from key stakeholders and commence a phased programme of transformation.

The remainder of this paper considers the options available and sets out a clear recommendation on a practical way forward and the next steps required for consideration by the Executive Sponsor Group.
7. **The process and evaluation criteria**

### 7.1 The process adopted to evaluate options

In developing our recommendations, we utilised a simple methodology. The working group developed an evaluation framework together with a long list of options which were then shortlisted and explored in further detail.

### 7.2 The evaluation criteria

The following summarises the criteria used to evaluate options and were agreed by both the work stream members and subsequently the Executive Leadership Group:

| Impact on children and young people | • The degree to which any option enables or hinders quality of care  
| |   | • The degree to which any option enables or hinders improvements to user experience  
| | | • The degree to which any option enables or hinders improvements to user outcomes  
| | | • The degree to which any option enables or hinders the need to address health inequalities  
| | | • The degree to which any option enables or hinders our aim to extend the reach of services (nos CYP accessing MH support/treatment)  
| Fit with local and national policy | • Alignment with Norfolk & Waveney commissioning strategy - The degree any option facilitates or supports current plans to integrate tier 2 and tier 3 CAMS?  
| | | • Adaptability with emerging policy and requirements - Ability to support further integration for children’s services.  
| | | • Stakeholder and political support - How the public will perceive proposed changes and any reputational risks  
| Legal and regulatory compliance | • The degree to which any option is compliant with legal / procurement issues  
| | | • The degree to which any option provides the necessary regulatory framework for the services to be able to operate lawfully and compliantly  
| | | • Requirement for consultation and regulatory approval  
| | | • Complexity of governance arrangements - How complex the governance model is between all parties  
| Impact on operational and clinical stability (incl. workforce) | • Operational sustainability and improvement - The degree to which any option may impact on operational performance and resilience to demand pressures  
| | | • Workforce attractiveness - The degree to which any option is likely to impact on workforce retention and motivation  
| | | • The degree to which any option ensures that the endstate is compatible with maintaining staff benefits, for example NHS or local government pensions  
| Deliverability and support for service transformation | • Provider/market appetite for for the option under consideration  
| | | • The level of disruption vs maintaining the status quo - pain for gain  
| | | • The skills and IT infrastructure requirement - Competencies and capabilities required to deliver transformation  
| | | • Change capacity required - Level of change required to implement the target service model and resources required  
| | | • Overall risk profile of any proposal  
| Resource requirement and time to benefit | • Time to benefit realisation - How quickly benefits will accrue once implemented  
| | | • The total cost to implement the new model including procurement costs - the direct and indirect costs of any formal process should be considered, alongside the cost of not acting  
| | | • The impact of any option on stranded costs for any one organisation  
| | | • The degree to which financial risk is transferred to providers  

8. Developing the long list of structural reform options

The work stream developed a long list of options for consideration and these are set out below:

<table>
<thead>
<tr>
<th>Option</th>
<th>Status Quo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do nothing</td>
<td>• Retain contracts in their current form - CCG &amp; NCC commissions directly with multiple providers</td>
</tr>
<tr>
<td>2. Maintain current arrangements and bolster management team capacity</td>
<td>• Could involve an existing provider utilising external expertise</td>
</tr>
<tr>
<td>3. Integrate through an alliance model</td>
<td>• Awarding a contract across a number of providers to deliver shared service specification</td>
</tr>
<tr>
<td>4. Prime provider model sub contracting with others</td>
<td>• Commissioners contract with a prime provider who in turn may subcontract with other providers - potential new market entrant or existing provider</td>
</tr>
<tr>
<td>5. Develop a Joint Venture (JV) model</td>
<td>• Either as a contractual joint venture between providers or by creation of a separate entity</td>
</tr>
<tr>
<td>6. NCC arms length body</td>
<td>• Council would be whole share holder - soft outsourcing</td>
</tr>
</tbody>
</table>

9. Shortlisting options and evaluating

As previously stated, evidence from elsewhere shows that for any structural reform to be success there is a need for the reforms to be closely aligned to the challenges being faced by either the organisation(s) or system. In the case of Norfolk and Waveney CYPMHs the key challenges relate to the requirement for more integrated services to deliver:

- A reduction in hand-offs and interfaces between services and providers
- The ability to move workforce flexibly across services to meet the needs of children and young people and to deliver THRIVE effectively
- A simpler provider landscape – easier for professionals, young people and families to navigate – matched with a simpler contract and commissioning arrangements;
- A move towards a digital infrastructure that supports integrated working – single care record, single staff log-in, integrated reporting and performance data
• A single governance structure for clinical governance and wider decision-making
• A single leadership structure with clear accountability for all aspects of service delivery

An initial assessment of the long list of options determined whether the option had the potential to make a significant difference to these challenges. The analysis determined that 3 options on the long list failed to offer the degree of benefits required by the system, due either to the limited impact on reducing fragmentation, or the degree of complexity involved. As a result, 3 options were discounted and we focused on the potential of the remaining three options which have the greatest potential to join up the existing range of services across Norfolk and Waveney.

