Healthier Lancashire & South Cumbria

Joint Committee of CCGs (Formal)

Thursday 4 March 2021
13:00 – 14:30 MS Teams Videoconference

Part 1

AGENDA

Item	Description	Owner	Action	Format
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Declarations of Interest/Conflicts of Interest Relating to Items on the Agenda	Chair	Note	Verbal
3.	Minutes of Previous Meeting and Actions – 14 January 2021	Chair	Approve	Attached
4.	Key Messages	Dr Amanda Doyle	Discuss	Verbal
5.	System Reform	Andrew Bennett	Discuss	Attached
6.	Lancashire and South Cumbria Medicines Management Group Recommendations	Brent Horrell	Approve	Attached
7.	Lancashire and South Cumbria Clinical Commissioning Policies for Glucose Monitoring Update	Brent Horrell	Approve	Attached
8.	System Quality and Performance Report	Julie Higgins	Discuss	Attached
9.	New Hospitals Programme a) Update b) Case for Change	Rebecca Malin	Discuss	Attached Verbal
10.	Partnership Pledge for Lancashire Family Safeguarding Model	Margaret Williams	Approve	Attached
Item for Information				
11.	All Age Briefing on Mental Health, Learning Disability and Autism Programme	Peter Tinson	Note	Attached
Any Other Business				
12.	Any Other Business	Chair	Note	Verbal

Date and Time of the Next Informal meeting of the new Strategic Commissioning Committee for Lancashire and South Cumbria:
Thursday 15 April 2021, 13:00-15:00, MS Teams

Date and Time of the Next Formal meeting of the new Strategic Commissioning Committee for Lancashire and South Cumbria:
Thursday 13 May 2021, 13:00-15:00, MS Teams

Minutes of a Formal Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs) Held on Thursday, 14 January 2021 via Microsoft Teams Videoconference

Part I

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Dr Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
Roy Fisher	Lay Chair	NHS Blackpool CCG
Graham Burgess	Lay Chair	NHS Blackburn and Darwen CCG
Kevin Toole	Lay Member	NHS Fylde and Wyre CCG
Dr Geoff Jolliffe	Clinical Chair	NHS Morecambe Bay CCG
Dr Richard Robinson	Chair	NHS East Lancashire CCG
Jerry Hawker	Chief Officer	NHS Morecambe Bay CCG
Paul Kingan	Chief Finance Officer	NHS West Lancashire CCG
Geoff O'Donoghue	Lay Member	NHS Chorley and South Ribble CCG
Doug Soper	Lay Member	NHS West Lancashire CCG
Dr Adam Janjua	GP and Chair	NHS Fylde and Wyre CCG
Dr Benjamin Butler-Reid	Clinical Director	Fylde Coast CCGs
Debbie Corcoran	Lay Member	NHS Chorley & South Ribble CCG
Dr Sumantra Mukerji	Clinical Chair	NHS Greater Preston CCG
Dr Lindsey Dickinson	Clinical Chair	Chorley & South Ribble CCG
Denis Gizzi	Accountable Officer	NHS Chorley South Ribble & Greater Preston CCGs
Dr Julie Higgins	Chief Officer	NHS East Lancashire CCG
Andrew Bennett	Executive Lead Commissioning	Lancashire and South Cumbria ICS
Gary Raphael	Executive Lead for Finance and Investment	Lancashire and South Cumbria ICS
Carl Ashworth	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Jane Cass	Locality Director	NHS England and Improvement
In Attendance		
Becky Higgs	Business Manager	Lancashire and South Cumbria ICS
Gary O'Neill	Senior Manager	NHS Morecambe Bay CCG
Beth Goodman	Head of Contracts and Acute Commissioning	NHS Blackpool CCG
Gemma Hedge	Planning, Transformation & Delivery Officer (Planned Care)	NHS East Lancashire CCG
Steve Thompson	Director of Resources	Blackpool Council
Neil Greaves	Head of Communications	Lancashire and South Cumbria ICS
Victoria Ellarby	Programme Director – System Reform	Lancashire and South Cumbria ICS
Stephanie Betts	Business Affairs Lead	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Affairs Co-ordinator	Lancashire and South Cumbria ICS

Routine Items of Business	
1.	**Welcome, Introductions and Apologies** The Chair, David Flory, welcomed members to the Formal meeting of the Joint Committee of CCGs (JCCCGs) held virtually via Microsoft Teams videoconference. Apologies had been received from Katherine Fairclough, Neil Jack (Steve Thompson representing) , Laurence Conwy
2.	**Minutes of the Previous Meeting Held on Thursday 5 November 2020** The minutes of the previous formal Joint Committee of CCGs Part I held on Thursday 5 November 2020 were agreed as a true record, proposed by the Chair David Flory and seconded by Roy Fisher **RESOLVED: That the minutes of the meeting held on Thursday 5 November 2020 be approved as a correct record.**

3.	**Declarations of Interests** A declaration of interest for CCG employees in relation to the System Reform agenda item was made. No other specific declarations of interest were declared. **RESOLVED:** **That all CCG Board members and staff declared an interest in respect of the item on the agenda on system reform.**
4.	**Key Messages** Amanda Doyle informed members of the ramping up of pressures across the system and the parallel demand on collective efforts supporting the successful roll out the vaccination programme at speed across Lancashire and South Cumbria. The letter from Bill McCarthy received that week and an expected national letter both reinforce the focus on the key system priorities of meeting demand in the hospital and primary care sector whilst maintaining elective care and rolling out of the vaccination programme. The letters asked that collective system resources should be focused on these priorities and that non-urgent work be put on hold.
5.	**System Reform Report from the CRG** Andrew Bennett gave a short introduction to an update on System Reform from the Commissioning Reform Group, which is a sub-committee of the JCCCGs working on a number of aspects of system reform since summer 2020. The report provided an update from three recent meetings that had taken place during December and January. The paper summarised the main areas of focus and also confirmed publication of a national consultation document called **Integrating Care: next steps to building strong and effective Integrated Care Systems across England** in November – this contains two options for the future development of ICS both of which have very direct implications for commissioning and commissioners. The two options lead to four particular consultation questions in the document. The consultation is now closed and responses being considered, and once the preferred option is known, this would need to go through a legislative process. Plans already in place in terms of system reform align to the national proposals and accelerating the pace of work, with 2021/22 being a transitional year. It was noted that, in light of national proposals, the ICS will not be proceeding to a vote of member practices on the establishment of a single CCG for L&SC. In December work stream leads supporting the commissioning reform programme were asked to provide examples of the scope of their work in light of the national policy document. It was recognised that a number of the work streams were suitable for the system as a whole rather than just commissioning ie quality & assurance, comms & engagement and aspects of the workforce work stream. Jerry Hawker has taken a lead on commissioning governance, developing proposals on governance and the importance of the role the JCCCG has to play in 2021/2022, to help the transition to a strategic approach to commissioning once the legislation is clear and to help with the close down of CCGS as implied by policy direction. Additional work is to be done to bring clear proposals through to individual CCG

	Governing Bodies to create the delegations for the Joint Committee in 2021/2022. The development of local place based partnerships , an issue being reviewed in the Commissioning Reform Group, continues to take action looking at how important they are in relation to policy direction, with a sense that the ICS is in a good place to take forward the ICPs given the work that has taken place already. Geoff Jolliffe, ICP chairs & CCG Chairs are to continue to have conversation with Primary Care colleagues to ensure full engagement in the development of ICPs. Andrew emphasised the section on communication and engagement, being conscious that stakeholders, partners, members of the public and particularly staff employed in the system have a need to understand the direction of travel and the practical implications of this work. The Joint Committee of CCGs was asked to: 1. Discuss and contribute views on the extensive development work taking place to ensure the CCGs in Lancashire and South Cumbria are in the best position to respond to future legislation regarding Integrated Care Systems. 2. Plan for further discussion with individual CCG Governing Bodies during quarter four to agree the transitional arrangements necessary for commissioning in 2021/22. Comments from the members: • Request for a standardised paper for CCGs to respond to for consistency • Importance of engaging with all stakeholders • To have an understanding on all responses across L&SC • Consider how we best engage with GP practices and to include primary care as a body when considering communications. • Ongoing links with the Regional team on progress via monthly meetings. **RESOLVED:** **That the Joint Committee of CCGs:** • **Positively contributed to the discussion of the paper and agreed to take the discussions forward to CCGs Governing Bodies** • **A standardised paper is to be designed for CCGs to respond to this work, with succinct narrative that explains the current position.** • **A process to be put in place to capture all responses across L&SC on what was agreed and what are the differences.** • **Geoff Jolliffe to work with ICP & CCG Chairs on how best to engage Primary Care colleagues going forward.**
6.	**Planned Care – use of the Independent Sector** Gary O'Neill presented a paper that provided an update on the actions planned by the ICS Planned Care Commissioners with respect to the Independent Sector contracts and included a Plan on a Page around which future actions will be developed. The JCCCG was requested to: 1. Agree the contents of the report 2. Agree the approach, and advise any additional recommendations from JCCCG

	Comments from members: • Need to ensure that we future proof this piece of work, so that it is a system wide approach. We need to equally ensure that we are commissioning capacity but doing the right 'stuff' and not increasing opportunities for delivering interventions of limited clinical effectiveness. • To consider how we feed GP referrals into most appropriate treatment point for those patients, how we align this work in the future and ensure that patients are treated in the most effective ways for them. • How do we ensure value for money (cost per case) • How are we going to work with GPs and hospitals to manage their waiting lists and ensure that we get patients in right place? • Single PTL – bring further info back to JCCCG. • Travel & transport need to be considered going forward **RESOLVED:** **That the Joint Committee of CCGS:** • General support from the Committee and agreed the contents of the report • Agreed the approach in line with comments received • Requested Gary to provide further clarification of additional recommendations following discussions within the meeting
7.	**ICS Dermatology Update Paper** Gemma Hedge provided an update in relation to the dermatology programme of work being carried out within L&SC Integrated Care System (ICS) and at Integrated Care Partnership (ICP) level by the Planned Care Team. Key points of the update paper: • To highlight the amount of work which is being undertaken between the ICPs between dermatology community providers and acute providers, working collaboratively to clear the backlog, amending pathways to support the use of technology • Development of standards that are equitable across L&SC mainly for community providers • The work being undertaken with NHSE&I and the outpatient transformation programme to deliver some of the rapid interventions (tele-dermatology triage, with 3 out of 4 hospitals across Lancashire &SC have or imminently have pilots to support tele-dermatology triage for the 2 week wait dermatology pathway – if successful to roll out in spring • A scoping paper for tele-dermatology triage that will support routine referrals in community with secondary care providers • Note to the recent paper re NHSE on system reform and the relaxing of procurement rules and the intention of going out to procurement for the community provider in October 2022. Gemma asked that the Joint Committee: 1. Agree the contents of the report 2. Receive a further update report in Spring 2021 3. Agree a partnership model for creating a delivery model for Dermatology services for the ICS Paul Kingan asked for West Lancashire CCG, although not signed up to the

	programme, to be kept in the loop of future progress. Amanda Doyle noted that the ICS cannot commit to additional contract spend when spend is being rolled over from block contracts. Dermatology is one area where a significant number of resources are spent on interventions of limited clinical value. There is a need to identify what capacity we are buying into what we spend on secondary care dermatology (unwanted variation) **RESOLVED:** **The Joint Committee of CCGs:** • **Agreed the contents of the report** • **To receive a further update report in Spring 2021** • **Agreed a partnership model for creating a delivery model for Dermatology services for the ICS**
Any Other Business	
13.	**Any Other Business** There was no other business.
Date and Time of Next Meeting: 4 March 2021 at 1.00pm-3.00pm via Microsoft Teams videoconference.	

Healthier Lancashire & South Cumbria

Joint Committee of CCGs

Action Log

Updated 25 February 2020

Item Code	Action	Responsible Lead	Status	Due Date	Progress Update
JCCCG210114-07	*ICS Dermatology* - Further update required.	Gemma Hedge	Open	13 May 2021	
JCCCG210114-06	*Planned Care – Use of the Independent Sector* –Clarification required for additional recommendations.	Gary O'Neill	Open	8 April 2021	

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

<table>
<tr><td>Title of Paper</td><td colspan="3">System Reform</td></tr>
<tr><td>Date of Meeting</td><td>4th March 2021</td><td>Agenda Item</td><td>5</td></tr>
<tr><td colspan="2">Lead Author</td><td colspan="2">Andrew Bennett</td></tr>
<tr><td colspan="2">Contributors</td><td colspan="2">Jerry Hawker, Alex Heritage</td></tr>
<tr><td colspan="2" rowspan="4">Purpose of the Report</td><td colspan="2">Please tick as appropriate</td></tr>
<tr><td>For Information</td><td></td></tr>
<tr><td>For Discussion</td><td>x</td></tr>
<tr><td>For Decision</td><td></td></tr>
<tr><td colspan="2">Executive Summary</td><td colspan="2">Members of the Joint Committee will be aware that the government has now published a White Paper (Integration and Innovation: working together to improve health and social care for all) which will lead to legislative changes for the whole system.

The ICS will therefore continue its wide-ranging System Reform programme with 2021/22 acting as a transitional year.

This paper confirms the actions currently being taken to:

• Agree the oversight arrangements for the System Reform programme in Lancashire and South Cumbria;
• Agree the proposed Strategic Commissioning Committee to be established from April 2021;
• Progress the priorities of the Provider Collaboration Board;
• Confirm that the ICP Development Programme is continuing with workshops in March 2021;
• Continue discussions between Local Government and NHS colleagues about the joint priorities for partnership working in the light of the White Paper.</td></tr>
<tr><td colspan="2">Recommendations</td><td colspan="2">The Joint Committee of CCGs is asked to:</td></tr>
</table>

	1. Discuss the implications of the White Paper for the current System Reform programme in Lancashire and South Cumbria. 2. Note the update on on the range of activities taking place to implement the ICS's System Reform Plan. 3. Comment on the actions being taken to establish the Strategic Commissioning Committee and its sub-committees from April 1st 2021.			
Next Steps	Actions will now take place as indicated in the report to establish the Strategic Commissioning Committee and its sub committees. It is expected that the SCC will hold alternating formal and informal meetings on a monthly basis during 2021/22, with additional meetings as required to support decision-making linked to the New Hospitals Programme.			
Is this a level 1 or Level 2 decision?	Level 1		Level 2	x
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable	
Patient and Public Engagement Completed	Yes	**No**	Not Applicable	
Financial Implications	Yes	No	Not Applicable	
Risk Identified			No	
If Yes : Risk				
Report Authorised by:	Andrew Bennett			

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

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

System Reform

Introduction

The purpose of this paper is to update the Joint Committee of CCGs on the range of activities taking place to implement the ICS's System Reform Plan. Actions are now taking place following the publication of a White Paper which contains proposals to place ICSs on to a statutory footing by April 2022.

1. Legislative recommendations to Government and Parliament

On 11th February 2021, the NHS published a formal report summarising the outcomes of the consultation on the *Integrating Care* policy paper which began in late November. The consultation report makes 5 recommendations to the Government and Parliament about legislating for the further development of ICSs. These recommendations are as follows:

Legislative recommendation 1: The Government should set out at the earliest opportunity how it intends to progress the NHS's own proposals for legislative change.

Legislative recommendation 2: ICSs should be put on a clear statutory footing, but with minimum national legislative provision and prescription, and maximum local operational flexibility. Legislation should not dictate place-based arrangements.

Legislative recommendation 3: ICSs should be underpinned by an NHS ICS statutory body ***and*** a wider statutory health and care partnership. Explicit provision should also be made for requirements about transparency.

Legislative recommendation 4: There should be maximum local flexibility as to how an ICS health and care partnership is constituted, for example using existing arrangements such as existing ICS partnership boards or health and wellbeing boards where these work well.

The composition of the board of the NHS ICS body must be sufficiently streamlined to support effective decision-making. It must be able to take account of local circumstances as well as statutory national guidance. Legislation should be broadly permissive, mandating only that the members of the NHS ICS Board must include a chair and CEO and as a minimum also draw representation from (i) NHS trusts and Foundation Trusts, (ii) general practice, and (iii) a local authority. As with CCGs now, NHSE/I should approve all ICS constitutions in line with national statutory guidance.

Legislative recommendation 5: Provisions should enable the transfer of primary medical, dental, ophthalmology and pharmaceutical services by NHS England to the NHS ICS body. Provision should also enable the transfer or delegation by NHS England of appropriate specialised and public health services we currently commission. And at the same time, NHS England should also retain the ability to

specify national standards or requirements for NHS ICSs in relation to any of these existing direct commissioning functions.

2. Publication of Government White Paper

On the 11th February, the Government also published a White Paper called "Integration and Innovation: working together to improve health and social care for all."

A link to the key document is set out here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf

The key measures set out in the White Paper are as follows:

- Support for the proposal to create statutory Integrated Care Systems (as set out above).

- Support for the proposal to scrap mandatory competitive procurements by which NHS staff currently require a significant amount of time to undertake tendering processes for healthcare services. Under the proposals, the NHS will only need to tender services when the NHS itself considers this has the potential to lead to better outcomes for patients. The Competition and Market Authority will no longer be involved in NHS oversight. Local NHS services will have more power to act in the best interests of their communities.

- The safety of patients is at the heart of NHS services. The upcoming Bill will put the Healthcare Safety Investigations Branch permanently into law as a Statutory Body so it can continue to reduce risk and improve safety. The Healthcare Safety Investigations Branch already investigates when things go wrong, so that mistakes can be learned from, and this strengthens its legal footing.

- Support for the proposal to formally fold Monitor and the Trust Development Authority (i.e. NHS Improvement) into NHS England.

- A package of measures to deliver on specific needs in the social care sector. This will improve oversight and accountability in the delivery of services through new assurance and data sharing measures in social care, update the legal framework to enable person-centred models of hospital discharge, and improve powers for the Secretary of State to directly make payments to adult social care providers where required.

- The pandemic has shown the impact of inequalities on public health outcomes and the need for Government to act to help level up health across the country. Legislation will help to support the introduction of new requirements about

calorie labelling on food and drink packaging and the advertising of junk food before the 9pm watershed.

NHS Leaders are keen to emphasise the importance of supporting staff through the period of organisational change which is implied by the legislation. This includes an employment guarantee for colleagues in the wider health and care system who are directly affected.

3. Supporting the development of Integrated Care Systems

To support implementation of the legislation, colleagues in the national and regional team have indicated that further guidance will be issued during 2021/22 after a process of co-development with local systems. We understand that this will cover areas such as:

- Functions, governance and accountability
- Financial Framework
- Digital and Data
- People and Culture
- Change Management, ICS Establishment and Organisational development
- Ongoing System Support and Development
- System Partnerships and Engagement

There will also be an ICS maturity matrix (known as a System Development Progression Tool) to support continued development over the next year. The development tool is designed to help ICSs identify and describe their key priorities for accelerating and embedding system working, including the development of capacity and capabilities they will need to be an effective, self-managing ICS by 1st April 2022. There will be opportunities to update the tool on a regular basis during the year.

