July 2017

North West London Collaboration of Clinical Commissioning Groups

Report of the NW London CCGs' collaboration board – July 2017

Version: 15 June 2017

Author: Emma Raha, collaboration governance manager, NW London CCGs

This report summarises the key issues recently discussed by the collaboration board (a joint committee) to bring transparency as we collaborate across our eight individually sovereign CCGs in NW London. It reports on the board's activity since the report to the previous governing body meetings in May (dated 26 April 2017) and provides details of the joint decisions taken.

Collaboration board meetings held between 20 April and 15 June 2017

Thursday 27 April 2017 – strategy and transformation
Thursday 4 May 2017 – primary care digital delivery (a new operational meeting) followed by business intelligence and informatics strategy
Thursday 18 May 2017 – strategy and transformation
Thursday 1 June 2017 – business intelligence and informatics ('digital commissioning') strategy followed by strategy and transformation

Decisions taken during the reporting period

At the board's meetings, the CCGs take joint decisions on Planned Procedures with a Threshold policies, which is an area of authority that has been delegated to the joint committee. Healthwatch representation and lay member representation on behalf of the CWHHE and BHH CCGs were present at the meetings where the board discussed and decided on the below areas of commissioning policy, described at section 1.

1. Commissioning policy developments

The board ratified the following policy on 27 April 2017:

1.1 NW London CCGs' PPwT policy for acupuncture, low back pain and sciatica (incorporating NICE guidance 59)

1. NW London CCGs do **not** commission spinal injections and the following interventions for low back pain:
   a. facet joint injections
   b. therapeutic medial branch blocks (see point 3)
   c. epidural steroid injections (except in sciatica; see point 4)
   d. intradiscal therapy
   e. prolotherapy
   f. trigger point injections with any agent, including botulinum toxin
   g. other spinal injections not specifically covered above

2. NW London CCGs do **not** commission acupuncture for any condition (e.g. back pain, sciatica, osteoarthritis)

3. NW London CCGs fund radiofrequency denervation for chronic low back pain when all of the following criteria are met:
   a. non-surgical treatment has not worked for them (see NICE pathway)

b. the patient has moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral
c. a diagnostic medial branch block provides at least 80% improvement on a visual analogue pain scale for the duration of the block
d. the patient is provided multiple blocks or denervations carried out in one session as a package of care

In addition:

- Retreatment is not routinely funded (application for retreatment requires request of funding via IFR demonstrating exceptional circumstances)
- Imaging is not offered for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation

4. NW London CCGs fund epidural injections (local anaesthetic and steroid) for sciatica where the pain is acute (defined as the onset of the pain being less than 3 months at time of referral) and severe.

5. NW London CCGs do **not** commission epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

6. NW London CCGs will not fund the following surgical procedures for non-specific low back pain. (Specific causes of LBP e.g. spondylolisthesis, scoliosis or severe structural disease are out of scope and not covered by this policy):
    - spinal fusion, except as part of a randomised controlled trial (RCT)
    - lumbar disc replacement

7. NW London CCGs recommend that imaging **should not be routinely offered** in a non-specialist setting for people with low back pain with or without sciatica.

The board further approved the following recommendations made by the NW London CCGs' Policy Development Group (PDG) to **decline** the Adacolumn and Biological Mesh business cases submitted by St. Mark's Hospital, London North West Healthcare NHS Trust, the reasons for which are set out below. The board was unanimous in agreeing the recommendations of the PDG, particularly due to the lack of evidence of clinical and cost effectiveness for both cases.

1.2 Adacolumn for patients with moderate to severe ulcerative colitis

The board approved the PDG's recommendation to decline the business case on the basis that there was insufficient evidence of both clinical and cost effectiveness to put forward a recommendation to support the use of Adacolumn.

It was noted that the NICE had not issued updated guidance about the use of Adacolumn since 2005, when it had been deemed as not clinically or cost effective. In addition, it was noted that there was no guidance issued from the British Society of Gastroenterology. The PDG noted that the costing in the business case was not representative of health economic modelling analysis and therefore it was not possible to determine if the treatment was cost effective. The PDG had concerns that the cohort of patients likely to be impacted by this device was potentially larger than described in the business case particularly if it were to be offered as a choice in place of biologics and surgery.