<table>
<thead>
<tr>
<th>Options Considered</th>
<th>Rationale</th>
<th>Shortlisted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do nothing</td>
<td>Fails to address any of the existing challenges and maintains status quo.</td>
<td>No</td>
</tr>
<tr>
<td>2. Maintain current arrangements and bolster management capacity</td>
<td>Not considered feasible and without other structural change would be unlikely to address the challenge of providing an integrated model of care.</td>
<td>No</td>
</tr>
<tr>
<td>3. Integrate through an alliance model</td>
<td>An alliance model would support and incentivize integration between providers across the health economy.</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Prime provider model sub-contracting with others</td>
<td>Subject to the capability of the prime provider and the effectiveness of subcontracting arrangements this model could provide an integrated model and a route to an ICS.</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Develop a Joint Venture Model</td>
<td>As with the alliance model above a joint venture would support integration between providers across the health economy and could be a route to an ICS.</td>
<td>Yes</td>
</tr>
<tr>
<td>6. NCC Arm’s length body</td>
<td>Discounted due to pensions issue, workforce acceptance of</td>
<td>No</td>
</tr>
</tbody>
</table>
Essentially the workstream considered the potential for integrating through the development of three shortlisted options:

- Alliance contracting
- Contracting joint venture, or
- Prime Provider

<table>
<thead>
<tr>
<th>Alliance Contracting</th>
<th>Corporate Joint Venture (JV)</th>
<th>Prime Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>An overarching contract between a number of parties agreeing to work cooperatively and share risk and reward. Commissioners could be party to the alliance agreement if there are obligations on the commissioner within the alliance too.</td>
<td>A contractual agreement between two or more parties to come together for the delivery of a particular project or service. The commissioner would contract with either a lead provider (contractual) or directly with a new entity (corporate).</td>
<td>Under this model the commissioner contracts with a single organization which either provides services directly as part of the agreement or sub contracts elements of the service to other providers. The prime provider holds each sub-contractor to account individually.</td>
</tr>
<tr>
<td><strong>Key Features:</strong> Equalit involving providers regardless of size – usually commissioner led; CCG manages collective performance only; Performance judged on overall outcome measures of the contract, aligning interests of the different providers;</td>
<td><strong>Key Features:</strong> JV accountable for provision of services and holds funds to pay for the activities of providers; Surpluses generated can be retained for reinvestment; All executive functions would be directly employed by the JV.</td>
<td><strong>Key Features:</strong> The prime provider could be a new or existing provider from within the local heath economy, or a consortium of providers; The CCG retains overall accountability for the commissioned service directly with the prime</td>
</tr>
</tbody>
</table>

non-NHS employer, risk appetite of NCC to be responsible for acute clinical services.
Sharing of risk and opportunities by all parties; and
Multiple organisations collaborating to achieve a specific defined goal.

non-executive team would be drawn from each provider organization and other independent sources; and
The organisation is resourced through secondment of key personnel.

provider while the prime provider holds any sub contactors to account individually;
The prime provider takes responsibility for service delivery and uses the terms of any sub contracts to leverage necessary changes across other providers.

Appendix A summarises the key features and provides a diagrammatic representation of the each of the models and the relationship between contracting parties. The following summarises the relative advantages and disadvantages of the models and their potential application and suitability locally.

<table>
<thead>
<tr>
<th>Alliance Contract Model</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Aligns objectives.</td>
<td>• Shared financial and clinical risk, reliant on the performance of other providers.</td>
</tr>
<tr>
<td></td>
<td>• No need for new organisational form.</td>
<td>• Requires multiple contracts, both alliance agreement and NHS standard contracts.</td>
</tr>
<tr>
<td></td>
<td>• Limits dominance of single organisation.</td>
<td>• May be unattractive to providers due to shared risks and rewards and requires strong relationships founded on trust, which may or may not be evident across the system.</td>
</tr>
<tr>
<td></td>
<td>• Potential to strengthen relationship between commissioners and providers.</td>
<td>• Considerable time and effort required up front to develop Alliance relationship.</td>
</tr>
<tr>
<td></td>
<td>• Commissioner manages collective performance only.</td>
<td>• Possibility of weak leadership and accountability unless</td>
</tr>
</tbody>
</table>
|                         | • Shares risks and rewards – incentivises closer collaboration an innovation. | }
### Applicability to CYPMHs in Norfolk & Waveney