4. Oversight of the System Reform programme – Lancashire and South Cumbria

In our System Reform plan in October 2020, we confirmed that a number of groups would take forwards the detailed work to progress our plans. There has been a distributed approach to the leadership of key pieces of work which is producing outputs for consideration by system leaders, boards and governing bodies.

As agreed with the ICS Board, during January and early February, a review has taken place of both the scope and the oversight arrangements of the System Reform workstreams. These are major areas of work with multiple interdependencies.

The scope of each area of work is now summarised in **Appendix 1** below.

The developing governance arrangements required to oversee this programme are summarised in **Appendix 2** below.

The Joint Commmittee is asked to note that an ICS development Oversight Group (ICS OG) is now being established with the following key roles:

- To act on behalf of the ICS Board to develop a statutory ICS, including a strategic commissioning function and place-based functions, in line with national publications and local thinking. This will include:
- Oversight of the overall System Reform Programme critical path
- Development of a Strategic Narrative which describes what it means to be an ICS in Lancashire and South Cumbria
- Development of a strategic commissioning function within the ICS (including. commissioning decision-making from April 2022)
- Development of a model for system support
- Development of a model of ICS Governance
- Development of a model of ICS Leadership

The ICS Oversight Group will also oversee and co-ordinate the work of a number of cross cutting workstreams including:

- The Quality, Performance and Assurance model for an ICS
- The Financial Framework for an ICS and for ICPs
- Workforce & HR
- Communications & Engagement

The ICS Independent Chair will chair the Oversight Group and invitations to colleagues from across the partnership have been circulated. The Group will meet for the first time in early March.

5. Commissioning Reform

CCG Governing Bodies have been meeting between the 15th-24th February to consider the recommendations to create a Strategic Commissioning Committee (SCC) for Lancashire and South Cumbria. This will use the vehicle of the existing Joint Committee of CCGs to take commissioning decisions on behalf of the whole system.

All CCG Governing Bodies have accepted the recommendations and work will now take place to establish the Strategic Commissioning Committee from the 1st April 2021. It is expected that the Strategic Commissioning Committee will hold its first meeting in public in May 2021.

It is expected that the SCC will hold alternating formal and informal meetings on a monthly basis during 2021/22, with additional meetings as required to support decision-making linked to the New Hospitals Programme.

Preparatory work has also begun to develop a number of sub-committees which will enable the SCC to discharge its functions during the transitional year 2021/22. **Appendix 3** provides an infographic showing how the Strategic Commissioning

Committee and its sub-committees are linked to other key parts of the ICS governance structure.

A key next step will be the formal agreement of all membership appointments in line with the updated terms of reference. This will confirm voting members drawn from CCGs, voting members drawn from the wider ICS Partners and appropriate non-voting members.

Discussions have been held with the Locality Director of NHSEI to confirm the involvement of the organisation in the Strategic Commissioning Committee. This has clarified the distinction between NHSEI's role in seeking assurance/oversight and its role as a Strategic Commissioner. It has been agreed in principle that a NHSEI Strategic Commissioning Representative will be the voting member and that NHSE Regional Locality Director should be invited as a non-voting member (subject to Chair's agreement).

A letter to each Local Authority confirming the proposed arrangements has been circulated by the ICS Chief Officer with additional informal discussions taking place with local Directors of Adult Social Care. Further work will be required to confirm representation from the Local Authorities.

In relation to the conduct of business by the new Strategic Commissioning Committee, CCG Chairs have set out clear expectations about the regular reporting of minutes and decisions of the SCC back to CCG Governing Bodies. CCG Governing Bodies will meet on a reduced frequency to ensure they can discharge their statutory duties during the transitional year of 2021/22.

Further meetings will also take place between CCG Audit Chairs and appropriate Chief Finance Officers to agree the remit of the CCG Finance Committee which will operate as a formal sub-committee of the SCC.

6. Provider Collaboration

The Provider Collaboration Board (PCB) has continued to prioritise a defined number of collaborative programmes on behalf of the ICS Board.

Given the imminent national guidance, more work will be required to find both the scope of provider collaboration and the resources required to allow provider collaboration to deliver its complex agenda.

National and Regional colleagues have set up a development process to advance effective models of provider collaboration. Lancashire and South Cumbria have been offered the chance to work with Regional and National colleagues in taking this forward.

In advance of this support, a draft PCB Transition Plan has been developed and shared with PCB members to start the initial scoping of the future PCB.

Initial objectives for the PCB Transition Plan have been developed to support a Target Operating Model:

- To describe how the current Provider Collaboration Board will evolve in response to new National Policy, Technical Guidance and anticipated legislative change as a key component of an Integrated Care System.
- Successfully transition the responsibilities and accountabilities of the pandemic cellular structures to ensure continuity and best practice is maintained on cessation of the national incident requirements.
- Clearly identify the system wide transformation programmes that the PCB will be accountable for, ensuring clarity of leadership, resource and their contribution to delivering against the ISC Clinical Strategy and Financial Recovery Plan.

7. ICP development

The ICP Development Advisory Group is continuing to oversee the next stage of ICP development work, as agreed by the ICS Board in December 2020.

Partners within each ICP have been completing the ICP Maturity Matrix which is followed by a dedicated feedback session to review responses by sector and consider what this means for each ICP.

Peer-to-peer reviews are now planned for the first half of March 2021, which will be facilitated by AQuA. The peer group will be selected from ICP Chairs, members of the ICP Development Advisory Group, and external subject matter experts provided via NHS England / Improvement and the Local Government Association. The Independent Chair of the ICS will participate in all sessions.

The first development workshop considering the success measures for ICPs took place on Thursday 11th February. This was a really positive session attended by a diverse mix of representatives from all sectors in the ICS and externally facilitated. Further workshops are planned in March relating to ICP leadership and ICP governance.

Due to the operational pressures linked to the pandemic which have been experienced in the first weeks of 2021, there has been a one month delay in the timeline of this work. This means that the proposals developed during these workshop sessions will now be shared and discussed more widely with senior leaders via a system wide workshop on 21st April 2021. A report on the outcomes will then be presented to the ICS Board at its meeting in May.

8. Local Government Reorganisation

In the light of the White Paper, Local Government and NHS colleagues are taking the opportunity to hold further discussions about the priorities for partnership working in Lancashire and South Cumbria. There are a number of significant opportunities to strengthen current arrangements in relation to population health and inequalities, adult and children's social care, support for vulnerable groups, mental health and learning disability services, care sector and intermediate care services.

Recommendations

The Joint Committee is asked to:

1. Discuss the implications of the White Paper for the current System Reform programme in Lancashire and South Cumbria.
2. Note the update on on the range of activities taking place to implement the ICS's System Reform Plan.
3. Comment on the actions being taken to establish the Strategic Commissioning Committee and its sub-committees from April 1st 2021.

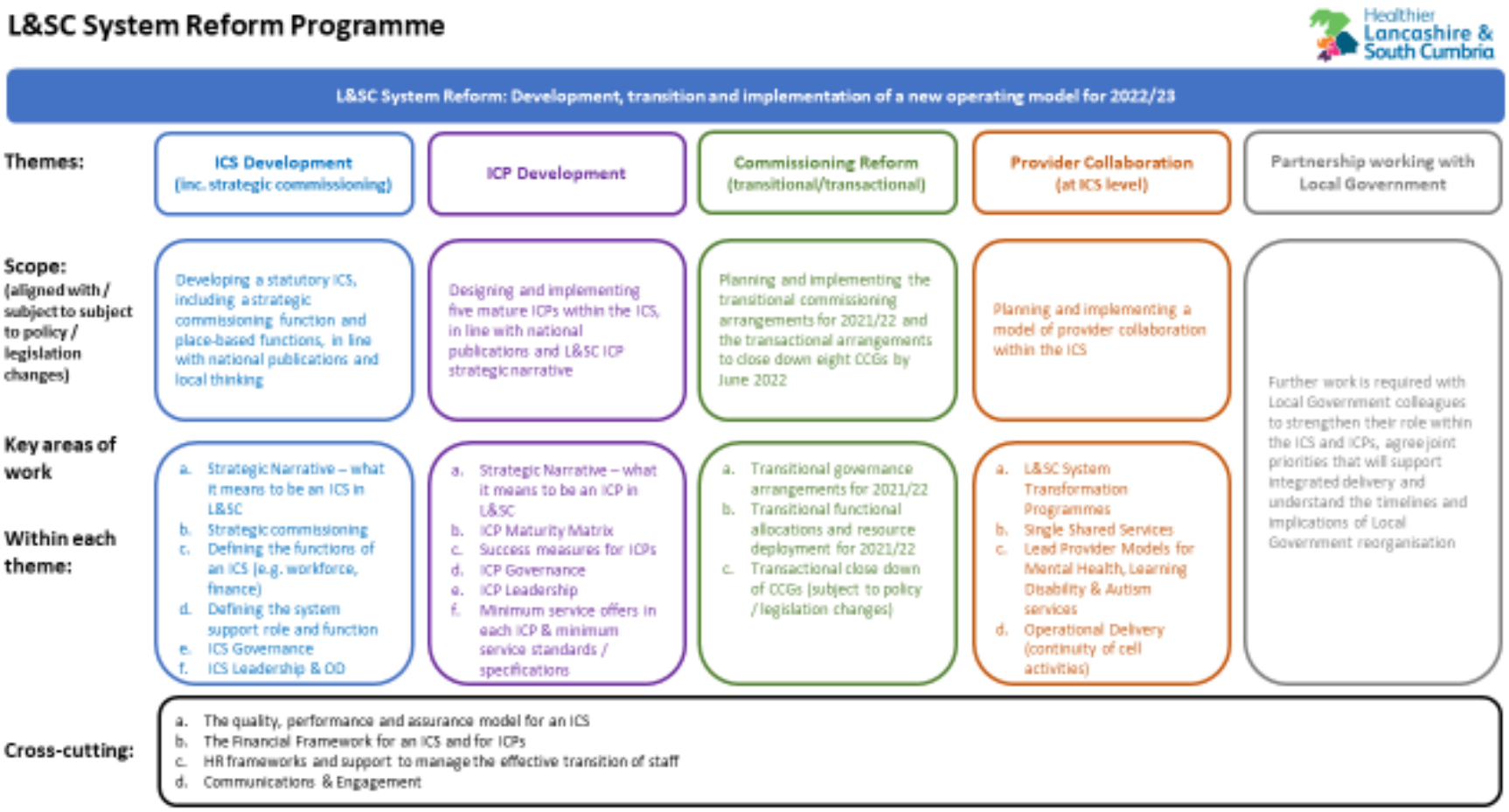
Andrew Bennett Executive Director of Commissioning

Jerry Hawker, Accountable Officer, Morecambe Bay CCG

Alex Heritage Director, Provider Collaboration Board

24th February 2021

Appendix 1: System Reform Workstreams



Appendix 2: System Reform Programme - Governance Arrangements

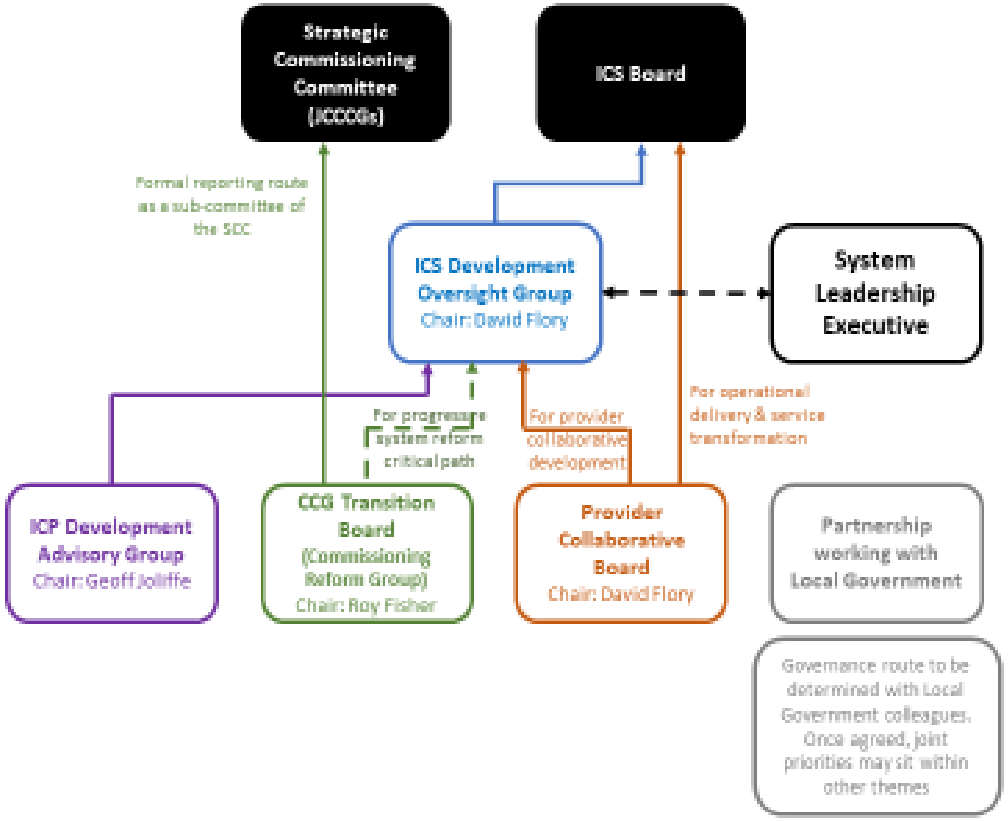
Governance Arrangements – Working draft

Healthier Lancashire & South Cumbria

The ICS Development Oversight Group will have oversight of the whole of the System Reform Programme (critical path, interdependencies, key risks, etc).

Progress on cross-cutting workstreams will be monitored by the ICS Development Oversight Group

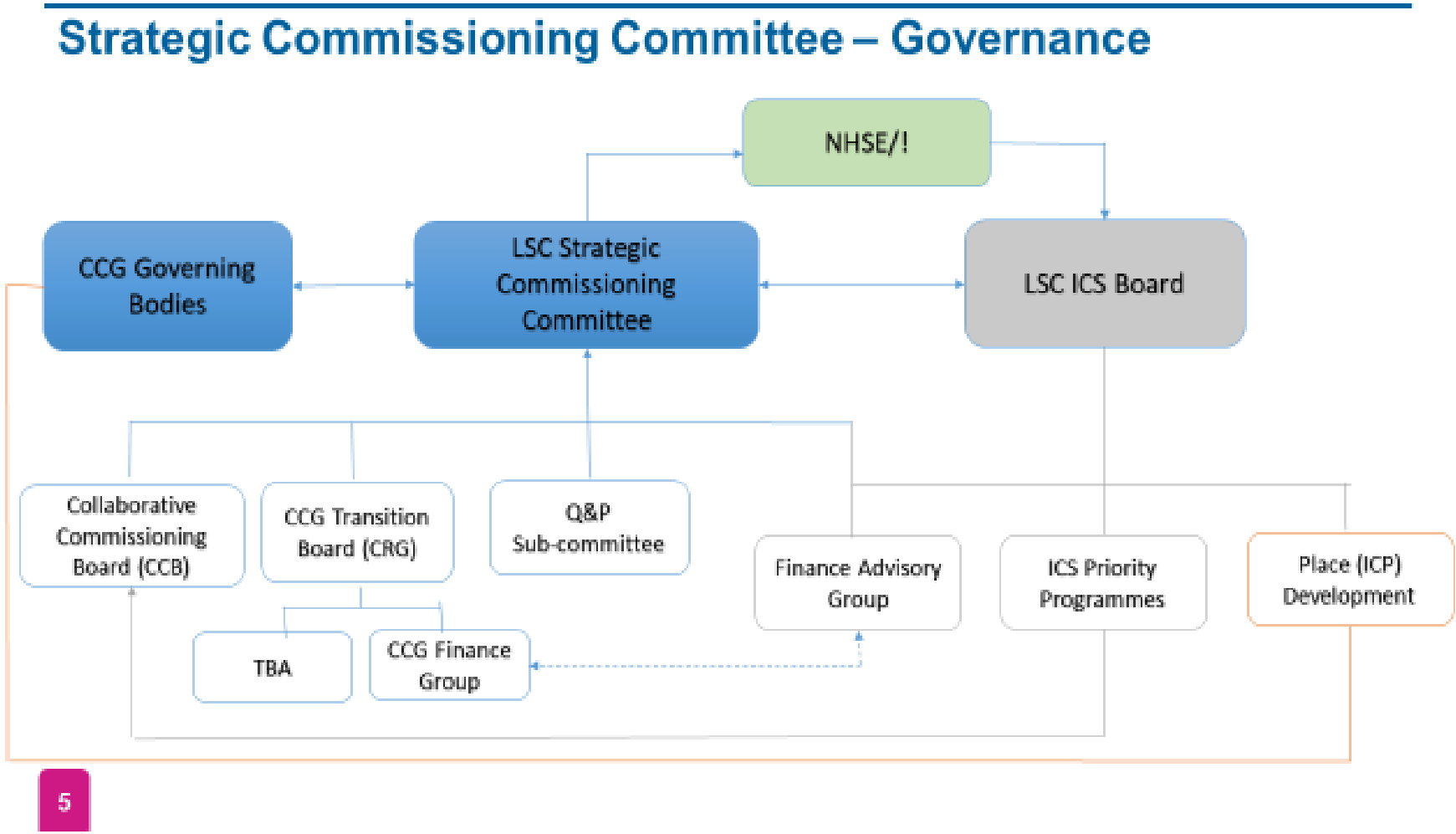
It will also act as the route in/out of the NW ICS Oversight Group.



Increased use of SLE as a forum to discuss key outputs from all system reform groups with senior system leaders across different sectors.

This will provide an opportunity to test / discuss / refine prior to public meetings of the ICS Board and SCC (JCCCGs).