1.3 Biological Mesh in repair of contaminated complex abdominal wall defects

The board approved the PDG's recommendation to decline the business case on the basis that at this stage there was insufficient evidence of clinical and cost effectiveness to put forward a recommendation to support the use of Biological Mesh. The PDG emphasised their willingness to review the case if resubmitted with a stronger clinical evidence base. In the meantime, for patients with evident exceptional clinical circumstances, the Trust could continue to apply for funding via the IFR route.

1.4 Benign skin lesions project – next steps

The board noted the work to date of the IFR/PPwT team to review pathways and activity for benign skin lesions (non-pigmented), which had highlighted the need to increase capacity in primary care in this area. The board agreed the team's proposal to assess capacity in community provision to enable fuller discussion.

In addition to the above developments in commissioning policy, the board discussed the CCGs' joint strategy and transformation work, reported at section 2 below, and our collaborative approach to digital commissioning, reported at section 3.

2. Strategy and transformation meetings – key areas of focus

2.1 Choosing Wisely – prescribing policy

The board has considered regional and national developments in the area of prescribing policy for products judged to be of limited clinical effectiveness. Over the course of 2017/18, the collaboration of CCGs will continue to explore together with local GPs, lead pharmacists, and patients, what approaches represent best value for prescribing to ensure the best possible quality of care and health outcomes for patients in NW London.

2.2 Reducing repeat prescribing waste

A medicines management programme is underway to evaluate current trends in repeat prescribing activity across NW London. The aim of the programme is to ensure that patients are only prescribed medicines that are (or continue to be) clinically required, and to ensure that patients have greater control over and involvement in their own ongoing medicines management planning. This includes an assessment of the range of prescribing systems in place and an evaluation of the impact this has on patterns of behaviour around self-led care.

2.3 Out of hospital hubs

The board reviewed common aspects in relation to out of hospital hubs planning processes in the light of transformation workstreams within the Sustainability and Transformation Plan (STP) and other sources such as the GP Five Year Forward View. It was proposed that support transformational work a central repository would be created to support further hub development, recognising that work is locally owned and informed by engagement with patients and clinicians, and there is no 'one size fits all' model. The board supported the principles of the offer for the strategy and transformation directorate to compile a guide to support local service planning and transformation alignment of out of hospital hubs with key developmental workstreams. It was recommended that the Clinical Board would form a sub-group to determine common clinical principles and

standards.

2.4 Transformation PMO ('TPMO') reporting to NHS England

The board was updated on the new transformation PMO reporting requirement to NHSE, which would apply to the NW London STP as a whole. The richness of the reporting would provide a detailed framework for performance management (operational outcomes) and financial control monitoring, as well as transformation delivery milestone reporting. It was recognised that national reporting requirements around the national priority areas are not fully aligned with the STP priorities and that it will be important that both can be monitored to demonstrate achievement against priorities to different audiences. The board recognised that this was likely to be challenging in the early stages.

2.5 NW London approach to maternity commissioning

There is a focus and momentum both nationally and at a North West London-level to drive maternity improvements, following the changes to maternity services in NWL in 2015 and National Maternity Review in 2016. The leadership of Maternity at a network level is now managed through the newly established local maternity network. The board was asked to discuss and generate recommendations for maternity commissioning to act in a more connected way to support both 'business as usual' maternity commissioning and the elements of maternity within Delivery Area 5 of the NW London STP. It was agreed that a maternity lead would be selected from among the local CCG leads.

2.6 Musculoskeletal transformation programme

Dr Ian Bernstein, Merav Dover and Jane Murphy presented an update on the NW London MSK transformation programme. The board noted that the service specification needed to be refreshed and pathways developed to manage co-morbidities better and to reduce elective demand. Programme objectives would be designed to increase patients' quality of life in terms of their mental health and their ability to be economically active. It was explained that the seven 'embryonic' programmes in this area were subject to affordability being tested locally and that the intention was to seek patient co-design in the projects and overarching governance structures that would be required. Best practice in this area was discussed and the 'Ontario' principle was cited, whereby a system of patient befriending before and after operations has a positive impact on health outcomes. The board understood that providers were in agreement that the programme was the right course of action, with the investing organisations directly accruing any resulting savings (i.e. through an appropriate risk/gain share arrangement). The next steps were for project business cases to be developed for review by CCG and Trust finance officers. The case for proportionate central resource to support this work would be taken into account as part of the S&T 2017/18 deliverables being developed.