- Offers the potential to implement more integrated and aligned working amongst the current providers, with for example, an enhanced management team, single point of access, one client management system and performance management framework.
- May not require any form of procurement process if the existing contracts with current providers continue unchanged.
- Potentially attractive to current providers as it could offer the possibility to demonstrate the ability to collaborate and transform services without the distraction of competition.
- However, it may be easier to put in place a more effective alliance where the relevant providers take on new contracts that are designed and co-ordinate with an alliance in mind, but this could necessitate a procurement process.
- Due to potential limitations in the ability of commissioners to vary existing contracts without triggering the requirement for advertising and procurement, this option may have limitations on the ability to affect service change through contractual means.
- Fits well with local commissioning strategy and likely to have stakeholder political support.
- Allows flexibility for NCC with Point One Contract to manage procurement risk and the potential to strengthen links with CCS and the Healthy Child Programme.
- Option likely to be acceptable to workforce.
- Would require strengthened leadership and infrastructure but represents a significant staging post towards further integration and an ICS longer term.

### Joint Venture (JV) Model

<table>
<thead>
<tr>
<th><strong>Advantages</strong></th>
<th><strong>Disadvantages</strong></th>
</tr>
</thead>
</table>
| • Aligns objectives and formalizes risk share arrangements.  
• Utilises provider organisations, resources and expertise with | • Objective alignment not as strong as in an integrated care organization.  

### Appropriate Governance Arrangements Established

- Objective alignment not as strong as in JV or ICS.
clearly stated terms and conditions of relationship.
- Shares risks and rewards – incentivizing closer collaboration and innovation.
- Contractual
- Flexible with easy entry/exit.
- Lower set-up costs.
- Corporate
- Single provider entity provides clear accountability to commissioners.
- Separate legal entity with limited liability.

- Significant time and resources required in developing JV agreement (contractual or corporate single entity).
- May be difficult to align providers with different cultures and management style.
- Contractual
- No limited liability.
- Requires additional contract (JV contract and NHS standard contract).
- Corporate
- Potential lack of ability of joint venture partners to demonstrate track record of transformation/integration at bid stage.
- Cost of formation
- Formalities and public filing requirements.
- ISAP definitely applies

#### Applicability to CYPMHs in Norfolk & Waveney

- Although aligns objectives and formalizes risk sharing arrangements, this option is considered high risk locally with limited national exemplars.
- Would require advertising and procurement as it would constitute a significant variation to existing contracts.
- Lack of local expertise and/or credible FT host locally.
- Would require significant time and resources to develop joint venture agreement and would require significant regulatory governance and approval.
- Given the current status of NSFT, this would be unlikely to command stakeholder or political support.
- This option likely to be less attractive to workforce due to potential changes to employment status.
- Overall this option is discounted because it is considered to be high risk and untested, this option would necessitate a significant amount of time
and effort associated with the establishment of a new entity with associated regulatory approval.

- The primary focus in the short term would be on creating a new entity which would distract from service transformation.

<table>
<thead>
<tr>
<th>Prime Provider Model</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advantages</strong></td>
<td><strong>Disadvantages</strong></td>
</tr>
</tbody>
</table>
| - Simple for commissioners to manage with simple contract for service. | - May be perceived as an unequal relationship with the prime provider being “in charge”.
| - Prime provider assumes direct control over service model with no doubt as to responsibility/liability. | - Cannot force sub-contractors to work together and therefore less suited to achieving integration.
| - Shifts clinical accountability on to prime provider with the option for sub-contracting dependent on need. | - Prime provider takes the risk regarding sub-contractor performance but may not have the sufficient skills in contracting, supply chain management and commissioning to manage relationships.
| - The commissioner has no direct relationship with sub-contractors. |  |

**Applicability to CYPMHs in Norfolk & Waveney**

- Although in principle attractive and would require commissioners to contract with one single entity, this option not considered feasible without advertising and following a procurement process.
- The only current local specialist provider, NSFT, is in special measures and has a challenging agenda associated with CQC, etc.
- The potential to attract a new market entrant considered to be unlikely.
- Significant costs associated with procurement process and inconsistent with local commissioning strategy.
- The concept of a single prime provider being able to provide all services without entering into sub-contracting arrangements is unlikely.

The sourcing workstream recognised that there is a relationship between the investment (both in time and effort) required to deliver integrated care and the level of integration and alignment achieved. The strength in alignment of
incentives increases when moving from an Alliance structure through to a more formal integrated care system where the level of integration is most developed.

Again, there is a relationship between the alignment of incentives and the drive for innovation, with the potential to deliver financial benefits and a more collaborative approach leading to the best results for children and young people. However, the cost and time to implementation increases from an Alliance to an ICS model reflecting the need to consider staging and gateways over time.

Although an ICS structure may represent the optimal long-term solution to the challenges facing children and young people’s mental health services, the system needs to consider the practical routes to a more integrated model. In this regard, a staged approach utilising an alliance model in the first instance, could be more practical in the short term and also more adaptable potentially over time, enabling emerging thinking around the development of a more holistic children’s service model to be developed.