Appendix 3: Strategic Commissioning Committee and its Sub Committees



Joint Committee of Clinical Commissioning Groups

Title of Paper	Lancashire and South Cumbria Medicines Management Group Recommendations: A briefing paper for the Healthier Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	4 March 2021	Agenda Item	6

Lead Author:	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU	
Purpose of the Report	For Discussion	
	For Information	
	For Approval	X
Executive Summary	The Lancashire and South Cumbria Medicines Management Group (LSCMMG) has developed recommendations for medicine reviews, medicine pathway, medicine policy and the implementation of NICE technology appraisals for adoption across Lancashire and South Cumbria.	
Recommendations	That the JCCCGs ratify the collaborative LSCMMG recommendations on the following: - *Semaglutide oral tablets for the treatment of adults with insufficiently controlled type 2 diabetes mellitus to improve glycaemic control as an adjunct to diet and exercise.* - *Domperidone as an aid to the initiation and maintenance of breast milk supply.* - *Amiodarone and dronedarone for the treatment of arrythmias.* - *NICE Technology Appraisals (October 2020 to January 2021).*	
Equality Impact & Risk Assessment Completed	Yes	
Patient and Public Engagement Completed	No	
Financial Implications	Yes	
Risk Identified	No	
If Yes: Risk	N/A	
Report Authorised by:		

DEVELOPMENT OF LANCASHIRE AND SOUTH CUMBRIA MEDICINES MANAGEMENT GROUP RECOMMENDATIONS:

1. INTRODUCTION

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

- *Semaglutide Oral Tablets for the Treatment of Adults with Insufficiently Controlled Type 2 Diabetes Mellitus to Improve Glycaemic Control as an Adjunct to Diet and Exercise.*
- *Domperidone as an aid to the initiation and maintenance of breast milk supply.*
- *Amiodarone and dronedarone for the treatment of arrythmias.*
- *NICE Technology Appraisals (October 2020 to January 2021).*

2. DEVELOPMENT PROCESS

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

2.2 The review process includes the following key steps:

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

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

- *Semaglutide oral tablets for the treatment of adults with insufficiently controlled type 2 diabetes mellitus to improve glycaemic control as an adjunct to diet and exercise.* *Semaglutide Oral Tabs New Medicine Assessment JCCCGs.docx*

- *Domperidone as an aid to the initiation and maintenance of breast milk supply.* *Domperidone breast milk final JCCCGs.docx*

- *Amiodarone and dronedarone for the treatment of arrythmias.* *Amiodarone and dronedarone SCG JCCCGs.docx*

- *NICE Technology Appraisals (October 2020 to January 2021).* Available at https://www.nice.org.uk/guidance/published?type=ta

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

Amiodarone and dronedarone for the treatment of arrythmias.

3.1 Amiodarone and dronedarone are recommended for the treatment of arrythmias in Lancashire and South Cumbria. This recommendation was reviewed following the publication of NHS England guidance relating to amiodarone and dronedarone.

3.2 In consultation with local specialists and CCGs, the LSCMMG has agreed to amend the commissioning position from "Amber0" (prescribed in primary care following recommendation by a specialist) to "Amber1" (prescribed in primary care under a shared arrangement agreed between specialists and primary care).

3.3 The updated commissioning position is not anticipated to have any resource impact on the local health economy. The LSCMMG agreed to the production of updated shared care guidelines and additional, temporary guidance to support secondary care specialists that are reviewing patients remotely during the COVID-19 pandemic.

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

Semaglutide oral tablets for the treatment of adults with insufficiently controlled type 2 diabetes mellitus to improve glycaemic control as an adjunct to diet and exercise.

4.1 Semaglutide oral tablets were prioritised for review following requests from clinicians at Lancashire Teaching Hospitals Trust, Blackpool Teaching Hospitals Trust and Fylde and Wyre CCG.

4.2 The LSCMMG agreed a "Green Restricted" RAG rating, restricting use for those patients eligible for glucagon-1-like peptides (GLP-1) who are unable to use subcutaneous formulations. The effectiveness of semaglutide is to be monitored at 6 months.

4.3 The acquisition cost of oral semaglutide is identical to the acquisitional cost of subcutaneous semaglutide and dulaglutide and similar to the remaining GLP-1 receptor agonists. Consequently, there is not expected to be any significant cost burden or saving associated with the use of oral semaglutide.

4.4 If semaglutide was used earlier in the treatment pathway due to the availability of an oral formulation this would result in a significant cost burden to the Lancashire and South Cumbria health economy, as GLP-1 receptor agonists have the highest acquisition cost of all the antihyperglycaemic agents.

4.5 The LSCMMG requested that GLP-1 prescribing trends are analysed and presented at the September 2021 meeting to ensure that prescribing is aligned with guidance.

Domperidone as an aid to the initiation and maintenance of breast milk supply.

4.6 Domperidone as an aid to the initiation and maintenance of breast milk supply was prioritised for review by the LSCMMG following a request by the Lancashire and South Cumbria Infant Feeding Network, as the drug could potentially be included in their guidelines.

4.7 The LSCMMG agreed a "Green Restricted" RAG classification for a maximum period of seven days at a total maximum daily dose not exceeding 30mg.

4.8 Mothers can be signposted to their GP only under conditions outlined in a domperidone information sheet agreed by the LSCMMG. Following discussion with the patient it will be the prescriber's clinical decision whether to prescribe off-label domperidone.

4.9 The “Green Restricted” RAG recommendation is not anticipated to cause any financial, equality or service impact issues.

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

NICE Technology Appraisals (October 2020 to January 2021).

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

5.2 Five CCG commissioned NICE TAs were identified: **naldemedine** for treating opioid-induced constipation (TA651); **galcanezumab** for preventing migraine (TA659); **liraglutide** for managing overweight and obesity (TA664); **upadacitinib** for treating severe rheumatoid arthritis (TA665); and **brolucizumab** for treating wet age-related macular degeneration.

5.3 TA guidance recommendations for **naldemedine**, **upadacitinib** and **brolucizumab** are not expected to create significant cost burdens to the Lancashire and South Cumbria health economy.

5.3..1 NICE do not expect this TA guidance for **naldemedine** to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population).

5.3..2 NICE estimate that commissioning of **upadacitinib** (applicable to secondary care) will have an annual resource impact of £94,434 in Lancashire and South Cumbria. The LSCMMG Rheumatoid Arthritis commissioning pathway has therefore been updated to include **upadacitinib** as a choice alongside the other “JAK inhibitors” in the pathway.

5.3..3 NICE estimate that commissioning **brolucizumab** in Lancashire and South Cumbria will generate a cost saving of £1,148,000 over a five-year period due to fewer intravitreal injections and hospitals attendances. The LSCMMG Ophthalmology Macular pathways will be updated to include **brolucizumab** as a treatment option in wet age-related macular degeneration.

5.4 NICE TA recommendations for **liraglutide** and **galcanezumab** are likely to have a significant impact on resources due to the increased cost of the interventions relative to existing treatments.

5.4..1 According to NICE costing assumptions using the drug tariff price, TA guidance for **liraglutide** (TA664) is expected to create an annual cost burden of approximately £400,000 across Lancashire and South Cumbria. However, an arrangement (commercially sensitive) has been agreed between NICE and the manufacturer to enable a lower acquisition price for **liraglutide** and therefore the cost burden is expected to be lower than £400,000.

5.4..2 According to NICE costing assumptions using the drug tariff price and a single professional follow up neurology appointment, TA guidance for **galcanezumab** is expected to create an annual cost burden of £1,447,566 in Lancashire and South Cumbria.

6. Conclusion

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

- *Semaglutide oral tablets for the treatment of adults with insufficiently controlled type 2 diabetes mellitus to improve glycaemic control as an adjunct to diet and exercise.*
- *Domperidone as an aid to the initiation and maintenance of breast milk supply.*
- *Amiodarone and dronedarone for the treatment of arrythmias.*
- *NICE Technology Appraisals (October 2020 to January 2021).*

Brent Horrell, Head of Medicines Commissioning,

NHS Midlands and Lancashire CSU

Joint Committee of Clinical Commissioning Groups

Title of Paper	Update of Lancashire and South Cumbria clinical commissioning policies for glucose monitoring: A briefing paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)		
Date of Meeting	4 March 2021	Agenda Item	7

Lead Author	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU, Chair of CPDIG.		
Purpose of the Report	Please tick as appropriate		
	For Information		
	For Discussion		
	For Approval	X	
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has updated the Policy for the Provision of Continuous Glucose Monitoring and Flash Glucose Monitoring to patients with Diabetes Mellitus in accordance with updated guidance from NICE and NHS England.		
Recommendations	That the JCCCGs ratify the policy update under a Chair's action pending a full review of the policy with consultation in Autumn 2021.		
Equality Impact & Risk Assessment Completed	Yes	No	**Not Applicable**
Patient and Public Engagement Completed	Yes	No	**Not Applicable**
Financial Implications	Yes	No	**Not Applicable**
Risk Identified	Yes	**No**	
If Yes : Risk			
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, Healthier Lancashire and South Cumbria ICS		

Update of Lancashire and South Cumbria clinical commissioning policies for glucose monitoring: A briefing paper for the Joint Committee of Clinical Commissioning Groups (JCCCGs)

1. Introduction

1.1 The Policy for the Provision of Continuous Glucose Monitoring (CGM) and Flash Glucose Monitoring (FSM) to patients with Diabetes Mellitus requires review. New NICE guidance has been issued (December 2020) and the NHS Long Term Plan (LTP) made a commitment to offer all pregnant women with type 1 diabetes CGM by March 2021. NHS Blackpool CCG has been allocated £90,000 annually until 2023/24, the duration of the NHS LTP (funding for 45 patients each year).

1.2 NHS England has also recommended that all people with diabetes using insulin and who are registered with a learning disability should be offered FSM. Funding of CCGs for the costs of FSM sensors is embedded within CCG baseline and CCGs will have already received their allocation. NHSE estimates that an additionally 3000 patients in England will benefit from this rollout, equating to approximately 100 patients in Lancashire and South Cumbria, at a total annual cost of £91,000.

2. Development process

2.1 The eight Lancashire and South Cumbria Clinical Commissioning Groups (CCGs) have an existing collaborative commissioning policy in place for the provision of CGM and FSM.

2.2 Following the publication of updated NICE clinical guidance NG3 Diabetes in pregnancy: management from preconception to the postnatal period; and updated NHSE's guidance for funding FSM in diabetes patients, the CPDIG undertook a review of the variations between the existing local collaborative commissioning policy and the updated guidance.

2.3 The CPDIG agreed that the existing policies required urgent revision to ensure provision of glucose monitoring devices to eligible patients in accordance with the NHSE timeline of the end of March 2021.

2.4 The local policy was amended in accordance with the updated national guidance and agreement was sought with a local lead endocrinologist.

2.5 The CPDIG agreed a plan to review the impact in September 2021 and support a more thorough consultation process at that point.

2.6 The updated version of the policy is available on the link below:

02. Draft update Policy for the provision of Glucose Monitoring Devices v0.1.2.docx

3. Key changes

3.1 The following criteria have been added to the policy:

- All pregnant patients with Type 1 diabetes offered CGM for a duration of 12 months.

- FSM may be offered as an alternative to CGM for a duration of 12 months for pregnant women with Type 1 diabetes who are unable to use CGM or express a clear preference for FSM.

- FSM may be offered to people with Type 1 diabetes or insulin treated Type 2 diabetes who are living with a learning disability and recorded on their GP Learning Disability register.

4. Recommendations

4.1 The JCCCGs is asked to ratify the policy update under a Chair's action pending a full review of the policy with consultation in Autumn 2021.

Brent Horrell, Chair of the CPDIG

24th February 2021

Joint Committee of Clinical Commissioning Groups (JCCCGs) Cover sheet

Title of Paper	Quality and Performance Report		
Date of Meeting	4th March 2021	Agenda Item	8

Lead Author	Dr Julie Higgins	
Contributors		
Purpose of the Report	Please tick as appropriate	
	For Information	√
	For Discussion	√
	For Decision	
Executive Summary	The ICS has agreed a quality and performance work stream that has set out the first phase of an accountability framework for the ICS and ICPs to enable the reporting and improvement of health inequalities, performance and quality. This paper is the first product from the quality and performance work stream that attempts to bring together collective oversight for commissioning. It provides a static summary of a dynamic report built in Aristotle and provides a high level ICS summary as well as summaries for each ICP. This is a work in progress and will be improved for subsequent JCCCG/Strategic Commissioning Committee meetings. The key next phase will be working to the dynamic reporting mechanism that will be required for the Quality and Performance Group which will report to the Strategic Commissioning Committee. Feedback from this JCCCG and the March CRG will inform the work going forward.	
Recommendations	The JCCCG is requested to note the contents of this initial Quality and Performance Report and support its development over the next months.	
Next Steps		

Is this a level 1 or Level 2 decision?	Level 1		Level 2	
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable	
Patient and Public Engagement Completed	Yes	No	Not Applicable	
Financial Implications	Yes	No	Not Applicable	

Risk Identified	Yes	No
If Yes : Risk	N/A	

Report Authorised by:	

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

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

JCCCG Quality and Performance Report –

4th March 2021

1. Introduction

The ICS has agreed a quality and performance work stream that has set out the first phase of an accountability framework for the ICS and ICPs to enable the reporting and improvement of health inequalities, performance and quality.

This paper is the first product from the quality and performance work stream that attempts to bring together collective oversight for commissioning. It provides a static summary of a dynamic report built in Aristotle and provides a high level ICS summary as well as summaries for each ICP. This is a work in progress and will be improved for subsequent JCCCG/Strategic Commissioning Committee meetings. The key next phase will be working to the dynamic reporting mechanism that will be required for the Quality and Performance Group which will report to the Strategic Commissioning Committee. Feedback from this JCCCG and the March CRG will inform the work going forward.

The Quality and Performance work stream will need to respond to the new national integrated assurance regime which is expected in Q1 that will bring together the IAF and SOF and Region will hold to account the ICS on 5 domains. Because of this expected change in reporting, we are limiting the work in finessing the Aristotle report. It is recognised that an interim team will need to be put in place to support the ongoing production and management of performance and quality at ICS level, nested with ICPs. To this end a functions analysis is underway. Terms of reference for a Quality and Performance Committee, reporting to the Strategic Commissioning Committee are under development.

The paper will demonstrate the performance reports currently available at different system levels. Appended are reports at ICS and ICP place. These reports do not include Quality indicators or reflect all of the risks that are currently being managed in the system.

The following report is the first draft of the Quality and Performance Report that will be developed into a comprehensive Quality and Performance Report over the next few months.

The source of the data is Aristotle, which is managed by MLCSU. Appended to this report is the dashboard relating to NHS Constitutional targets. These have understandably been impacted by the pandemic and whilst some of the indicators are attributed to providers, clearly the wider system has responsibility for delivery. Each of the ICPs has been asked to complement the report with a one page narrative that unpacks their current performance and informs committee on actions and progress on improvement.

2. Performance Indicators

The Performance Indicators appended to this report are based on NHS Constitution performance indicators at an ICS level and further broken down into ICP areas. The latest available data set in Aristotle has been used. The ICP data on the appended dashboards are for the period in month so below are some of the indicators for the cumulative ICS position broken down into ICP:

- A&E 4 hour target of 95% - ICS performance cumulative to January 21 is 85.66%

Bay Health and Care Partners	86.34%
Central Lancashire	86.47%
Fylde Coast	85.59%
Pennine Lancashire	84.62%

- 18 weeks incomplete referral to treatment performance target of 92% - ICS performance cumulative to December 20 is 58.51% for providers and 62.09% for CCGs

Bay Health and Care Partners	Provider	55.57%	CCG	56.04%
Central Lancashire	Provider	53.96%	CCG	65.10%
Fylde Coast	Provider	60.19%	CCG	57.85%
Pennine Lancashire	Provider	66.94%	CCG	65.70%
West Lancashire			CCG	71.85%

- Total number of incomplete referrals to treatment under 18 weeks – target 92% and ICS cumulative performance is 58.51% Provider and 62.09% CCG at the end of December 20

Bay Health and Care Partners	Provider	55.57%	CCG	56.04%
Central Lancashire	Provider	53.96%	CCG	65.10%
Fylde Coast	Provider	60.19%	CCG	57.85%
Pennine Lancashire	Provider	66.94%	CCG	65.70%
West Lancashire			CCG	71.85%

- Patients waiting over 52 weeks for treatment (not included in the appendix) is 7,108 for the ICS providers and 7,956 for CCGs at the end of December 20.

LTH	3,153
UHMB	1,402
BTH	1,140
ELHT	770
Spire FC	643

Bay Health and Care Partners	1816
Central Lancashire	2123
Fylde Coast	2336
Pennine Lancashire	1525
West Lancashire	156

The specialties with the most patients waiting over 52 weeks are trauma and orthopaedics, general surgery, ophthalmology and ENT which combined account for 73% of the total for providers.

- 2 weeks cancer performance following urgent referral has a target of 93% of patients being seen. The ICS cumulative performance is 87.76% for providers and 88.18% for CCGs

Bay Health and Care Partners	Provider	70.60%	CCG	70.83%
Central Lancashire	Provider	88.87%	CCG	89.29%
Fylde Coast	Provider	96.32%	CCG	94.47%
Pennine Lancashire	Provider	93.42%	CCG	93.25%
West Lancashire			CCG	91.34%

Mental Health and Ambulance performance is not included at present although IAPT performance is in the pack but not updated on the system as yet. This important data will be developed and included in future reports.

The report also contains one page summaries of actions supporting improving the performance against metrics in the respective ICPs.

3. Quality Summary

Referral to Treatment (RTT)

The overall position for 52 weeks for Lancashire and South Cumbria is increasing as demonstrated in the performance report. There are processes in place both with Trusts and out of area providers in terms of monitoring levels of harm and no harm has been reported to date. It should be recognised that the 52 week position is likely to deteriorate further as a result of the national clinical validation programme where all patients are been clinically validated by their lead consultant and given a priority code. Work continues at an ICS level in order to determine the recovery position. In order to provide assurances around patients on the existing waiting list the Trust are following the mandated National Clinical Prioritisation Programme.

Nosocomial infections

During November and December 2020 the CCGs reported a high community prevalence rate for Covid19 infections. Outbreaks of nosocomial infection were also reported across Trust and care settings during this period and created a cause for concern. This was closely monitored at a local and regional level with a number of actions put in place.

Safeguarding

The full impact of Covid19 on safeguarding is not yet known. Emerging risks relate to abuse and neglect of adults and children, which may be hidden due to reduced visibility and not being seen by professionals. In addition, there is recognition that the third wave is having a real impact on families in terms of increased levels of hardship.

Continuing Health Care (CHC)

A trajectory for eligibility assessments and reviews for all cases on the caseload by the end of March 2021 was set and CCG's are reporting non-compliance with this trajectory. Regular meetings are being held with the Chair of the Individual Patient Activity (IPA) Steering Group and Senior Responsible Officer (SRO) for IPA across Lancashire & South Cumbria. A recovery plan has been developed.

CAMHS

Current waiting times for CAMHS are 2.6 weeks at East Lancashire Child and Adolescent Services (ELCAS) and 24.6 weeks at Lancashire & South Cumbria NHS Foundation Trust (LSCFT). Utilising the additional investment into CAMHS from the Long-Term Plan, a waiting list initiative has been agreed with LSCFT to support a reduction in wait times, with the ultimate aim of bringing LSCFT into the 4 week target aspiration set by NHS England. Regular monitoring and progress of the initiative is reported through the ICS CAMHS Performance and Data Sub-Group of the ICS CAMHS Board.

4. Recommendation

The Committee is asked to note the contents of this initial Performance Report and support its development over the next months.

Dr Julie Higgins
Joint Chief Officer, Blackburn with Darwen and East Lancashire CCGs

Appendix 1:

Pennine Lancashire CCG

1. Performance Overview

The pandemic has had a significant impact on performance metrics and has the potential to widen health inequalities in Pennine Lancashire. The narrative below is some of the responses happening locally building on the excellent work of the local providers who have worked collaboratively in supporting the local population.