2.7 Future of digital communications for the CCGs

Senior members of the communications and IT teams presented a proposal to develop detailed plans for a unified digital communications platform for the NW London CCGs. The board noted the current landscape consisting of separate hosting solutions across websites, extranets and intranets, and the opportunity to consolidate costs and processes to improve effective communications and reduce overall inefficiencies. The context to this included three digital communications portals being due for replacement or migration due to obsolescence, or issues with user functionality. The board welcomed the recommendation that solutions be found enabling staff working for multiple CCGs to

publish once to multiple sites. The need for content management resource was further noted. The board reflected on overall opportunities to strengthen collaboration through a unified approach to broader communications strategy, and its important role in increasing transparency and in deepening patient and public involvement.

3. Digital commissioning (delivery and strategy) – key areas of focus

3.1 Revised terms of reference (TOR)

New terms of reference were discussed, which the board has recommended for approval by CCG governing bodies. The new TOR reflect changes to the informatics strategy and business intelligence session, which has been renamed 'digital commissioning strategy'. A new and linked operational meeting has also been established to provide sufficient space for managing the ICT service and to take joint decisions on how Estates and Technology Transformation Funding (ETTF) funding, held by NHSE on behalf of the STP, will be spent in line with the specifications approved by NHSE.

3.2 Cyber security business case

The board noted the major cyber security incident in May, which had affected hundreds of NHS organisations, which provided the backdrop to discussions about bringing Information Governance, cyber security and Caldicott Guardian structures closer together. The importance of protecting patient information was discussed and members agreed the need to achieve sufficient access and information sharing whilst also managing safe and secure systems. The board was supportive of the proposals and asked that further work be carried out to confirm proposed funding and staffing arrangements.

3.3 Whole systems integrated care ('WSIC') dashboard

The board has begun to discuss the potential future options for WSIC noting the CCGs' relationship with McKinsey & Company in parts of its development. It was agreed that a business case would be brought back to the board with a view to recommending to the CCGs a joint 'once for NW London' decision. Members concurred that due to its importance to CCGs in terms of data analytics, the product needed to be accelerated to maturity and it was recognised that there were would be different routes available to doing so, with varying attendant risks and costs to be considered collaboratively.

3.4 NW London STP Digital Programme Board and Local Digital Roadmap (LDR)

Proposals for what could be done given a reduce funding base would be brought back to the collaboration board. In discussion on Global Digital Exemplar (GDE) plans, the board was advised that Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust had achieved 'fast follower' status and had been awarded £10m and £5m respectively to improve their digital maturity. The board noted the emerging change in direction from central government relating to the application of Local Digital Roadmap funding, which would now prioritise secondary care settings, noting that this would have repercussions on the level of remaining funds available to pursue the digital agenda for integrated out of hospital care.

3.5 BI procurement update

CCGs had indicated that they were keen to re-launch WHYSE, which as a robust interim solution (pending future re-procurement) was now ready for licensed system users to

use. It was noted that a full London-wide BI procurement had been finalised and agreed; however, launch would be delayed until September 2018. It was confirmed that governing bodies have signed off the specification for procurement and the whole of London had benefitted from the NW London CCGs' specification. It had been considered prudent to join the London-wide initiative, as it was strategically important to have a single data warehouse service.

3.6 Digital transformation programme

The board received an updated on external funding for primary care digital services, capital and WiFi funding.

3.7 ICT service performance

An aggregate report on a CCG by CCG basis was received for information.

About the NW London CCGs' collaboration board

The collaboration board meets fortnightly on a Thursday to discuss strategy and transformation proposals across NW London. It brings together eight CCG chairs, two chief officers and shared directors to discuss joint strategic objectives and proposals in order to form a consensus view taking into account the needs of local health populations. Additional members attend depending on the meeting mode and these include lay members, additional clinical Governing Body representatives and Healthwatch. It has delegated authority from the CCGs in which it can take joint decisions in response to the recommendations of NWL CCGs' Policy Development Group on Planned Procedures with a Threshold (PPwTs).

The board additionally serves to guide the CCGs' overall approach to the contracts rounds and to developing business intelligence and informatics strategy, as well as to develop for approval and then review progress against the NWL CCGs' joint finance strategy which funds joint areas of strategy and transformation as well as provider transition support.