10. Routes to a more integrated care model – system working and governance

Regardless of which structural option is pursued there are a number of ways the system can drive change within Norfolk and Waveney. Again, it is critical that there is agreement or understanding of these routes and how they can influence the future direction of system development.
Every organisation will have a different view on how transformation will impact on them and consequently how it should be developed. These vested interests will either hinder or support progress in the coming years. Accordingly, this section of the paper considers three potential routes that need to be understood and assessed for their impact and applicability locally.

10.1 Routes to an integrated model
In considering the way forward, the three routes considered are:

- A provider led model based on a proposition to commissioners;
- A system/economy led model based on strategic collaboration involving commissioners and providers; and
- A commissioner led model primarily based on procurement competition and contractual transactions.

The system leadership need to make a conscious decision on which approach to adopt. In deciding which route to follow, the system should ask itself some fundamental questions, some of which were considered and commented on as part of the diagnostic work completed in Phase 1 of the programme. Questions to be considered, include:

- What is the maturity of the relationship between commissioners and providers?
- What is the appetite and capability of existing providers to lead the required changes?
- What level of resource and time will be required?
- What behaviours are required?
- What is the potential impact on the workforce?
- What is the impact on the provider landscape?

Dependent on which model is deployed the system needs to recognize the impact of different approaches and how they can drive very different organizational and individual behaviours. These in turn can impact on both service outcomes and system success or failure over time.
A provider organisation or collaborative of providers take a lead in developing and driving a proposition to take to commissioners. Provider(s) must demonstrate both capability and capacity to lead change.

Local providers and commissioners collaborate to jointly develop an ICS overtime. No single provider leads the process with the commissioners taking a more central role with an opportunity to strengthen leadership and development of the model and service specification and seek the most capable provider/s via competitive tender procurement. Existing provider(s) will respond to such a tender either as lead provider or through a collaboration with other providers.

The providers retain more control over who to partner with/or not? Greater ability to ensure the incentives, risk/reward share is aligned with provider interests. Potentially faster lead time to develop the commercial proposition.

Utilises the capabilities and expertise of organisations already delivering CYPMH services. The ability to pool resources and capacity from other organisations in order to develop the ‘best fit’ solution for the local system. Relationships between all providers in the local system potentially strengthened. Time to implement the solution would be faster than a purely competitive route.

Clear focus on most capable provider and who has the competencies and capabilities to lead service transformation. Potentially encourages new market entrants and competition. Through procurement process, commissioners are able to enter into a competitive dialogue to test value for money.
Potentially will not lead to as fully integrated services and system over time. There is a risk that a lead provider could compete to become the lead provider and promote their own commercial/organisational interests. Provider(s) need to demonstrate that they are credible in their capability to transform CYPMHs.

Providers will lose some ability to influence the risk/reward share. Time to develop the commercial proposition may be extended due to requirement to negotiate with all parties. Way forward is dependent upon the willingness of all system players to collaborate and act in good faith.

Drives competitive behaviours potentially pitching organisation against organisation. May destabilise existing providers and the workforce. Can be resource intensive and requires system resolve to oversee process to conclusion.

<table>
<thead>
<tr>
<th>Local Assessment</th>
<th>Local Assessment</th>
<th>Local Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>To date, current providers have not demonstrated the capability or credibility to drive local change themselves. Key players, for example, NSFT, already have big agendas (CQC and being in special measures) and don’t currently have the capacity or credibility to drive change.</td>
<td>What appears to be emerging locally is an approach that is more collaborative and responsive in nature. The governance workstream is proposing a new CYPMH Board based on partnership working with Commissioners and providers shaping CYPMH strategy and delivery.</td>
<td>Not consistent with commissioner strategy. Likely to be seen by providers as counterproductive given the extent to which the current programme has been developed in an open and collaborative environment. Not likely to command stakeholder or political support.</td>
</tr>
</tbody>
</table>

Taking account of the above assessment, the clear view is that a collaborative route is the preferred way forward and is consistent with emerging thinking around system governance and the ambition, over time to move towards an ICS.

However, it should be noted that a collaborative route, described above, doesn’t automatically negate the need for commissioners to agree changes, or to advertise a contract and to potentially procure services. Indeed, the requirement to formally
advertise any contract will be dependent upon a number of issues considered in the Mills and Reeve advice received last year, and set out in Appendix B.

11. Requirement to deliver transformation

11.1 Requirement to reform core elements of the system and transform services
Regardless of which route is adopted, there needs to be a very clear understanding that in order to develop a more integrated system it will require reform to core elements of the health and care system, including:

- Care pathways;
- Workforce deployment;
- Staff terms and conditions;
- Information and technology;
- Contracting and reimbursement;
- Organisational structures; and
- Regulatory environments.