1.1. Covid-19 Services

The CCGs introduced a Covid19 Virtual Ward (CVW) in October 2020 which has now received 1,488 referrals and has made 1,431 discharges by mid-February. The referrals include step down patients from East Lancashire Hospitals NHS Trust (ELHT) to support an early, safe discharge from the hospital setting. The post covid-19 syndrome service is scheduled to start in February.

1.2. Demand Management

The CCGs and ELHT introduced Advice and Guidance during November. The initiative has already had 1,225 advice and guidance requests by the end of January which has changed the patient's treatment and directly avoided 106 hospital referrals. It is hoped to expand this technology into community settings in the future.

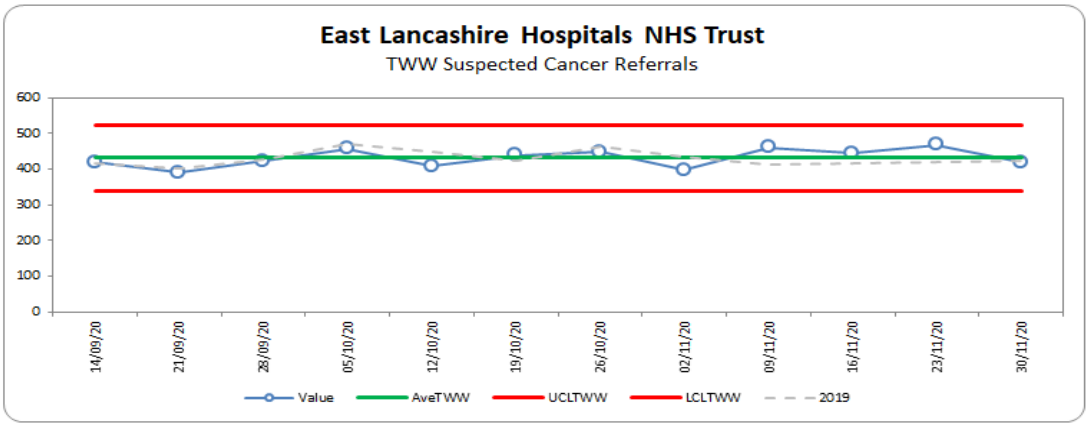
1.3. Restoration

GP referrals are returning to expected levels including those on an urgent two week wait pathway.

TWW Suspected Cancer Referrals

	14/09/2020	21/09/2020	28/09/2020	05/10/2020	12/10/2020	19/10/2020	26/10/2020	02/11/2020	09/11/2020	16/11/2020	23/11/2020	30/11/2020
TWW Referrals	419	391	422	457	408	439	448	397	461	445	468	419
AveTWW	431.17	431.17	431.17	431.17	431.17	431.17	431.17	431.17	431.17	431.17	431.17	431.17
UCLTWW	524.49	524.49	524.49	524.49	524.49	524.49	524.49	524.49	524.49	524.49	524.49	524.49
LCLTWW	337.84	337.84	337.84	337.84	337.84	337.84	337.84	337.84	337.84	337.84	337.84	337.84

2019	417	403	427	469	449	424	465	436	413	418	421	424
Variance (No.)	2	-12	-5	-12	-41	15	-17	-39	48	27	47	-5
Variance (%)	0.5%	-3.0%	-1.2%	-2.6%	-9.1%	3.5%	-3.7%	-8.9%	11.6%	6.5%	11.2%	-1.2%



ELHT are slightly ahead on its phase 3 plan for elective admissions and first outpatients but down marginally on outpatient followups. There is an outpatient transformation programme that is looking to embed best practice and digital solutions where appropriate – work in

Dermatology pathway has been implemented. The ICP has supported the work of the Elective Care Recovery Group and the establishment of contracts with the Independent Sector to deliver more capacity for the ICS. This includes a specific piece of work to support the ophthalmic waiting list.

2. Quality Reorting:

Five areas have been identified for collective reporting as work on quality reporting proceeds.

2.1. Referral to Treatment (RTT)

Overall position for 52 weeks for Pennine Lancashire is increasing as demonstrated in the performance report. There are processes in place both with ELHT and out of area providers in terms of monitoring levels of harm and no harm has been reported to date. It should be recognised that the 52 week position is likely to deteriorate further as a result of the national clinical validation programme where all patients are been clinically validated by their lead consultant and given a priority code. The Trust are working on dating and managing patients in P2 priority where patients should receive their treatment within 1 month, which is leading to further delays for routine patients.

2.2. Nosocomial Infections

ELHT currently have 7 x wards affected by a nosocomial outbreak. This is a reduction from 16 x wards at the end of January 2021. Actions to control and prevent nosocomial infections include screening patients on admission and again on day 3 and day 5 of admission. Weekly IPC audits are in place to look at hand hygiene, PPE compliance, social distancing and the environment. There is an increased and robust cleaning regime in place. Patients are advised to wear masks when mobilising, on transfers to another department and when having direct clinical care with staff (if tolerated). Patients are encouraged to inform a member of staff when they have been to the bathroom to ensure cleaning is taking place promptly. Extra alcohol gel dispensers have been ordered and will be placed at lifts, strategically placed alcohol gel stations and the entrances to the site.

2.3. Continuing Healthcare (CHC)

A trajectory for eligibility assessments and reviews for all cases on the caseload by the end of March 2021 was set and the Pennine Lancashire CCG's are reporting non-compliance with this trajectory. Regular meetings are being held with NHS E&I with the Chair of the Individual Patient Activity (IPA) Steering Group and Senior Responsible Officer (SRO) for IPA across Lancashire & South Cumbria. A recovery plan has been developed with considerable actions to be delivered during the last two weeks of February and early March 2021 which includes a revised trajectory. The plan was shared with the Out of Hospital Cell and Adult Social Care Cell week commencing 15th February 2021 and has been submitted to NHS E&I. The main reasons for the delays have been staff recruitment, retention and absence and ability for third parties to pick up the gap. These are being address in the recovery plan.

2.4. Safeguarding

The CCGs safeguarding service continue to focus strongly on the impact of Covid19 on our children and vulnerable adults through a range of work streams.

Pennine CCGs are also engaging in a wider development of safeguarding practice including an ongoing pilot for our local Multi-Agency Safeguarding Hub which has recently been extended due to the positive feedback. There is also a proposal to

review how we respond to significant concerns around Domestic Abuse through our multi-agency arrangements. This includes a new model of Multi-Agency Risk Assessment Conference delivery being drafted.

The CCG has continued to deliver its ongoing statutory function, which has seen some increase in complex cases and ongoing referrals for safeguarding reviews of significant incidents and deaths.

2.5. CAMHS

Current waiting times for CAMHS are longer than desired. Utilising the additional investment into CAMHS from the Long-Term Plan, a waiting list initiative has been agreed with LSCFT to support a reduction in wait times, with the ultimate aim of bringing LSCFT into the 4 week target aspiration set by NHS England. Regular monitoring and progress of the initiative is reported through the ICS CAMHS Performance and Data Sub-Group of the ICS CAMHS Board.

Appendix 2:

Central Lancashire ICP

1. Performance Overview

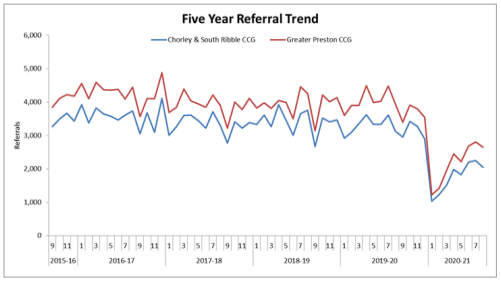
The pandemic has had a significant impact on performance metrics within the Central Lancashire area. The narrative below summarises the latest Covid19 position, and details some of the work of local providers and commissioners to address some key performance issues.

1.1. Covid-19 Services

Numbers of Covid19 patients in hospital continue to reduce, and there has been a decrease in the number of patients testing positive in the community for the 3rd successive week. Critical Care beds are being maintained at super surge level and occupied at around 82% capacity. Staffing sickness levels on the whole are reducing, although certain teams remain challenged, e.g. Community Dietetics, Diabetes, SALT and continence services are stretched. Primary Care continues to experience high demand for routine appointments and significant calls regarding vaccinations.

Demand Management

- The last 12 months have not been typical for GP referral demand
- There was a significant dip in GP referrals to all providers from our CCGs from March 2020 to June 2020, and whilst there has been some recovery since, the position at November 2020 was still just over 70% of pre-Covid levels
- On a Year to Date position 2020/21 has seen levels of GP referrals reduce by 46.3% from 2019/20



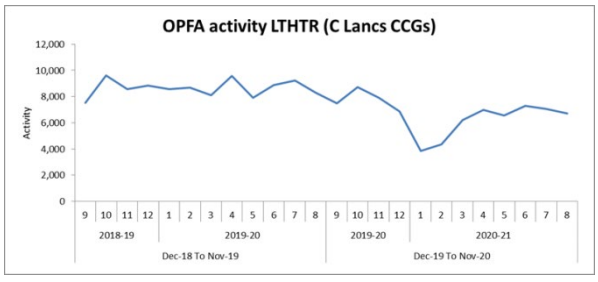
YTD Position			
Ref Year	Referrals	Var	% Var
2016-17	64,052		
2017-18	59,003	-5,049	-7.9%
2018-19	59,856	853	1.4%
2019-20	58,722	-1,134	-1.9%
2020-21	31,536	-27,186	-46.3%

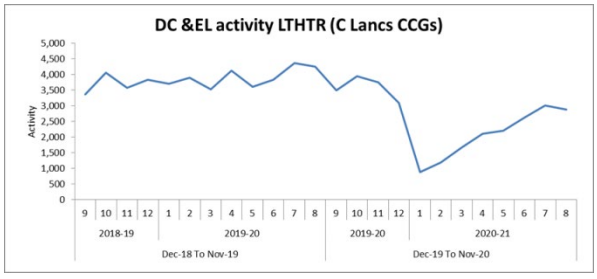
Those specialties with the largest reduction YTD in terms of volume are T&O, Ophthalmology and Gynaecology.
Local work to reduce demand on acute services includes:

- Patient-Initiated Follow-Ups – in specific specialties to implement alternatives to structured follow-up pathways
- Implemented the MB CCG A&G system – promotes communication between Primary and Secondary care prior to referral
- Supporting ICS-wide solutions such as the Clinical Validation Tool and the use of digital solutions

1.2. Restoration

GP referrals have returned to approximately 70% of pre-Covid19 levels as per the above. In terms of activity, as of M8 Outpatient first appointments were nearly back at pre-Covid19 levels (approx. 88%), however Daycase and Inpatient rates have not recovered as quickly and are approximately 70-75% of pre-Covid19 levels (see graphs below):





Locally the ICP has supplemented the National 'Help Us To Help You' campaign (designed to encourage early presentation and reduce DNAs) with local social media content, as well as the production of packs for General Practice to help reassure patients around primary care access. The outpatient transformation programme is looking to redesign services and pathways to drive efficiencies. The ICP is also supporting ICS-wide solutions, for example the use of Independent Sector capacity to support Trusts – locally this capacity is well utilised but is mainly being used by ERS patients rather than those transferred from Lancashire Teaching Hospitals (LTH).

2. Quality Reporting GP & CSR CCGs

2.1. Referral to Treatment (RTT)

The numbers of 52 week breaches have continued to rise in Central Lancashire with 4747 recorded breaches in December 2020 Work continues at an ICS level in order to determine the recovery position. In order to provide assurances around patients on the existing waiting list the Trust are following the mandated National Clinical Prioritisation Programme

- A detailed breakdown of the waiting list into the 'Priority' categories (by speciality) was shared with the CCG in Jan 2021 and will be updated monthly. Each patient priority grouping is underpinned by an action plan
- Divisions have been tasked with reviewing each P2 patient that remains untreated by end of Jan 2021 to ensure that there is a treatment plan in place for these patients
- High numbers of P2 patients have been identified within gastro and cardiology therefore these are currently being reviewed in line with the 'Federation of Surgical Specialty Associations Clinical Guide to Surgical Prioritisation during the Coronavirus Pandemic guidance' to ensure the prioritisation is aligned correctly
- Divisions are working through their P5 & 6 patients to determine their clinical priority (with a focus on when to communicate with the P2's within this cohort in order that the patient understands the clinical risks if they choose to delay treatment)
- Any harms that may be identified will be reported to the CCG via StEIS where appropriate;
- The Trust collates all Covid19 related incidents and will ensure that any level of harm due to delays in treatment is captured within their quarterly incident report. The CCGs will continue to monitor this monthly.

2.2. Nosocomial infections

During November and December 2020 the CCGs reported a high community prevalence rate for Covid19 infections. Outbreaks of nosocomial infection were also reported across Trust and care settings during this period and created a cause for concern. This was closely monitored at a local and regional level with a number of actions put in place

- Reconfiguring of the acute hospital bed base to create 'zones' in line with the patients Covid19 status
- Point of Care testing in ED areas to direct patients to the most appropriate bed
- Enhanced emphasis on staff social distancing, lateral flow testing and PPE measures (across all settings)
-

- All Trusts required to complete a self-assessment against the NHS Infection Prevention Control Board Assurance Framework (IPC BAF) with detailed action plans (this was shared with the CCG)
- Supportive assurance visits from the NHSE/I regional IPC team
- MDT oversight and support for Care Homes where required
- Additional assurances have been gained from an in depth presentation from the Trust highlighting actions taken to reduce nosocomial infection rates at the CCG Quality & Performance Committee
- Weekly oversight of nosocomial infection issues via the ICP Senior Leadership Team
- Roll out of the Covid19 vaccination programme.

As at 23rd February 2021 a significant reduction in the numbers of outbreaks of nosocomial infection / nosocomial rates can be seen across Care Home and acute Trust settings.

It has been apparent throughout this period that patients may have suffered harm as a result of nosocomial infection. The CCGs are awaiting Regional guidance on how this will be managed in order to ensure a standardised approach.

2.3. NHS Continuing Health Care

- The initial trajectory was submitted to NHSE and has been revised to update on the current position
- Additional capacity has been sought from third parties to complete assessments Further staffing resource will be on boarded to the LSC team from other MLCSU teams
- NHSE/I requested a recovery trajectory/improvement plan from the ICS for completing all deferred referrals by 31 March 2021, this included COVID funded packages and incomplete checklist referrals prior to the COVID emergency period.
- The completion of all deferred assessments by the 31st March will not be met by the ICP or the ICS, MLCSU are working on a recovery plan of meeting the trajectory by the end of April discussion are ongoing with NHSE/I re recovery plans and assurances.

Risks;

- Financial implications (CCG/LA/Individual)Patients not reviewed as per framework
- Patients at risk of being in wrong placement/inappropriate package of care
- Financial sustainability of care home sector if residents moved.
- Challenges for regulated care in order to prepare for high volume of reviews
- Challenges for CHC workforce due to demand on the service and volume of workload.

2.4. Safeguarding

The full impact of Covid19 on safeguarding is not yet known. Hidden Harms for adults and children post Covid19 remain a concern. Emerging risks relate to abuse and neglect of adults and children, which may be hidden due to reduced visibility and not being seen by professionals. A summary of health insights of the impact of Covid-19 on safeguarding is being collated to influence a partnership responsive plan.

The pandemic has impacted on the dental assessment performance for Looked After Children. This is reported to be a national and local issue with variation across Lancashire. Discussions are taking place with the ICS Dental Lead in securing bespoke provision for Looked After Children in accessing dental care.

The Liberty Protection Safeguards (LPS) are due to be implemented April 2022. The LPS brings new responsibilities in the role of 'Responsible Body' to the CCGs and Acute Hospitals Trusts. An ICS workshop is planned on the 9 March 2021 to work up a delivery model for the CCGs as the system reforms develop.

2.5. Mental Health – increased incidence of suicide

The CCGs have sadly seen a rise in the numbers of reported suicides during the Covid19 pandemic. Patients in receipt of care are StEIS reported and each case is thoroughly reviewed by the CCG Serious Incident Review Panel. Actions taken include

- Assurances presented to the CCG Quality & Performance Committee from the ICS Mental Health team re the programmes of work in place in relation to suicide prevention
- Escalation of concerns to the CCG Governing Body.
- Escalation of concerns to commissioning colleagues in Pennine (who are lead commissioner for MH services).
- High numbers of cases were noted to be unallocated to a care co-coordinator (thereby presenting a risk). Consequently weekly meetings were put in place with the service manager to ensure this is reducing
- Currently collating all Serious Incident Panel comments for StEIS reported incidents (during the last 12months). Any trends and themes will be discussed with Pennine CCGs and the Mental Health trust in order to gain assurances around actions in place to address this issue.

Appendix 3:

West Lancashire CCG

1. Performance Overview

The CCG has been working with partners across both Merseyside and Lancashire to ensure a robust response to the pandemic and the related restoration of patient services.

Several key performance measures have been steadily improving over the last few months and compare well to the national average position. For instance, the 18-week referral to treatment target at the end of December was 71% compared to 60% nationally. Cancer waiting time performance is slightly better than the national picture and adult mental health IAPT waiting times are above target, albeit with much lower referrals into the system, signalling potential high levels of unmet need. Community Mental Health Teams performance is good and there are no unallocated cases.

1.1. Covid-19 Services

The CCG implemented COVID Oximetry@ home in December 2020. 152 referrals have been received with 96 discharges up until mid-February. Access points are currently at GP practice, red site, A&E and designated settings, with plans to roll out to care homes underway.
The COVID Virtual Ward (CVW) at Southport and Ormskirk Hospital launched on 15th February 21 which includes:

- S&O CVW 9-5 seven days a week – escalation outside of this to 111 / 999 or attend AED as per guidance. Gen Med consultants cover Mon-Fri and AED consultants at weekends
- MCFT Telehealth will provide monitoring each day from 9-5 with escalation to S&O senior identified clinician as required
- Virtual ward round taking place daily at 3.30pm with S&O senior clinician and MCFT Telehealth team
- S&O hospital discharge letter will identify to GPs any patient on the covid virtual ward.

In respect of Long COVID, the West Lancashire local holistic assessment hub is now live. This is an evolving model and we continue to work with our partners in terms of further developing the pathway.

1.2. Demand Management & Restoration

The Clinical Assessment Service (CAS) was implemented 24/7 in West Lancashire to co-inside with NHS 111 First “Go Live” in November. The CAS has been extended to take additional code sets and will soon also be able to re-validate downgraded calls from NWAS. The local CAS is consistently deflecting over 80% of calls referred.

General practice is utilising the online “Consultant Connect” service which has proven to reduce referrals to hospital and takes the burden off acute services. The CCG continues to work with system partners to monitor and improve hospital waiting time performance. There is a particular focus on 52 week-plus waits, recognising these have increased nationally across the NHS. Southport hospital has relatively low levels of 52 week plus waits, the lowest in Cheshire & Merseyside at the present time. Work is ongoing to find “mutual aid” solutions for several fragile specialties at the Trust.