Specifically, in the case of the CYPMH services there will need to be considerable work undertaken to:

- Bring together capabilities, skills and resources currently across many organisations into a single enterprise;
- Revise care pathways, building on best practice and the Thrive model of care to better meet individual needs;
- Realign the activities of care professionals (including primary care, community, mental health, social and educational) around the Thrive model and patient needs as opposed to being bound by organisational structures; and
- Transition towards an outcome based contracting model that incentivises prevention and proactive care and rewards outcomes rather than inputs.

To oversee this scale of change it will be essential to ensure that the system has appropriate governance arrangements in place, but also that it creates and maintains the right environment between different parts of the system to build and sustain success over time. This work is being taken forward through a parallel work stream but is compatible with a range of integrations approaches.
11.2 Competencies and capabilities required to deliver transformation

Regardless of whichever route is chosen, the success of the overall programme will be dependent upon the engagement of the most appropriate providers who collectively have the appetite, competencies, capabilities and capacity to deliver the required transformation.

<table>
<thead>
<tr>
<th>Competencies</th>
<th>Capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Technical and commercial</td>
<td>Having the right infrastructure, systems and processes to support planning and commercial management</td>
</tr>
<tr>
<td>Relational</td>
<td>Ability to engage and work with the public, patients and partners to support the delivery of services</td>
</tr>
<tr>
<td>Transformational</td>
<td>Commitment and ability to deliver transformational change</td>
</tr>
<tr>
<td>Strategy and Vision</td>
<td>A clear strategy and vision for integrated care</td>
</tr>
<tr>
<td></td>
<td>This will underpin service integration and will need to be shared by all organisations and supported by commissioners</td>
</tr>
<tr>
<td>Leadership and Governance</td>
<td>Excellent clinical and managerial leadership</td>
</tr>
<tr>
<td></td>
<td>Clear governance and accountability structure in place</td>
</tr>
<tr>
<td>Processes</td>
<td>Clearly understood management processes to enable co-ordinated delivery and alignment across multiple organisations.</td>
</tr>
<tr>
<td>Technology</td>
<td>IT data systems will need to be in place to enable patient and performance information to be measured, monitored and shared.</td>
</tr>
<tr>
<td>Performance management</td>
<td>Performance requirements and expectations will need to be understood by all organisations involved in the delivery of the services</td>
</tr>
</tbody>
</table>
Financial and Risk Management | Risk and management controls are required to identify and manage safety, reputational, demand and financial risks. Clear approach to support allocation of resources and investment in services.

People and Culture | The ability to recruit and retain an appropriately skilled workforce across a number of organisations.

Sourcing and Collaboration | Providers will need to access resources from and collaborate with a range of organisations including the third sector.

Set against these requirements, we would recommend that the system undertakes an assessment of the systems preparedness to implement complex transformational change. A gap analysis should be used to help inform decisions around the potential parties to any future agreement.

Essentially, there needs to be a willingness on the part of existing providers to supplement existing capacity within organisations to address any identified capability and competency gaps. Based on work to date, there is a clear expectation that the leadership and infrastructure to support change in CYPMH services will need to be strengthened.

12. Overall assessment and recommendation on sourcing options

12.1 Recommendation on sourcing option

Taking together, both the assessment of structural options (considered in section 9) routes to system reform (considered in section 10) and the requirement for transformational competencies (considered in section 11), the preferred and recommended option is that an alliance model offers a practical and feasible option for the next stage of developing CYPMH services in Norfolk and Waveney.

In summary, an alliance model offers the potential to:
• Achieve structural reform, subject to the willingness and commitment of providers to work together;
• Enable current providers to continue to work together to achieve a move towards THRIVE and integration of tiers 2 and 3 services;
• Align the interests of providers and commissioners, as a pragmatic first step towards an ICS model.
• Limit workforce disruption;
• Avoid distraction and cost of a lengthy procurement process;
• Pursue this option in parallel with the NHS assurance process leading to public consultation probably in spring 2020;
• Be compatible with the review of adult mental health services and the future determination of NSFT;
• Allow flexibility for NCC with Point 1 contract to manage procurement risks
• Further explore potential links with CCS and the healthy child programme; and
• Leverage additional capacity and capabilities to support service transformation at an alliance level, for example, appointment of an Alliance MD, Medical Director, etc.

Although an alliance model is not considered to be the optimal end state it does represent a significant stepping stone towards an ICS and would allow commissioners to be part of the alliance agreement.

This approach would offer the opportunity for commissioners to test both the appetite and capability of existing providers to deliver transformation and is aligned to the Norfolk and Waveney Commissioning Strategy. Similarly, we would envisage that this approach should be seen positively as an opportunity for provider organisations to demonstrate their capabilities and to enhance their credibility and reputation. It is also a good fit with the approach being taken in Suffolk and should therefore minimize service anomalies and equity issues for the population of Waveney, and smooth other border issues for locations such as Thetford.

12.2 Conditions for an alliance model
Given the scale and pace of change required we would recommend that there is a structured programme with clearly defined check points and milestones along the route to an alliance agreement. Furthermore, we would propose a number of conditions would need to be attached to the proposed way forward, including:
• Commissioners being party to the alliance agreement with clearly defined responsibilities and obligations; for example, commitment to service investment and leadership/transformational support
• Agreement and alignment of individual contracts to underpin new service model and outcomes
• Development of a clear road map and milestones to track progress and to hold all parties to account
• Agreement and commitment of providers to develop an alliance model, with draft heads of agreement prepared and signed off by September 2019, shadow operation for the alliance from October 2019 to drive transformation and to bed in new relationships and working arrangements and a go live start date in October 2020 (subject to NHS assurance and public consultation).

12.3 Associated procurement risks
As previously stated, the adoption of an alliance model does not automatically negate the need to follow a procurement process.

Procurement of health care services in the NHS is carried out under two sets of regulations: the so-called section 75 regulations 2, made under powers in the Health and Social Care Act 2012, and the Public Contracts Regulations 2015, which implement EU rules on public procurement. The two sets of regulations overlap in terms of some of their requirements but following one of them does not automatically mean a commissioner is meeting the requirements of the other.

Under the Public Contracts Regulations, contracts over a certain amount (£615,278 over the lifetime of the contract) need – with some limited exceptions – to be advertised by the commissioner in the Official Journal of the European Union (OJEU). Where more than one provider subsequently expresses an interest, this would require running an applicable competitive procurement process.

The services under consideration fall within what is known as the ‘light touch regime’, under the Public Contracts Regulations 2015 allowing flexibility for commissioners to decide their own appropriate process and timescales, provided that they are reasonable, proportionate, transparent and allow equal treatment of all providers.
Notwithstanding the fact that the NHS is currently consulting on proposed changes that may, or may not, affect future requirements for commissioners to procure services, the default position today, is that commissioners are required by the Public Contract Regulations 2015 to advertise services of this value and to undertake some competitive procurement process if required.

12.4 Requirement for legal advice

In 2018 commissioners sought legal advice from Mills & Reeve (Appendix B) on options for commissioning children’s and young people’s mental health services. At the time, the advice confirmed that there were a number of ways in which the services could be commissioned going forward. The advice stressed the importance of completing the service redesign work so as to conclude what services are needed, their scope and function. Mills & Reeve further advised that only then would it be possible to identify the best route to commissioning services and whether or not a competitive procurement would be required.

This report, in no way represents a legal opinion and Rethink Partners would strongly advise that commissioners seek further legal and procurement advice on any option(s) under consideration.

13. Assurance process and requirement for consultation

Given the scale of transformation and the changes proposed it is likely that the new service model being developed, and scheduled to start in October 2020, would be considered to be a ‘substantial development or variation’. This raises the question of liaison with HOSCs in Norfolk and Suffolk and agreement about what arrangements need to be put in place for public consultation. Essentially, if there is a requirement for consultation, and this seems likely, then there is an NHSE led assurance process that needs to be navigated before consultation can commence.

This will entail assurance on all aspects of the proposed change – not just the consultation process itself. This process is run at either a regional or national level; and given the status of NSFT, the latter seems likely.

The NHSE assurance process is based on four key tests:
• Strong public and patient involvement
• Consistent with current and prospective need for patient choice
• Clear clinical evidence base
• Strong support from clinical commissioners

14. **Key next steps**

To progress, the system now needs to confirm its chosen direction, seek consensus from key stakeholders, including provider organisations and commence a phased programme of transformation.

The following sets out at a high-level next step.

• Urgent discussions with providers to test appetite for an alliance model.
• Develop an early draft of an Alliance Heads of Terms to confirm parameters and approach; this must be developed collaboratively, but quickly and seek to achieve sign-up to key terms and arrangements for the proposed shadow operating period. It has been suggested that connecting with a system already operating alliance models would be very helpful and that some training and development on this topic for the system would also be useful and timely.
• Consult with regulators around emerging thinking and obtain clarification on any requirement for public consultation and associated assurance processes.
• Early engagement with HOSC (Norfolk and possibly also Suffolk)
• Develop critical path with clear timelines and milestones with clear gateways for critical decision points.
• Progress dialogue with provider partners and undertake an analysis of the system’s competencies and capabilities to progress system change with a view to identifying gaps.
• Based on a ‘gap analysis’, revalidate collaboration as preferred option and assess partner requirements for any future alliance model.
• Confirm partnering options with both regulators and commissioners.
• Finalise and agree Heads of Agreement by September 2019.
• Move to shadow operation from September and turn Heads of Agreement into formal contractual relationship.
Consider resource / capability requirements to support and manage this process alongside achieving service transformation; in particular there is a need for strong commissioning leadership, strengthened provider leadership within the alliance, and finance / legal / OD support and programme management to manage the process of transition.