In respect of Mental Health, a new IAPT pilot commenced in November utilising locally skilled third sector (CVFS) staff to give wider choice of therapy available. This will provide valuable complementary support as referrals increase.

Appendix 4

Fylde Coast CCGs

1. **Performance Overview**

   This is intended as a high-level update on performance for the Fylde Coast, the focus is on delivery against the NHS Constitution performance metrics at Blackpool Teaching Hospitals NHS Foundation trust (BTH).

   The position in December 2020 highlights the significant impact of the pandemic on urgent care and elective waiting times. Both the number of 52-week waiters and the size of the diagnostic waiting list have increased during the month. To support recovery of the elective backlog, BTH is working closely with the Independent Sector to move over long waiting patients where possible. Elective recovery is being led at system level, by the Lancashire and South Cumbria Hospital Cell. The Cancer Alliance is leading on recovery work across the ICS for all the cancer metrics.

Fylde Coast Performance Headlines	
Urgent care (BTH)	○ **A&E 4 hours;** 79.7% in December 2020, which is similar to delivery in November 2020. The average number of attendances in 2020-21 is 11,000 per month, this compares with an average of 18,500 in 2019-20. ○ **Trolley waits over 12 hours** for patients waiting to be admitted remain high in December 2020 at 51 (although they are lower than the level in November of 83). 50 of these were medical breaches and one was a mental health breach. ○ **Ambulance response times** at a North West Ambulance Service level (NWAS) have improved slightly in December.

Planned care (BTH)	Fylde Coast referrals for April – December 2020 are 28% lower than the number seen in the same period of 2019, with the highest variances in orthopaedics, ophthalmology, ENT and gynaecology. Advice and Guidance was introduced in July 2020 and has had a direct impact on avoiding unnecessary hospital referrals. BTH is also undertaking virtual outpatient appointments wherever possible.
	
	○ **% patients seen within 18 weeks** (BTH) was 64.7% in December, this is a slight improvement from 64.5% in November.
	○ **Total referral to treatment waiting list** (BTH-inpatients and outpatients) has reduced by 716 in December or 3.5%. Approximately half of the over 18 week waiters are in three key specialties; orthopaedics, general surgery and gynaecology. Where possible, long waiting patients are being transferred over to the independent sector.
	○ **Number of 52-week waiters**
	  ○ At BTH there were 1301 at the end of December 2020, an increase of 176 since November 2020 (or 16%) with notable increases in orthopaedics, general surgery and ophthalmology.
	  ○ At Spire, there were 648, which was a marked increase of 165 or 34% since November 2020.
	○ **Diagnostics** % waiting greater than 6 weeks (BTH)– was 25.1% in December and the full diagnostics waiting list also increased slightly, up to 5418. There has been a slight reduction in the number of long waiters for key tests including colonoscopy, flexi sigmoidoscopy and gastroscopy. Additional capacity has been put in place where possible although restrictions linked to COVID are impacting on throughput. Long waiting patients are triaged weekly to ensure those at highest risk are prioritised.

2. Quality Reporting

2.1. Referral to Treatment (RTT)

In December BTH were reporting 1301 (validated) patients waiting over 52 weeks for an elective procedure. During the same time period FC CCGs were reporting 2336.

BTH report that 558 reviews have taken place. 21 patients were identified as moderate harm, and these are being reviewed with clinical teams to assure consistency of approach and quality of review and to determine the next steps. There have been zero severe harms identified.

2.2. Nosocomial Infections

W/c 11.01.2021 BTH reported:

- 70 Community onset – swab taken within 2 days of admission
- 17 Hospital onset – Indeterminate, swab taken 3-7 days after admission
- 11 hospital onset – Probable, swab taken 8-14 days after admission
- 13 Hospital onset – Definite, Swab taken 15 days or more after admission
- Total number of cases 111
- Total number of nosocomial infections 24

The infection prevention team at BTH continue to undertake RCAs of all nosocomial cases and present their findings to the bi-monthly WHIPC meeting.

Most recent findings from the RCAs are

- Previous exposure to other known positive patients
- Cases linked to outbreaks
- Failure to rescreen negative patients on day 5-7 of admission.

Actions undertaken by the Trust are.

- Rolling PCR staff testing and extra environmental cleaning of known hotspot areas.
- Point of care testing service operates 12 noon to 7:00pm daily, to ensure rapid test results during peak activity in ED and other admission areas.
- Five Clinell Rediroom isolation pods have been delivered and staff commenced training on the 12th February 2021.
- An alternative to the mediscreen, which cannot be fitted in certain bed areas has been sought and trialling will commence in the near future, if successful all areas without a screen will have these fitted to the bed space.

2.3. Continuing Healthcare (CHC)

As at 16/2/21
FWCCG 24 pre-March incomplete assessments, 89 deferred, as a result of covid.

BCCG 46 deferred assessments, as a result of covid.

No specific harms identified to-date

2.4. Safeguarding

The full impact of Covid19 on safeguarding is not yet known. Emerging risks relate to abuse and neglect of adults and children, which may be hidden due to reduced visibility and not being seen by professionals. In addition, there is recognition that the third wave is having a real impact on families in terms of increased levels of hardship.

Blackpool - Domestic Abuse. Health are working with the local authority and the constabulary to develop a refreshed MARAC process inclusive of resource requirements.
Dental assessment performance for Looked After Children has been impacted as a result of the pandemic. This is variable across Lancashire but has been reported as a national issue. Negotiations with the ICS dental lead are taking place to look at securing provision for Looked After Children in accessing dental care.

Safeguarding Reviews - CSPRs, SARs and DHRs continue. Presently across the Fylde Coast there are; CSPRs, 8SAR, 3MALR 1, DHR 2
3 Regulated Providers are in a Quality Improvement process under RADAR. 1 of these is suspended to new admissions.

2.5. CAMHS delays and backlog

Fylde Coast ICP – CAMHS Performance – December 2020
National Access Rates – Rolling 12 Month Position

Data is provided by our two main providers, Blackpool Teaching Hospital and Lancashire & South Cumbria Foundation Trust and for the Voluntary Sector Providers: Achieve Change and Engagement (A.C.E), N-Compass North West & Kooth.

Services commissioned by Fylde Coast CCGs are exceeding the National Access Rate target (35%) – for Blackpool CCG 54% of children and young people aged under 18 are receiving treatment by NHS funded community services; for Fylde and Wyre CCG this is 60%.

Dec '19 – Nov'20 National Data (All providers)			
	12 mth National Rolling Position	**Prevalence**	**% achieved**
Blackpool CCG	1,605	2,952	54%
Fylde and Wyre CCG	1,620	2,702	60%
L & SC (TOTAL)	14,860	32,966	45%

Waiting Lists – No. of CYPs waiting to be seen

The numbers of children and young people waiting to be seen has increased (an additional 77 children and young people are waiting to be seen) within our NHS commissioned services across the Fylde Coast.

CCG	Provider	Service	Nov 20	Dec 20	Trend
BCCG	**BTH**	CAMHS, Youtherapy, CASHER & <18s seen by AMH	455	526	↑
	LSCFT	CPS	17	18	↑

FWCCG	**BTH**	Youtherapy and CASHER	124	117	
	LSCFT	CAMHS/CPS	36	42	

Waiting Times (Average No. Of Weeks)

There has been an improvement in the reduction of the average waiting times in 3 out of 4 services delivered by our main providers (BTH and LSCFT), compared to the previous month.

CCG	Provider	Service	Nov 20	Dec 20	Trend
BCCG	**BTH**	CAMHS, Youtherapy, CASHER & <18s seen by AMH	8.4	9.3	
	LSCFT	CPS	34.1	22.1	
FWCCG	**BTH**	Youtherapy and CASHER	9.1	8.4	
	LSCFT	CAMHS/CPS	13.1	12.3	

Actions taken to mitigate:

- LSCFT have implemented a recovery plan to address the long waits within Blackpool CPS. Commissioners are meeting with LSCFT on a regular basis to monitor this.
- Investment, through the CYP Transformation Plan and LTP, will see increased clinical capacity in all services with a focus on reducing numbers waiting and waiting times in the first instance.
- Performance is monitored through the CYP Emotional Wellbeing and Mental Health Performance Dashboard.

Appendix 5:

Morecambe Bay CCG

1. **Performance Overview**

Many of the functions and statutory responsibilties of the CCG are now being led through the Lancashire and South Cumbria Covid-19 Pandemic Incident Cells. For the remainder of the financial year, the CCGs focus remains on patient safety, equity of access and reducing potential harm.

1.1. COVID Response

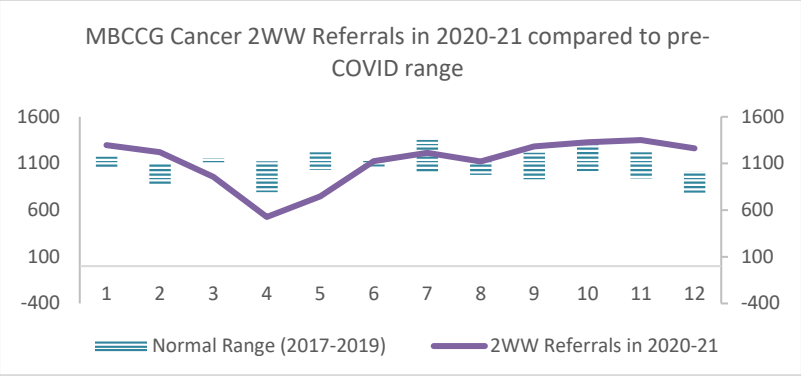
Since December 2020, COVID19 cases increased significantly with a higher proportion requiring intensive care and ventilation compared to earlier surges. Alongside the usual factors associated with winter, this has led to intense pressure within the acute hospital. The CCG has led daily calls to ensure that we maximise safe and timely patient discharge. Currently the number of Medicaly Fit For Discharge (MFFD) patients is reducing at both Furness General and the Royal Lancaster Infirmary. The main challenge has been the loss of Care Home and Residential Care capacity due to COVID19 outbreaks.

The CCG is working closely with providers to support delivery, a key area of focus being support to the care home and residential sector. Throughout winter, A&E performance has remained comparible with previous financial years and the system has not escalated above OPEL 3. This indicates that our winter planning actions have been succesful at maintaining stablity during abnormal system pressures. The system continues to focus on the delivery of vaccinations at pace, receiving acknowldgement nationally on the speed and performance of our local processes.

1.2. Demand Management (January 2021)

The table below shows the current demand trends to the University Hospitals of Morecambe Bay for MBCCG patients, compared to the same month in 2019-20 (Our pre-COVID19 baseline). Demand remains reduced and the CCG is evaluating what level of *supressed demand* may present in the future financial years. A key focus has been ensuring cancer two week referrals (2WW) are restored to normal levels. Although referrals in January have reduced due to COVID19 pressures, the chart below shows that demand has both recovered and increased during quarters 2 and 3 or 2020-21.

Cancer 2WW	-15.2%
GP Referrals	-42%
Community Services	-24.5%
A&E Attendances	-23.8%
Admissions from ED	-18.5%



1.3. Restoration of Services

Overall UHMB remain slightly below plan on their phase three recovery ambitions. Capacity for outpatients and elective admissions has been impacted by the COVID19 surge and the need to release both staff and beds. Workforce is also a factor with UHMB having reported up to 10% sickness rates and the trust having to plan for staff

taking delayed annual leave. The system is however exceeding its plans in areas such as endoscopy where targeted use of the independent sector has helped to reduce waiting list and speed up the cancer diagnostic pathway. Overall, recovery plans have been robust and developed with CCG and Primary Care support.

2. Quality Reporting:

2.1. Harms associated with 52 weeks

The CCG has been working with UHMB to track to impact of increasing elective waits, the local system is able to track the number of A&E attendances for this patient cohort and the potential *failure demand*, where patients access an alternate service due to their agreed treatment plan being delayed. Key trends and changes are being explored to ensure we proactively identify potential risks. The CCG receives the actions that UHMBT are taking to mitigate risks to patients.

2.2. Nosocomial infections

The CCG works closely with providers in the prevention and monitoring of nosocomial infections. Local processes are in place with active engagement from providers. Post infection reviews are carried out for Clostridium difficile, MRSA and COVID-19 cases with ongoing action plans in place to ensure learning is embedded into practice. The reduction and monitoring of GNBSIs is a continued focus of the CCG. A plan has been developed to establish priorities in the reduction of infection and to support the antimicrobial resistance (AMR) work stream to maintain antibiotic effectiveness.

2.3. Continuing Healthcare (CHC)

The CCG has been working with UHMBT and Local Authorities in identifying causal factors of the Discharge to Assess (D2A) six week pathway breaches and enabling processes to reduce these. As the national Discharge Support Fund ends on the 31st of March 2021, the CCG awaits further detail of any replacement scheme.

Deferred Assessment cases have transferred to MLCSU who have identified additional resources to meet earlier agreed completion trajectories by the end of March. The CCG continues to work with MLCSU and community providers in undertaking a review of ongoing delays in completion of DST in South Cumbria.

2.4. Safeguarding / CAMHS issues

The Safeguarding Professionals across the ICS footprint have continued to utilise their expertise and network approach to provide greater consistency in the delivery of statutory functions during the COVID pandemic. The ICS Designated Network is working closely with NHSE, Partner Agencies and Providers as we move in to Phase 3 of our COVID response, planning for recovery and management of a potential surge in referrals and activity.

We are working closely with safeguarding partners to promote early help services to those in need. We continue to support our providers to manage a number of complex cases in relation to mental health support to children and young people (including those who looked after) and cases arising from hidden harm, which are presenting late, in crisis and with high complexity. Our safeguarding partners are also prioritising the response to abuse outside of the home.

We currently have two Child Practice Reviews and one Domestic Homicide/Mental health Homicide Review underway.

Appendix 6:

See separate document attached.

Performance Metrics

	Metric	RAG
1	% Patients seen within 2 weeks for an urgent GP referral for suspected cancer	
2	% Patients seen within 2 weeks for an urgent referral for suspected cancer [BREAST]	
3	% Patients receiving definitive treatment within 31 days of a cancer diagnosis	
4	% Patients receiving first definitive treatment within 62 days	
5	% Patients waiting 6 weeks or more for a diagnostic test	
6	% Incomplete RTT pathways within 18 weeks	
7	Total number of patients on an incomplete RTT pathway	
8	Number of patients waiting over 52 weeks on an incomplete RTT pathway	
9	Ambulance handovers – 30 min delay	
10	% A&E waits under 4 hours	
11	Early Intervention Psychosis - % in 2 weeks of referral	
12	Improving Access to Psychological Therapies (IAPT) – Roll out (access)	

% 2 Weeks Cancer – Urgent GP Referral

ICS Level: Lancashire & South Cumbria

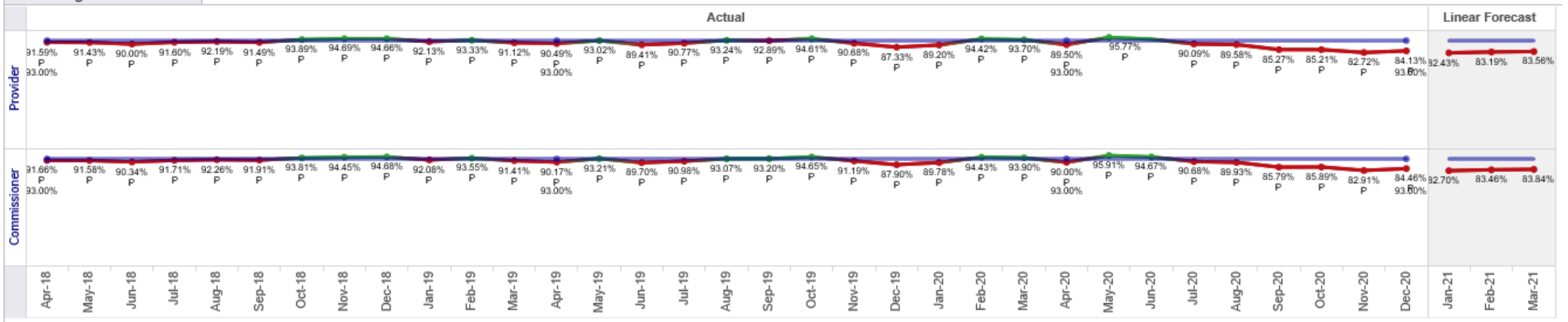
% Patients seen within two weeks for an urgent GP referral for suspected cancer (Monthly)

	Provider		YTD
Value	Dec-20	84.13%	87.76%
Target	Dec-20	93.00%	93.00%
Forecast	Jan-21	82.43%	87.76%

	Commissioner		YTD
Value	Dec-20	84.46%	88.18%
Target	Dec-20	93.00%	93.00%
Forecast	Jan-21	82.70%	88.18%

% 2 Wks Cancer Urgent

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
		Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
Commissioner	84.46% Dec-20	68.15% Dec-20	68.11% Dec-20	74.83% Dec-20	75.85% Dec-20	97.62% Dec-20	94.34% Dec-20	95.74% Dec-20	94.78% Dec-20	85.90% Dec-20

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
		Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	84.13% Dec-20	68.11% Dec-20	68.15% Dec-20	75.20% Dec-20	76.40% Dec-20	74.83% Dec-20	95.81% Dec-20	93.28% Dec-20	97.62% Dec-20	94.44% Dec-20	94.91% Dec-20	95.74% Dec-20	85.90% Dec-20

% 2 Weeks Cancer – Urgent Referral (Breast)

ICS Level: Lancashire & South Cumbria

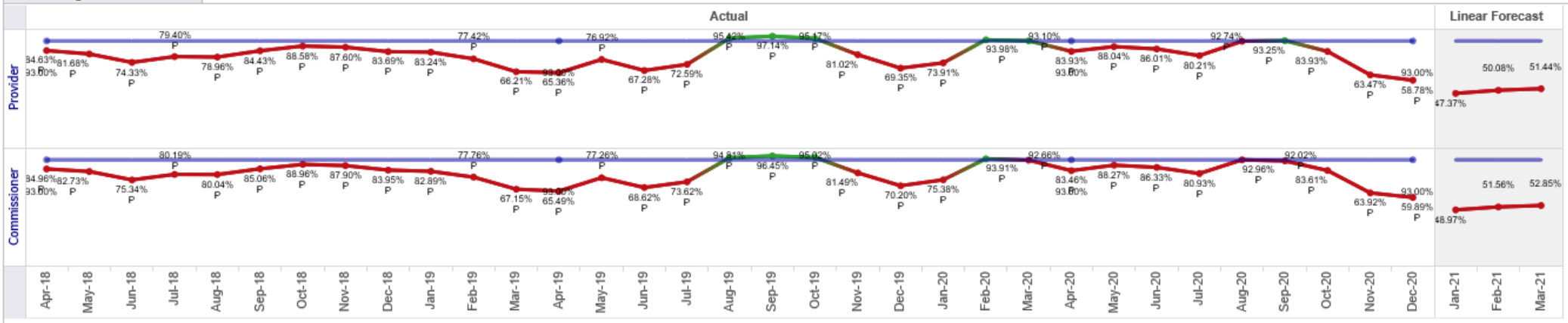
% of patients seen within 2 weeks for an urgent referral for breast symptoms (Monthly)

	Provider		YTD
Value	Dec-20	58.78%	78.15%
Target	Dec-20	93.00%	93.00%
Forecast	Jan-21	47.37%	78.15%

	Commissioner		YTD
Value	Dec-20	59.89%	78.46%
Target	Dec-20	93.00%	93.00%
Forecast	Jan-21	48.97%	78.46%

% Cancer 2 Wks Breast

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations											
	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire		
		Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner		
Commissioner	59.89% Dec-20	4.00% Dec-20	6.12% Dec-20	2.26% Dec-20	3.97% Dec-20	95.28% Dec-20	91.89% Dec-20	88.07% Dec-20	86.09% Dec-20	62.86% Dec-20		
		Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire		West Lancashire
		Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	58.78% Dec-20	6.12% Dec-20	4.00% Dec-20	4.69% Dec-20	3.23% Dec-20	2.26% Dec-20	93.44% Dec-20	90.00% Dec-20	95.28% Dec-20	85.19% Dec-20	86.58% Dec-20	88.07% Dec-20	62.86% Dec-20

% 31 Day Cancer – Definitive Treatment

ICS Level: Lancashire & South Cumbria

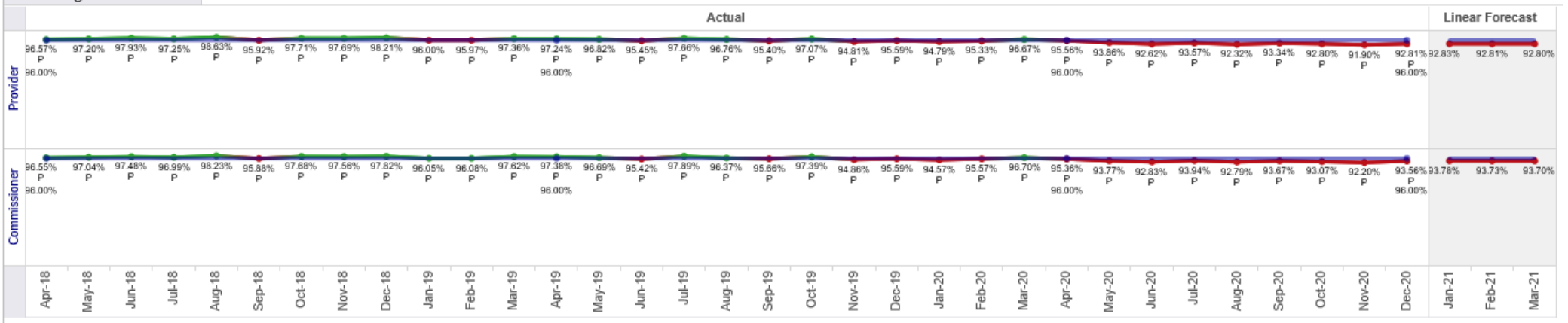
% of patients receiving definitive treatment within 1 month of a cancer diagnosis (Monthly)

	Provider		YTD
Value	Dec-20	92.81%	93.16%
Target	Dec-20	96.00%	96.00%
Forecast	Jan-21	92.83%	93.16%

	Commissioner		YTD
Value	Dec-20	93.56%	93.45%
Target	Dec-20	96.00%	96.00%
Forecast	Jan-21	93.78%	93.45%

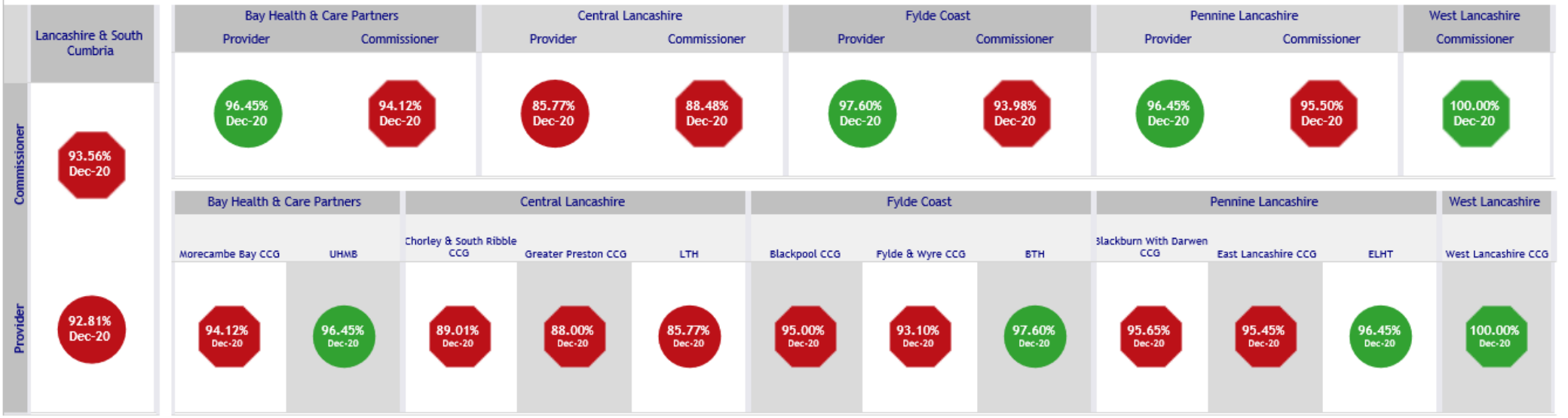
% Cancer Within 1 Month

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations



% 62 Day Cancer

ICS Level: Lancashire & South Cumbria

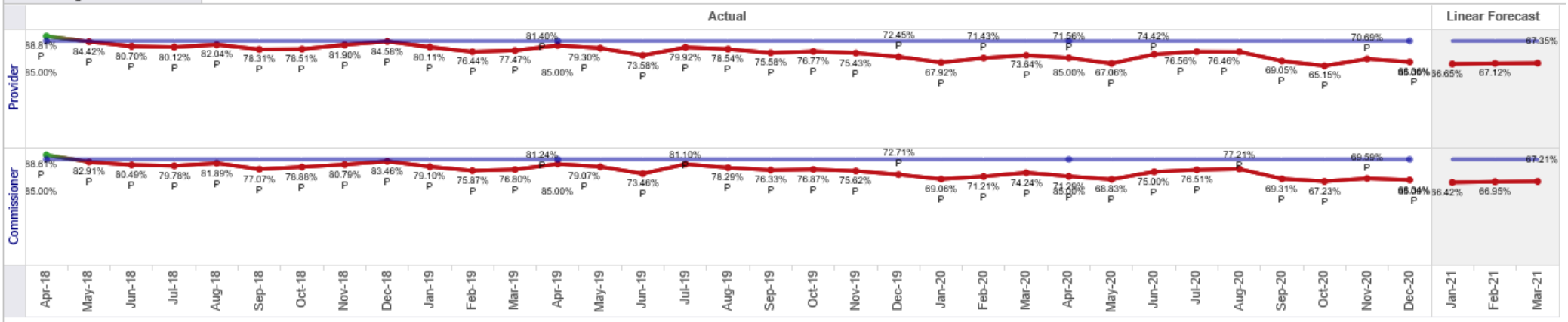
% of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (Monthly)

	Provider		YTD
Value	Dec-20	68.36%	70.95%
Target	Dec-20	85.00%	85.00%
Forecast	Jan-21	66.65%	70.95%

	Commissioner		YTD
Value	Dec-20	68.34%	71.33%
Target	Dec-20	85.00%	85.00%
Forecast	Jan-21	66.42%	71.33%

% Cancer Within 62 Days

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
		Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
Commissioner	68.34% Dec-20	67.61% Dec-20	66.67% Dec-20	64.41% Dec-20	66.96% Dec-20	70.00% Dec-20	67.54% Dec-20	72.86% Dec-20	70.18% Dec-20	73.68% Dec-20

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
		Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	68.36% Dec-20	66.67% Dec-20	67.61% Dec-20	64.71% Dec-20	68.75% Dec-20	64.41% Dec-20	69.39% Dec-20	66.15% Dec-20	70.00% Dec-20	77.78% Dec-20	67.82% Dec-20	72.86% Dec-20	73.68% Dec-20

% 6 Week Diagnostic Waiters

ICS Level: Lancashire & South Cumbria

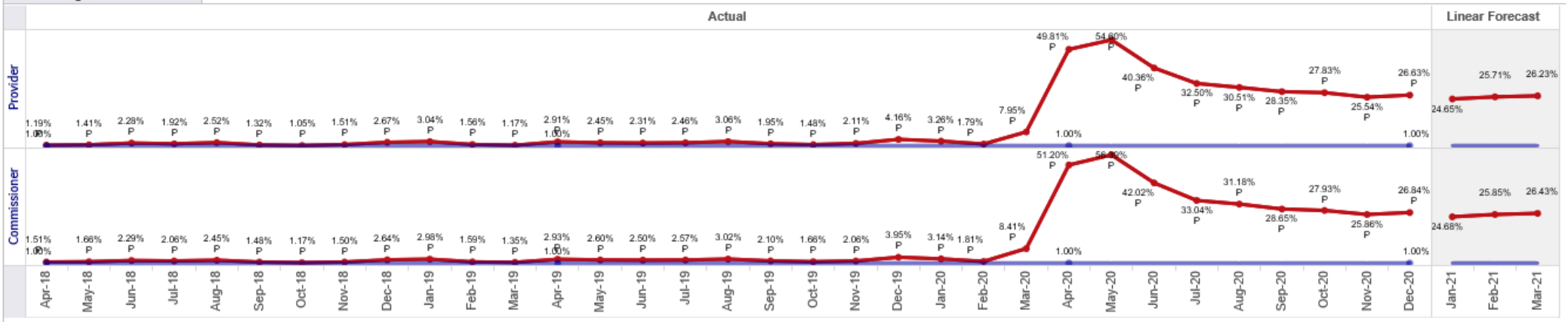
% of patients waiting 6 weeks or more for a diagnostic test

	Provider		YTD
Value	Dec-20	26.63%	33.86%
Target	Dec-20	1.00%	1.00%
Forecast	Jan-21	24.65%	33.86%

	Commissioner		YTD
Value	Dec-20	26.84%	33.56%
Target	Dec-20	1.00%	1.00%
Forecast	Jan-21	24.68%	33.56%

% Waiters 6 Wks Diagnostics

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Commissioner

Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
26.84% Dec-20	10.25% Dec-20	14.86% Dec-20	42.52% Dec-20	37.73% Dec-20	25.14% Dec-20	29.23% Dec-20	20.73% Dec-20	24.41% Dec-20	18.81% Dec-20

Provider

Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
	Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
26.63% Dec-20	14.86% Dec-20	10.25% Dec-20	37.26% Dec-20	38.04% Dec-20	42.52% Dec-20	30.67% Dec-20	27.78% Dec-20	25.14% Dec-20	23.68% Dec-20	24.74% Dec-20	20.73% Dec-20	18.81% Dec-20

% Incomplete 18 weeks RTT

ICS Level: Lancashire & South Cumbria

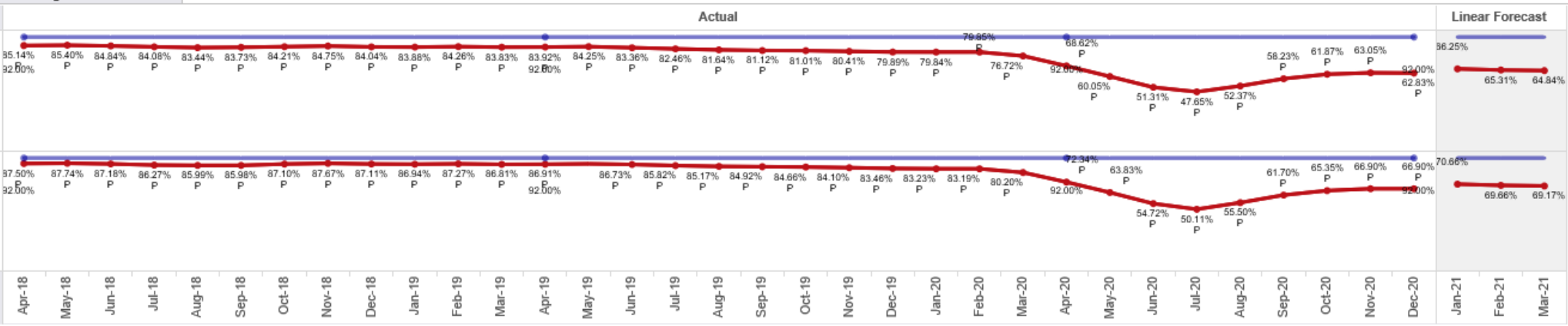
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

	Provider		YTD
Value	Dec-20	62.83%	58.51%
Target	Dec-20	92.00%	92.00%
Forecast	Jan-21	66.25%	58.51%

	Commissioner		YTD
Value	Dec-20	66.90%	62.09%
Target	Dec-20	92.00%	92.00%
Forecast	Jan-21	70.66%	62.09%

% Incomplete 18 Wks RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
		Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
Commissioner	66.90% Dec-20	59.53% Dec-20	60.24% Dec-20	57.03% Dec-20	69.62% Dec-20	64.65% Dec-20	60.92% Dec-20	74.18% Dec-20	72.09% Dec-20	79.25% Dec-20

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
		Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	62.83% Dec-20	60.24% Dec-20	59.53% Dec-20	70.21% Dec-20	69.12% Dec-20	57.03% Dec-20	60.40% Dec-20	61.43% Dec-20	64.65% Dec-20	71.95% Dec-20	72.15% Dec-20	74.18% Dec-20	79.25% Dec-20

Total number of Incompletes RTT

ICS Level: Lancashire & South Cumbria

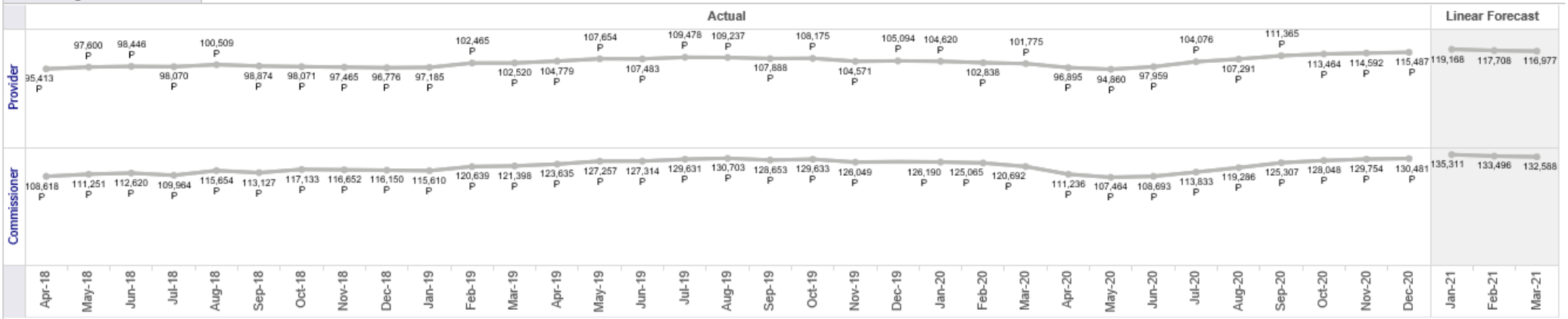
Total Number of Incompletes under and above 18 weeks RTT

	Provider	
Value	Dec-20	115,487
Target	Dec-20	
Forecast	Jan-21	119,168

	Commissioner	
Value	Dec-20	130,481
Target	Dec-20	
Forecast	Jan-21	135,311

Total no. of Incompletes RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
		Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
Commissioner	130,481 Dec-20	25,031 Dec-20	27,478 Dec-20	44,085 Dec-20	31,966 Dec-20	19,705 Dec-20	28,939 Dec-20	26,666 Dec-20	34,979 Dec-20	7,119 Dec-20
Provider	115,487 Dec-20	27,478 Dec-20	25,031 Dec-20	14,776 Dec-20	17,190 Dec-20	44,085 Dec-20	14,184 Dec-20	14,755 Dec-20	19,705 Dec-20	10,840 Dec-20	24,139 Dec-20	26,666 Dec-20	7,119 Dec-20

	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
	Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	27,478 Dec-20	25,031 Dec-20	14,776 Dec-20	17,190 Dec-20	44,085 Dec-20	14,184 Dec-20	14,755 Dec-20	19,705 Dec-20	10,840 Dec-20	24,139 Dec-20	26,666 Dec-20	7,119 Dec-20

Over 52 week waiters

Referral to Treatment (RTT) Waiters Dashboard - Over 52 Weeks

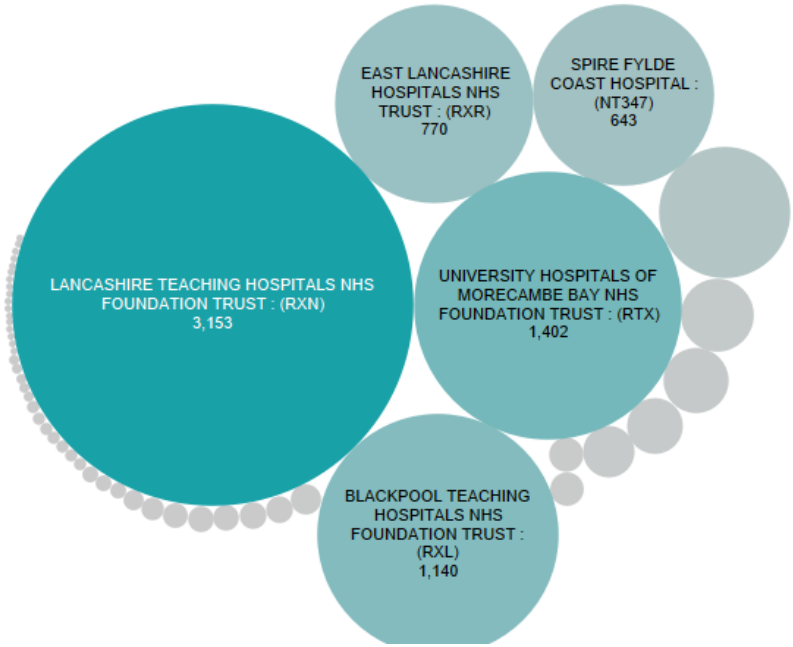
Midlands and Lancashire Commissioning Support Unit