15. Appendices

Appendix A – Summary of the key features and diagrammatic representation of the each of the models and the relationship between contracting parties.

Appendix B – Mills & Reeve Legal advice.
CHILDREN AND YOUNG PEOPLE’S MENTAL HEALTH ALLIANCE BOARD

TERMS OF REFERENCE

Introduction

Following a wide-ranging review of Children and Young People’s Mental Health Services (CYPMH), the five Clinical Commissioning Groups (CCGs) across Norfolk and Waveney and Norfolk County Council (NCC) have agreed to establish a new cross system Board to be responsible for relevant aspects of CYPMH planning, commissioning and provision. This will be known as the CYPMH Alliance Board.

The Board’s core purpose is to be the leadership vehicle for CYPMH in Norfolk and Waveney. It is a mixed commissioner and provider forum, in keeping with the ‘one system’ approach to the transformation of CYPMH and the wider development of Norfolk and Waveney as an Integrated Care System (ICS).

The Board is not a sub-committee of the statutory bodies, but has authority to act on behalf of the relevant bodies through the delegated authority of the Board’s members and the Section 75 Agreement between the CCGs and NCC.

The Sustainability and Transformation Partnership (STP) recently established a Children’s and Young People work stream, with the Executive Director of Children’s Services at NCC taking on the role of Senior Responsible Officer (SRO). Work to transform CYPMH falls within this workstream.

The Alliance Board replaces a range of other fora, including:

- CAMHS Redesign Steering Group
- CAMHS Strategic Partnership
- CAMHS Joint Commissioning Group
- CYP IAPT Partnership

As the functions of these groups now fall within the remit of the Alliance Board, they will be stood down with immediate effect.

Purpose
The core purpose of the Alliance Board is to be the cross-system forum that provides leadership for, and takes decisions about, all relevant aspects of CYPMH. It is the focal point for this set of services.

The remit of the Board is deliberately wide ranging; it is intended to be provide clarity of system (not organisational) decision making and accountability for CYPMH. Its principal purpose is to: set strategic direction and ensure delivery of system plans; lead service transformation; collectively assess and improve operational delivery; act as the Executive Group for the Section 75 Agreement (Part B, see below); monitor system financial performance; develop and sign off system plans and submissions; manage relevant interfaces with regulators regarding CYPMH on behalf of the system; develop the alliance agreement and related contracts; take an overview of service performance.

Operation of the Board – Part A and Part B

It is the intention that in most circumstances the full Alliance Board will meet together to discharge its duties (“Part A”). However, there will be a small number of occasions when it will be necessary for the commissioning members of the Board to meet separately in order to take decisions that must, under the current legislative and regulatory framework, exclude providers (“Part B”). Examples include:

- When the Board is acting as the Executive Group for the Section 75 Agreement
- In taking decisions about an individual provider’s contract
- In taking decisions on procurement or contract award or other commercially sensitive issues where a member of the alliance has an actual or potential conflict of interest

Financial delegation

In establishing this Board, the five CCGs in Norfolk & Waveney and NCC have agreed to delegate to it the authority to take decisions about the way in which the current funding for mental health services is used to best meet the needs of CYP. They have done this by developing a Section 75 agreement encompassing all existing expenditure between the parties on relevant CYPMH services (primarily ‘tier 2’ and ‘tier 3’ services).

For the avoidance of doubt, the Alliance Board is not authorised to change the aggregate level of funding (or the contributions of the individual parties). It may, however, make recommendations to the five CCGs and NCC about proposed changes to the level or nature of funding.

Core functions

Matters for all members (Part A)

The Board’s core functions are to:

- Receive and consider information and data on the current and future mental health needs of CYP and families and develop plans to meet these needs
- Receive regular insight reports on the views and preferences of CYP and families
- Ensure that all aspects of CYPMH (including the work of the Board itself) actively seek and act on the views of CYP and their families
• Develop and agree strategic plans for the transformation of CYPMH service, including the further development of the service model and determining priorities for development; oversee and be accountable for delivery of these plans
• Develop and implement the system Alliance contracting approach; specifically development and timely review of the alliance agreement
• Develop and introduce system outcome measures and KPIs that will apply to all organisations, including quality/waiting time standards for relevant services
• Receive and consider financial, performance and quality reports; develop and implement recovery plans as required
• Develop and agree on behalf of statutory bodies relevant CYPMH national and regional reports and submissions, including the Local Transformation Plan (LTP);
• Be the main point of interface with NHS regulatory bodies for whole system CYMPH issues¹
• Develop and agree system-wide approaches to key CYPMH issues including:
  o Workforce planning and development
  o Innovation and research
  o Capacity modelling
  o Development of the third sector
• If required, develop recommendations for JSCC/CCG Governing Bodies/NCC Corporate Board on potential changes to the financial envelope, significant service change or changes to key agreements such as any Section 75
• Take an overview of the performance of existing services
• Liaison with NCC and SCC to promote and enable wider integration of children’s services and ensure wider plans for health, social care, and education are congruent with and take account of CYPMH issues
• Liaison with NHSE specialised services on tier 4 services and the development of new pathways
• Collectively agree the Board’s annual work plan and risk register
• Oversee the development of the Alliance contract
• Ensure there is effective communication to the wider system about CYPMH