** Areas shaded blue can be used as filters by selecting them.

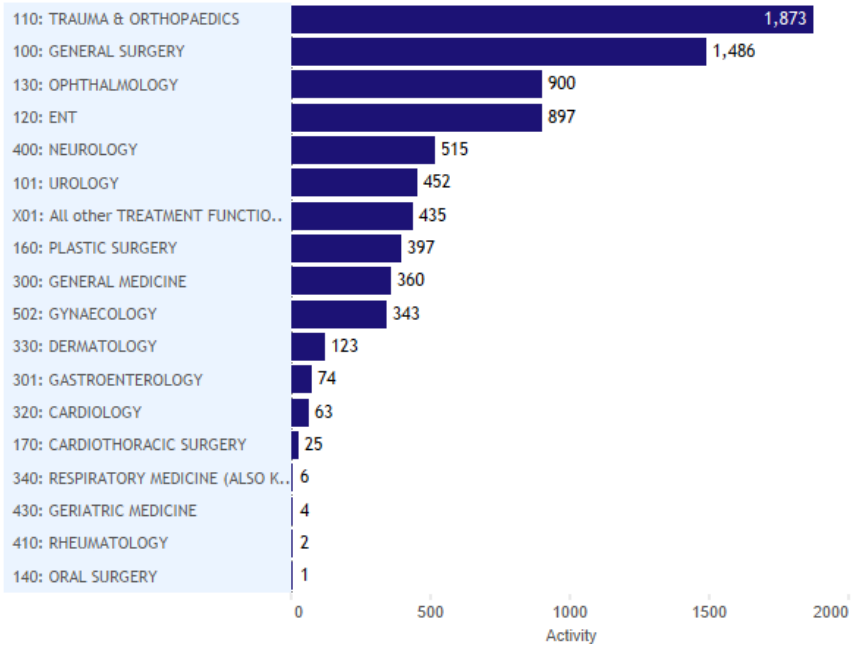
Referral to Treatment : 2) Incomplete pathways for all patients (unadjusted);
CCG Name : *;
Fiscal Year : 2020-21; Fiscal Month : December 2020
Provider: All; Treatment Function: All

Select Referral To Treatment Pathway		
2) Incomplete pathways for all patients (unadjusted)		
Fiscal Year	**Select Month**	**Select Measure**
2020-21	December 2020	Over 52 Weeks

Actuals by Provider - Over 52 Weeks (Select Provider to filter data **)



Actuals by Treatment Function - Over 52 Weeks **



Ambulance Handover 30 min Delays

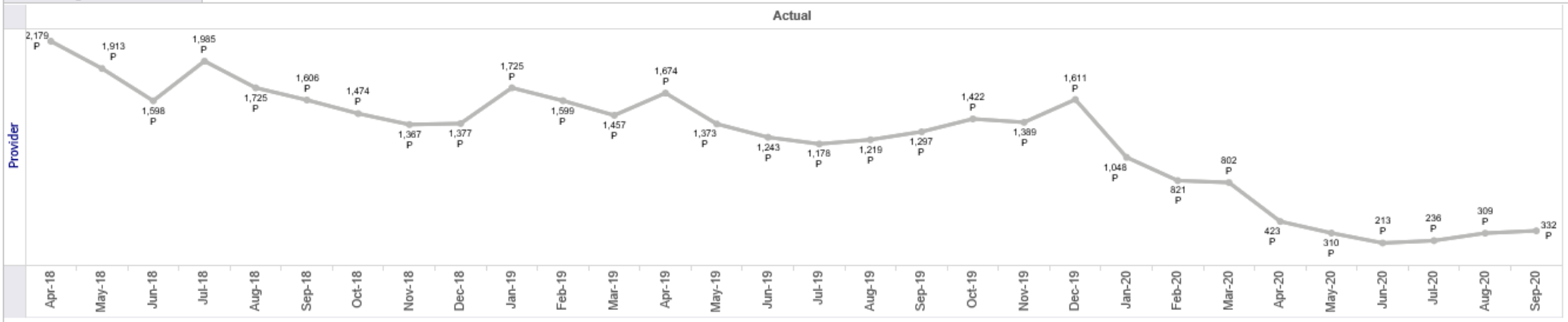
ICS Level: Lancashire & South Cumbria

Amb: 30 Min Handover Delays

	Provider		YTD
Value	Sep-20	332	1,823
Target	Sep-20		
Forecast	Oct-20		

Amb: 30 Min Handover Delays

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations			
Lancashire & South Cumbria	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire
Provider	Provider	Provider	Provider	Provider
332 Sep-20	130 Sep-20	23 Sep-20	35 Sep-20	144 Sep-20
Provider	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire
	UHMB	LTH	BTH	ELHT
	130 Sep-20	23 Sep-20	35 Sep-20	144 Sep-20

A&E : <4 Hour Waits % All Types

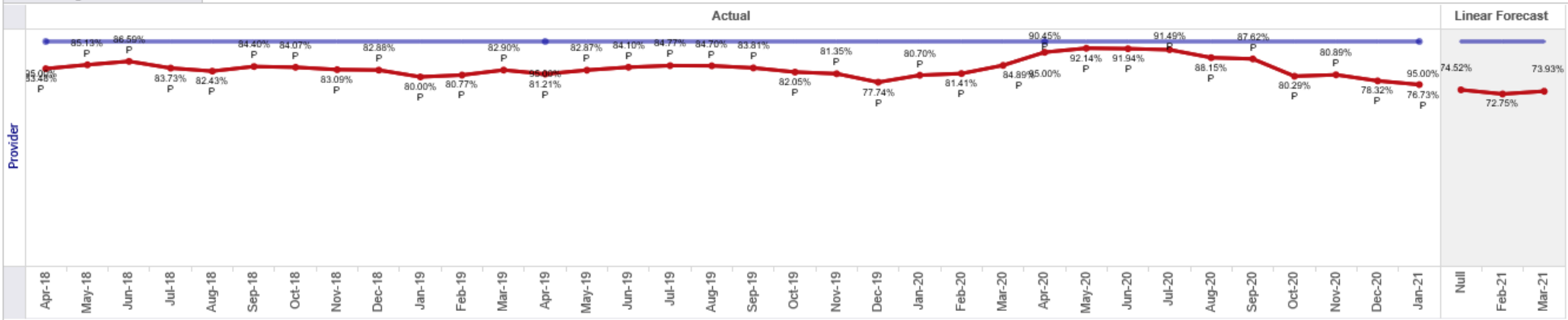
ICS Level: Lancashire & South Cumbria

A&E: <4 Hour Waits % All Types (Unify)

	Provider		YTD
Value	Jan-21	76.73%	85.66%
Target	Jan-21	95.00%	95.00%
Forecast	Feb-21	72.75%	85.66%

A&E: <4 Hour Waits % All Types (Unify)

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations			
Lancashire & South Cumbria	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire
	Provider	Provider	Provider	Provider
	77.60% Jan-21	81.38% Jan-21	78.24% Jan-21	71.01% Jan-21
Provider	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire
	UHMB	LTH	BTH	ELHT
76.73% Jan-21	77.60% Jan-21	81.38% Jan-21	78.24% Jan-21	71.01% Jan-21

Early Intervention Psychosis - % in 2 Weeks

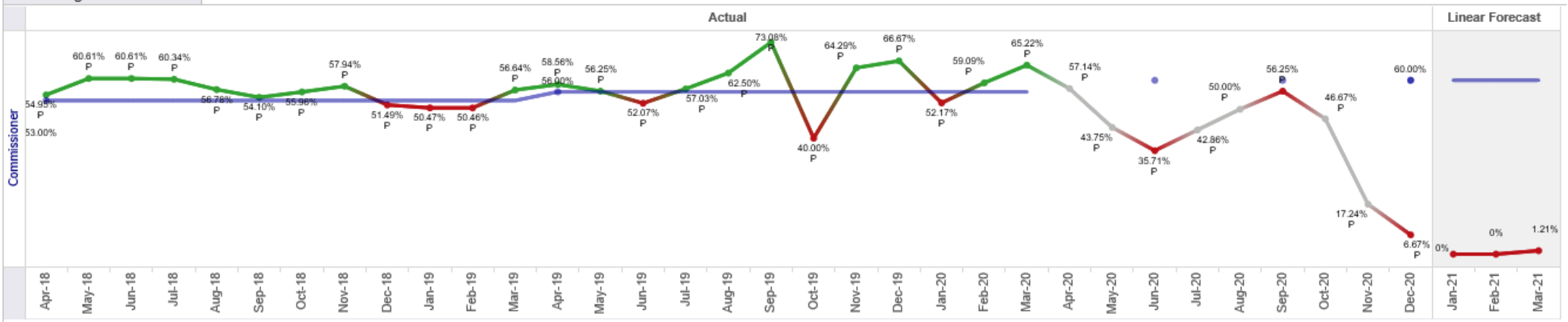
ICS Level: Lancashire & South Cumbria

% First episode of psychosis within two weeks of referral

	Commissioner		YTD
Value	Dec-20	6.67%	27.98%
Target	Dec-20	60.00%	60.00%
Forecast	Jan-21	-6.79%	27.98%

% EIP Within 2Wks Referral

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Commissioner

Lancashire & South Cumbria	Bay Health & Care Partners Commissioner	Central Lancashire Commissioner	Fylde Coast Commissioner	Pennine Lancashire Commissioner	West Lancashire Commissioner
6.67% Dec-20	0.00% Dec-20	0.00% Dec-20	15.38% Dec-20	10.34% Dec-20	0.00% Dec-20

Bay Health & Care Partners	Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
Morecambe Bay CCG	Chorley & South Ribble CCG	Greater Preston CCG	Blackpool CCG	Fylde & Wyre CCG	Blackburn With Darwen CCG	East Lancashire CCG	West Lancashire CCG
0.00% Dec-20	0.00% Dec-20	0.00% Dec-20	25.00% Dec-20	0.00% Dec-20	7.69% Dec-20	12.50% Dec-20	0.00% Dec-20

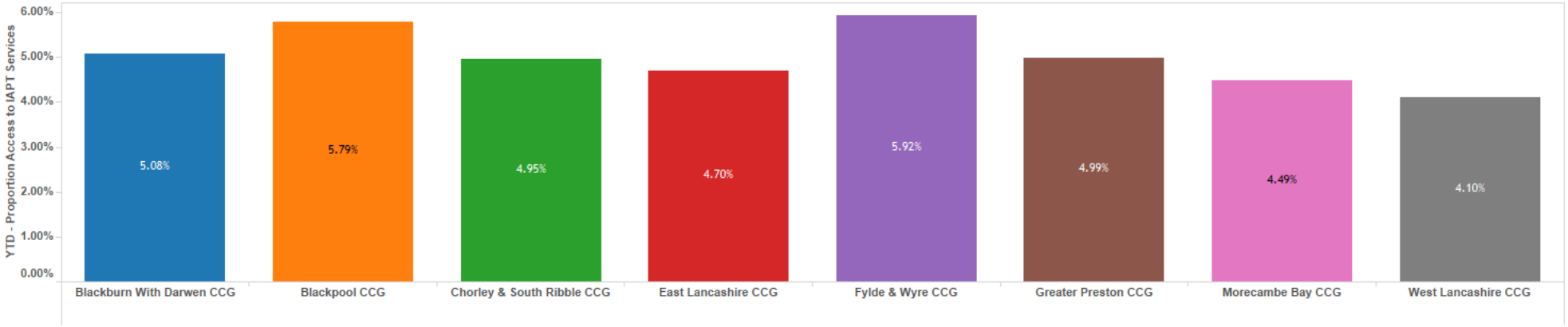
Aristotle

Improving Access to Psychological Therapies (IAPT) - Access and Recovery Rates

NHS Midlands and Lancashire Commissioning Support Unit

Area	Financial Year	Select data by
Lancashire	2020-21	Proportion Access to IAPT services %

Selected Area: Lancashire
Financial Year: 2020-21
The graph shows year to date figures for Proportion Access to IAPT services %. To filter for a particular month, click on the month name in the table below.



Data from NHS Digital Monthly Extracts

CCG Name	April	May	June	July	August
Blackburn With Darwen CCG	0.76	0.69	1.12	1.09	1.42
Blackpool CCG	1.09	0.93	1.23	1.34	1.18
Chorley & South Ribble CCG	1.12	0.63	0.90	1.12	1.19
East Lancashire CCG	0.94	0.54	0.91	1.14	1.16
Fylde & Wyre CCG	1.36	1.00	0.75	1.39	1.42
Greater Preston CCG	1.08	0.69	0.94	1.20	1.08
Morecambe Bay CCG	0.87	0.59	0.90	1.12	1.01
West Lancashire CCG	0.61	0.50	0.93	0.97	1.08

Data from NHS Digital Quarterly Extracts

CCG Name	Q1
Blackburn With Darwen CCG	2.57
Blackpool CCG	3.28
Chorley & South Ribble CCG	2.65
East Lancashire CCG	2.38
Fylde & Wyre CCG	3.12
Greater Preston CCG	2.71
Morecambe Bay CCG	2.38
West Lancashire CCG	2.09

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Title of Paper	New Hospitals Programme Report		
Date of Meeting	4 March 2021	Agenda Item	9

Lead Author	Rebecca Malin, Programme Director				
Contributors	n/a				
Purpose of the Report	Please tick as appropriate				
	For Information	✓			
	For Discussion				
	For Decision				
Executive Summary	This is the monthly update report of progress of the New Hospitals Programme. Notable updates this month include the planned launch of the New Hospitals communications and engagement plan and the publication of the draft case for change. Slides will accompany this paper to include the responsibilities of the JCCCG and a clear workplan up to and including the NHSE checkpoint assurance 1 meeting in June 2021.				
Recommendations	The JCCCG is requested to note the contents of the report and receives a further report at its meeting in April 2021. Note extraordinary meetings will be arranged in line with the NHSE checkpoint assurance 1 meeting in June 2021.				
Next Steps					
Is this a level 1 or Level 2 decision?	Level 1	✓	Level 2		
Equality Impact & Risk Assessment Completed		No			
Patient and Public Engagement Completed		No			
Financial Implications	Yes				
Risk Identified	Yes				
If Yes : Risk	As per the programme risk register. Reviewed on a monthly basis as per the governance arrangements.				

Joint Committee of Clinical Commissioning Groups (JCCCGs)

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

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

Joint Committee of Clinical Commissioning Groups (JCCCGs)

NEW HOSPITALS PROGRAMME REPORT

February 2021

1. Background

1.1 Colleagues will be aware that University Hospitals of Morecambe Bay NHS FT (UHMB) and Lancashire Teaching Hospitals NHS FT (LTHTr) were awarded £5m each as seed funding to progress the required business cases to secure capital investment to redevelop/replace the ageing estate which is no longer fit for purpose.

1.2 This is a once in a generation opportunity to secure around £1bn funding to build brand new hospital facilities for local people in Lancashire and South Cumbria. We want to use this investment to help improve the health of local people by offering patients and staff access to advanced, purpose-built hospital facilities in our area.

1.3 This funding is for hospitals, but we understand that it is only one part of broader health services and cannot improve our population's health on its own. This is a collaborative programme, involving all NHS organisations in our area and will be part of a wider programme of improvements in healthcare provision.

1.4 Clearly, this is a fundamental and critical programme which will shape the future service model for our people; those who work within it, those cared by it and the wider population of Lancashire and South Cumbria for a whole generation.

1.5 This monthly report details items for the members to be sighted on.

2. Communications and engagement

2.1 This month the Programme Strategic Oversight Group (SOG) received a presentation on the communications and engagement plan. The plan aims to communicate:

- **excitement** about this once in a generation opportunity
- **raise awareness** and **drive involvement** in the process
- we are **reaching out** to the excluded
- led by **clinical and patient voices**
- stakeholders can **trust our methods and intentions**
- people should feel they **know what is going on**
- there is a **rolling programme** of information and involvement opportunity
- to leave a **positive communications legacy**

2.2 We now have approved core narrative, key messages, media release and are aiming to introduce our internal and external communications and engagement wk. 1st March 2021. This includes a letter to our stakeholders across Lancashire and South Cumbria (L&SC) and launching a website, social media and a digital engagement platform.

2.3 Over the coming months our plan will build and make use of a variety of methods in order to reach our wide population and workforce. This includes a New Hospitals Programme colleague summit hosted by Amanda Doyle, Chief Officer for the L&SC ICS in April 2021.

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Joint Committee of Clinical Commissioning Groups (JCCCGs)

3. Clinical and operational leadership

3.1 Via the Clinical Oversight Group (COG) the programme has secured some excellent clinical and operational colleagues to join the programme team. A number of clinicians (Acute, Community and Primary Care) have already started in post and more will take up post over the coming weeks. Evidence suggests transformation such as this is far more successful and sustainable when led by clinicians. I am therefore delighted to have appointed approximately 25 clinicians who will play a critical leadership role in designing our future clinical service models.

3.2 The programme will continue to review requirements via the COG and respond accordingly.

4. Developing clinical service models

4.1 A series of workshops involving clinical and operational colleagues from across the ICS continued in January. This concluded phase 1 drawing together the 'as is' position and agreeing the principles (for each clinical area) they will use to guide the development of clinical service models. Throughout February and March our health planning team continues to work with clinicians to design clinical service models. Draft models will be published for partners to review and comment in March along with further workshops led and attended by our clinical colleagues.

4.2 Our aim is for the clinical service models to be endorsed in April ahead of the North West Clinical Senate validation at the end of the month. This is an essential element as we progress developing of a long list of options in May 2021.

5. Developing our case for change

5.1 Workshops were held in January and February to shape our case for change. These were attended by our workforce, governors and patients from across the ICS and provided a range of perspectives and valuable insight regarding why we need new hospitals in L&SC. We specifically discussed opportunities, benefits, what may get in our way and how we may address these. It is essential we create a compelling case for

change that our clinicians and patients advocate. I would like to thank all who attended and helped develop our first draft case for change.

5.2 We have now assimilated the output and combined with valuable messages from the clinical workshops. Along with supplementary desktop research and analysis this has formed our draft case for change which is published for partner review throughout Feb-March 2021 prior to publishing a subsequent draft at the end of March. Our case for change will continue to evolve as we progress our thinking this year.

6. Progress against plan

6.1 The Programme Management Group (PMG) meets monthly and receives/discusses progress against the timeline, critical milestones and key risks.

6.2 This month the group focused. As at February 2021 progress is on track against the critical path milestones. A weekly deep dive of progress against plan is undertaken with risks identified with associated mitigation and/or escalation as per governance arrangements.

7. Working with the national DHSC-NHSEI team

7.1 As anticipated, representatives from the L&SC New Hospitals Programme and the national programme team from NHSEI and DHSC will come together for a round table discussion in March 2021. This will largely focus on clarifying the scope of the programme and its deliverability. Our team will be led by Amanda Doyle and preparatory work is underway.

8. Engaging with other HIP programmes

8.1 To avoid reinventing the wheel and to learn from each other, the programme team has connected with other schemes namely Leeds Teaching Hospitals, University Hospitals of Leicester and South Devon and Torbay. In addition, PWC and ETL have established networks of other schemes. Sessions have included estates advice, governance, carbon zero and developing the PCBC.