Matters reserved for commissioning members only (Part B)
• To act as the Executive Group overseeing the Section 75 Agreement
• Where required, take commissioning/contractual action to promote improvement of existing services, including consideration of alternative providers
• If required, develop recommendations on the further development of, or conduct of, any procurement within the market for CYPMH services in Norfolk and Waveney
• Oversee the development of the Alliance Contract (commissioner only aspects)

¹ For the avoidance of doubt, the Alliance Board does not (and cannot) have delegated accountability for liaison with regulators (e.g. CQC) on organisation-specific issues
The Board may establish sub-groups or task and finish groups to support it in the discharge of its functions.

**Membership and Quorum**

- Executive Director of Children’s Services, NCC, SRO for CYP, STP* (Chair)
- Associate Director for Children and Young People, CCGs*
- Associate Director of Financial Planning and Transformation, CCGs*
- Assistant Director of Early Help and Prevention, NCC*
- Head of Education Vulnerable Groups Achievement and Access Services, NCC*
- Assistant Director, Transformation, CYP, Suffolk County Council*
- Associate Director of Nursing and Quality, CCGs*
- Associate Director/Head of Mental Health, CCGs*
- Chief Executive/Service Director, NSFT
- Clinical Director, NSFT
- Commissioning Manager for CYP, NCC/CCGs
- Chief Executive, Ormiston Families
- Chief Executive, MAPP
- Head of Service, Norfolk Children and Young People’s Service, CCS
- Clinical lead, CYPMH Services*
- Assistant Director of commissioning (tier 4), NHS England*
- Chair/Vice Chair of relevant CYP/family networks
- CYPMH Communications leads
- Co-opted 3rd sector representative
- [DN – links to PCNs and Primary Care?]
- [DN – may want to include CCS?]

*Part A and B members; all other members are Part A only*

The Board will be quorate if (a) two thirds or more of its members are present, and (b) at least one of the Chair or Vice Chair is present. If a member cannot attend a meeting, a named deputy can be nominated, provided they are able to contribute and make decisions on behalf of the person that they are representing.

The Alliance Board will be chaired by the Executive Director of Children’s Services, NCC and the Associate Director for Children and Young People, CCGs will act as the Deputy Chair. Where the Chair is absent, the Deputy Chair will take on the role of the Chair.

**Accountability and reporting**

The Alliance Board is accountable to both the Joint Strategic Commissioning Committee (JSCC) and the Senior Leadership Team of NCC Children’s Directorate [DN – may need to be Corporate Board?].
The minutes of the Alliance Board, together with a cover note highlighting any decisions made, will be circulated to JSCC and NCC SLT within 10 working days of the Alliance Board meeting.

In recognition of the important place of CYPMH occupies within wider children’s services, the Board will also report informally to the STP Executive, the N&W Children and Young People Strategic Partnership Board and other fora as required.

**Co-production and engagement**

The Board will seek to ensure that all parts of CYPMH – including its own work – encourage and promote co-production and engagement with service users.

**Conduct of Business**

Meetings will be held monthly. The agenda will be developed by the CYPMH Team in discussion with the Chair. Circulation of the meeting agenda and papers via email will take place at least three working days before the meeting is scheduled to take place.

**Decision Making and Voting**

The Board will at all times aim to make decisions by reaching a consensus among its members. Where this is not possible, the Chair will ask all members to vote. A simple majority of members (in either Part A or Part B) is required to reach a decision. The Chair will have the casting vote in the event of an equal number of votes.

**Confidentiality**

Information obtained during work of the Board must only be used for the purpose it is intended. Particular sensitivity should be applied when considering financial, activity and performance data associated with individual services and institutions. The main purpose of sharing such information is to support the development of CYPMH and should not be used for other purposes (e.g. performance management, securing competitive advantage in procurement).

Members of the Board are expected to protect and maintain as confidential any privileged or sensitive information. Where items are deemed to be privileged or particularly sensitive in nature, these should be identified and agreed by the Chair.

**Support**

Support to the Alliance Board will be provided by the joint CYPMH Team.

**Review**

These terms of reference will be formally reviewed at least annually.

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_June 2019_