9. Conclusion

9.1 This update covers the period January – February 2021.

10. Recommendations

10.1 The Committee is requested to note the contents of the report and receive a further report at its next meeting.

Rebecca Malin, Programme Director
February 2021

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Title of Paper	Partnership Pledge for Lancashire Family Safeguarding Model		
Date of Meeting	4th March 2021	Agenda Item	10

Lead Author	Margaret Williams Health Safeguarding Executive Lead and Louise Burton Designate Professional	
Meetings item previously discussed at	CCB (9 February 2021) Safeguarding Business Leaders Meeting (16 February 2021) Safeguarding Health Executive (23 February 2021)	
Purpose of the Report	Please tick as appropriate	
	For Information	✓
	For Discussion	✓
	For Decision	✓
Executive Summary	In early December the Lancashire Family Safeguarding Partnership requested a nomination from Health to sign the partnership pledge (Appendix A) Following discussions in February at CCB and the Safeguarding Health Executive as requested, this is now being brought to the attention of the Joint Committees of CCGs. The Lancashire Family Safeguarding model is a new way of working aimed at preventing children going into care. Alongside other partners, the JCCCGs is asked to endorse the model and nominate an Accountable Officer to sign the pledge document at Appendix A on behalf of the CCGs.	
Recommendations	The JCCCG is requested to: • Note the reference to the independent evaluation of Family Safeguarding in Hertfordshire and four other authorities, the expected improvements for our populations, health partnership and children and families • Endorse the Lancashire Safeguarding Family model and nominate an	

Joint Committee of Clinical Commissioning Groups (JCCCGs)

	Accountable Officer to sign the pledge document (Appendix A) on behalf of LSC CCGs				
Next Steps					
Is this a level 1 or Level 2 decision?	Level 1		Level 2		
Equality Impact & Risk Assessment Completed	Yes				
Patient and Public Engagement Completed	Yes	No	Not Applicable		
Financial Implications		No			
Risk Identified	Yes				
If Yes : Risk	Some potential workforce training impact				
Report Authorised by:					

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

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

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Joint Committee of Clinical Commissioning Groups (JCCCGs)

Partnership Pledge for Lancashire Family Safeguarding Model

Executive Summary

In early December the Lancashire Family Safeguarding Partnership requested a nomination from Health to sign the partnership pledge (Appendix A)

Following discussions in February at CCB and the Safeguarding Health Executive as requested, this is now being brought to the attention of the Joint Committees of CCGs.

The Lancashire Family Safeguarding model is a new way of working aimed at preventing children going into care.

Alongside other partners, the JCCCGs is asked to endorse the model and nominate an Accountable Officer to sign the pledge document at Appendix A on behalf of the CCGs.

About the Model

The model was introduced across Lancashire following a successful bid to the Department of Education in the Autumn 2019; initially supported by the Chair of the Children and Young People and Maternity Commissioning Network.

The Lancashire Family Safeguarding model encompasses a 'Think Family' approach which includes intervention that enables more families to be supported. This includes additional support from specialist adult workers including: Probation, LSCFT Mental Health and Third Party Voluntary Sector coming together to be part of delivering a multi-disciplinary team approach, primarily to work directly with families to address Domestic Abuse, Alcohol and Substance Misuse and Mental Health in the home.

The ICS system is expecting reduced numbers of children going into care with more children remaining safely at home wherever possible. This is achieved through a more collaborative way of working where parents are motivated to identify the changes needed within their own families to achieve improved outcomes for children.

The financial case for Family Safeguarding is strong and system savings have been identified based on the reduction in looked after children and child protection plans alone. It is understood that as the model develops partners will also see a similar benefit.

The findings of an independent evaluation of Family Safeguarding in Hertfordshire and four other authorities can be accessed via the designated professional network. The evaluation findings demonstrate statistically significant reductions in looked after children numbers and/or Child Protection Plans in the two years following the introduction of Family Safeguarding. Police call-outs reduced by up to two-thirds and signs that Family Safeguarding is reducing the frequency of unplanned, reactive mental health contacts amongst the adults it supports.

Improving Population Outcomes

Data regarding mental health outcomes in the evaluation is encouraging with a reduction in emergency/crisis contacts and use of front door mental health services amongst the adults supported by Family Safeguarding. This reduction in conjunction with more progressive and planned mental health support is an outcome from Family Safeguarding that not only benefits the adults and families concerns but also the mental health systems where the model is implemented.

The example below highlights Family Safeguarding's work to encourage better mental health outcomes:

'A case was referred in to Family Safeguarding due to conflict in the home between the mother and her children. There were reports of physical and verbal abuse from the mother, school attendance was poor and there were concerns over child criminal exploitation.

The mother had previously been referred for talking therapy but had not attended. The Mother also had a recent history of contacts with the Crisis Resolution and Home Treatment Team.

Through Family Safeguarding, the mother attended weekly dialectical behaviour therapy sessions focusing on distress tolerance and emotional regulation. Her engagement enabled the case to be held within Family Safeguarding and not to be escalated to the Community Mental Health Team.

The Mother has shown a reduction in emotional deregulation, has taken part in community activities and has started exercise classes. The Mother has also maintained engagement with Intensive Management of Personality Disorders and Clinical Therapies Team.

The children's school attendance has improved considerably and there has been an increase in positive family activity, e.g. birthday parties and a holiday. The children reported having "more fun" and said their mum was "less stressy".

At the time of writing the case had been closed to social care.

Other Localities of Lancashire and South Cumbria

The implementation of Lancashire Family Safeguarding will also align with the other Local Authorities of the ICS who have models with similarities: Blackpool Families Rock is a strength based model focusing on family strengths co-produced with children and young people. The model is similar to the Signs of Safety used in Cumbria and is grounded in partnership and collaboration with families and other professionals. Blackburn with Darwen utilise a risk sensible and strength based assessment model to identify the level of help and protection required to assist children to grow up in circumstances that achieve their best outcomes.

Additional Context

Nationally the number of children in care has doubled in the last 20 years. In Lancashire, the child protection system had become too focussed on risk. The system did not support open, honest relationships with families or partnership working. As previously indicated a key outcome of Lancashire Family Safeguarding is to reduce the numbers of children coming into care. An additional benefit is to reduce the amount of exposure to harmful parental behaviour that children may witness to improve longer term life. The key being children and young people remain with their families when it is safe to do so.

Recommendations

The JCCCGS is requested to:

- Note the findings of an independent evaluation of Family Safeguarding in Hertfordshire and four other authorities, the expected improvements for our populations, health partnership and children and families
- Endorse the Lancashire Safeguarding Family model and nominate an Accountable Officer to sign the pledge document (Appendix A) on behalf of LSC CCGs

Margaret Williams
Safeguarding Health Executive Lead
24 February 2021

Appendix A

DATED 16 September 2020

Partnership Pledge of the Multi-Disciplinary Family Safeguarding Teams

Between

(1) LANCASHIRE COUNTY COUNCIL

AND

(2) CHANGE GROW LIVE (CGL)

AND

(3) WE ARE WITHYOU

AND

(4) NATIONAL PROBATION SERVICE (NPS)

AND

(5) LANCASHIRE AND SOUTH CUMBRIA NHS FOUNDATION TRUST (LSCFT)

AND

(6) LANCASHIRE CLINICAL COMMISSIONING GROUPs/ICS LANCASHIRE AND SOUTH CUMBRIA ORGANISATIONS

AND

(7) LANCASHIRE CONSTABULARY

AND

(8) THE POLICE AND CRIME COMMISSIONER FOR LANCASHIRE

THIS Partnership Pledge is made from **16 September 2020**

BETWEEN:

1.	**LANCASHIRE COUNTY COUNCIL**	County Hall, Pitt Street, Preston, Lancashire, PR1 8RL (the "Council");
2.	**CHANGE GROW LIVE** (CGL - registered charity number: 1079327 and registered company number 3861209)	registered office is 3rd Floor North West Suite Tower Point 44 North Road Brighton East Sussex BN1 1YR ("CGL")
3.	**WE ARE WITHYOU**	Part Lower Ground Floor, Gate House, 1-3 St John's Square, London, England, EC1M 4 DH
4.	**NATIONAL PROBATION SERVICE**	Preston Probation office, 50 Avenham Street, Preston, PR1 3BN
6.	**LANCASHIRE AND SOUTH CUMBRIA NHS FOUNDATION TRUST (LSCFT)**	Sceptre Point, Sceptre Way, Walton Summit Road, Walton Summit Centre, Preston, PR5 6AW
7.	**LANCASHIRE CLINICAL COMMISSIONING GROUPs/ICS LANCASHIRE AND SOUTH CUMBRIA ORGANISATIONS** NHS Lancashire Clinical Commissioning Groups: **NHS** Chorley and South Ribble **CCG**. **NHS** East Lancashire **CCG**. **NHS** Fylde and Wyre **CCG**. **NHS** Lancashire North **CCG**. **NHS** Greater Preston **CCG**. **NHS** West Lancashire **CCG**	

	NHS Morecambe Bay **CCG**	
8.	**LANCASHIRE CONSTABULARY**	Saunders Lane, Hutton, Preston, PR4 5SA
9.	**THE POLICE AND CRIME COMMISSIONER FOR LANCASHIRE**	PO Box 100, County Hall, Preston, Lancashire, PR1 0LD

Known together as the "Parties" or individually as the Party. This Partnership Pledge is a linked document to the Family Safeguarding Partnership Commissioning Plan.

1. Introduction

1.1 In 2020 we, the above mentioned organisations, decided to create a radically different approach to child protection We set out to do this by creating multi-disciplinary teams of social workers, domestic abuse, adult mental health and substance misuse specialists to tackle the 'toxic trio', which place children at the highest risk of harm.

1.2 We adopted motivational interviewing, as the unified method of practice, to genuinely engage families in change, rather than monitoring their compliance.

1.3 We agreed to place the Adult's Specialist Workers within Children's Services under the direction of a Social Work Team Manager.

1.4 We put in place a comprehensive Information Sharing Protocol in order to improve decision making and risk management for children and families.

1.5 We designed a group supervision process to ensure shared ownership of the work undertaken with families and the risks arising from it.

1.6 We ensured our staff were provided with personal and clinical professional development from within their respective disciplines

1.7 We call this method of service delivery our Family Safeguarding model. The model was originally set up with a grant from DfE Innovation fund and was independently evaluated by the University of Bedfordshire, commissioned by the DfE.

1.8 The partnership agreed that if the model was successful in keeping children safely at home with their families, and contributed to cost savings across the

public purse we would continue to explore funding mechanisms across the partnership in order to sustain this way of working into the future.

This pledge outlines how the partnership will continue to work together to achieve improved outcomes for high risk children and families in Lancashire.

2. DEFINITIONS AND INTERPRETATION

2.1 In this Partnership Pledge the following words shall have the following meanings:-

“Agreement”	means this Partnership Pledge
“Commencement Date”	means 16 September 2020
“Term”	means 3 years from 16 September 2020
"Family Safeguarding Teams”	means the multi-disciplinary teams within the County of Lancashire.
"Data Protection “Legislation"	means the Data Protection Act 1998 ("DPA"), and all applicable laws and regulations relating to processing of personal data and privacy, including where applicable, the guidance and codes of practice issued by the Information Commissioner and the GDPR;
“DfE”	means Department for Education
“GDPR”	means the General Data Protection Regulation as set out in Regulation (EC) 2016/679 which came into force in the UK on 25 May 2018 and as amended and or updated from time to time.
“HR”	means Human Resources
“Policies”	means The Council’s ICT Acceptable Use Policy and Data Protection Policy.

2.2 In this Partnership Pledge (except where the context otherwise requires):

- use of the singular includes the plural (and *vice versa*) and use of any gender includes the other genders;
- a reference to a party is to a party to this Agreement and shall include that party's personal representatives, successors or permitted assignees;
- a reference to persons includes natural persons, firms, partnerships, bodies corporate and corporations, and associations, organisations, governments, states, foundations, trusts and other unincorporated bodies (in each case whether or not having separate legal personality and irrespective of their jurisdiction of origin, incorporation or residence); and;
- a reference to a Clause or Schedule is to the relevant clause of or schedule to this Agreement; a reference to a sub-clause or paragraph is to the relevant sub-clause or paragraph of the Clause or Schedule in which it appears.

2.3 General words are not to be given a restrictive meaning because they are followed by particular examples, and any words introduced by the terms "including", "include", "in particular" or any similar expression will be construed as illustrative and the words following any of those terms will not limit the sense of the words preceding those terms.

2.4 Any reference to a statute, statutory provision or statutory instrument includes a reference to that statute, statutory provision or statutory instrument together with all rules and regulations made under it as from time to time amended, consolidated or re-enacted.

3. TERM

3.1 This Agreement is for a period of three years from 16 September 2020 until 16 September 2023.

3.2 During this period, the Agreement will be reviewed in October 2021. The second review will be commenced no later than October 2022.

3.3 The Agreement may be terminated by any of the Parties provided that a minimum notice period of ninety (90) days is given to the other parties.

3.4 This Agreement may be extended for a period of up to two (2) years on the same working arrangements and agreed in writing.

4. Family Safeguarding day to day team management matters

4.1 The Lancashire County Council Team Manager will have responsibility for the day-to-day running of the Family Safeguarding Team.

4.2 The Council's Director of Children's Social Care, has overall responsibility for all the Family Safeguarding Teams.

4.3 Professionals from NPS, CGL, We are with you, and LSCFT (Health) will have Group Case supervision and management oversight provided on day to day basis by the Council team manager. Line management responsibilities and decisions about allocation, capacity and structure of work will remain with the relevant Party who will also provide professional and clinical supervision.

4.4 It is the responsibility of the Parties to carry out employment checks for all workers in the Family Safeguarding Service that satisfy the requirements of the Council's safe staffing policy and/or the partner agency equivalent and compliant policy.

For each worker the Council's Human Resources will request confirmation that the necessary checks have been carried out and may request to see evidence of this in certain circumstances.

4.5 In the event of long term absence by any of a Parties workers due to reasons of maternity, it is the expectation that back-fill will be provided by the employing Party.

4.6 In the event of long term absence by a Party's workers due to reasons of sickness, any back-fill decision will be at the sole discretion of the provider and at their cost.

4.7 In the event of long term ill health/poor performance, which causes a sustained and detrimental impact on the ability of the worker to fulfil the responsibilities of their role, and therefore the service, after due application of the relevant Parties Management and Human Resources policy; it is the expectation that an alternative worker will be identified (and seconded) by the employing Party.

4.8 Formal procedures such as discipline, grievance, and performance management will be managed by the relevant employing Party. It is anticipated that there may be instances when it is necessary for members of staff from one or more of the other Parties to take part in proceedings led by another Party; for example if called to be a witness in a formal disciplinary hearing. In such cases the employing Party will be required to take steps to ensure workers co-operate with these processes. These cases will be dealt with on a case by case basis in accordance with the relevant Party's policy and procedure ensuring that guidance has been sought from the Party's HR Department.

4.9 In the event that the Team Manager identifies any issues relating to the conduct or performance of a staff member employed by one of the Parties they will discuss this with the relevant line manager and seek HR guidance from the employing Party's Human Resources Department to determine what action may be appropriate.

4.10 The Parties, in delivering the Family Safeguarding Service shall ensure that they act with all due skill, care, that a diligent, competent, qualified and trained person in this area of work would do.

4.11 The Council will be responsible for providing a safe and satisfactory working environment complying with statutory requirements.

5. Commissioning arrangements

5.1 Key Performance Indicators - Monitoring Information and reporting

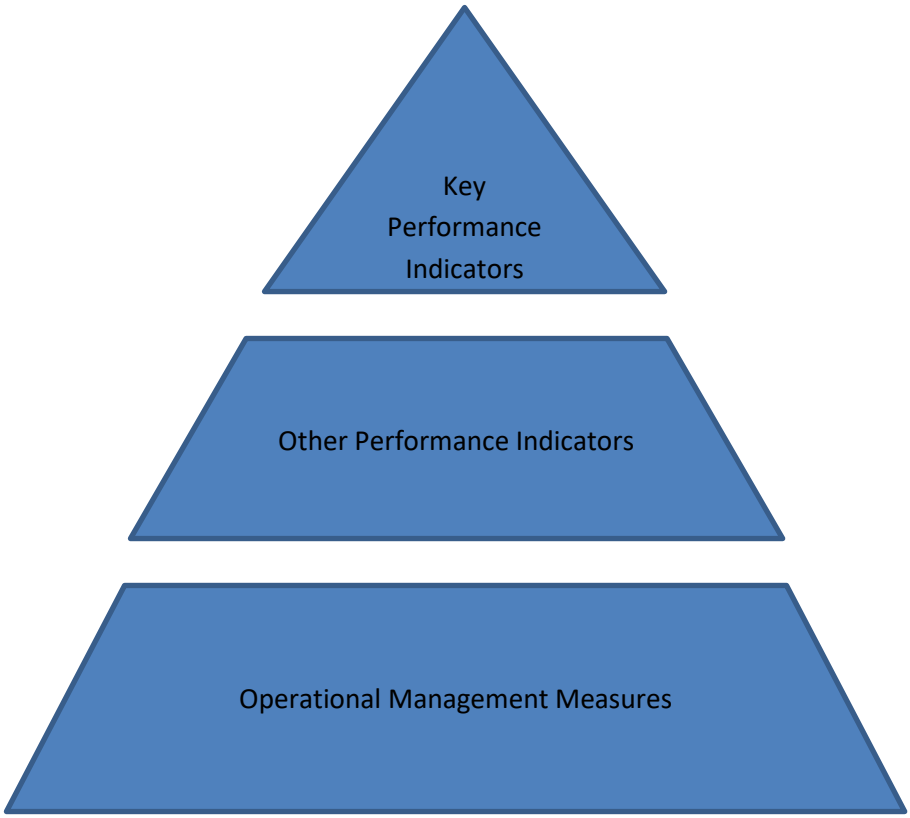
We have worked with groups of representatives from across the partnership to establish a group of key indicators to enable us to measure the performance of the project in a number of areas. These measures will be used in conjunction with the formal project evaluation to establish the success, or otherwise, of the various elements of the project.

5.2 The Whole Performance Framework

There will be a larger number of measures that will make up the wider project evaluation and operational management of the project and the Key

Performance Indicators form part of the whole performance framework as shown below:

5.3 Family Safeguarding Performance Framework



5.4 Key Performance Indicators

We are focusing on the key performance measures that will make the case for each of the partners to confirm success for their element of the project and allow them to make the case for future investment to guarantee sustainability of the family safeguarding teams approach.

The basis of the inclusion in the Key Performance Indicators is as follows:

- The programme and changes are intended to directly impact this measure
- The indicator is readily collected, or already collected
- Partners are willing to take responsibility for providing this data
- The indicator is of specific interest to one or more partners
- The indicator preferably has a positive financial impact on one or more partner

5.5 The table below shows what will be measured and what a positive measure should show.

Performance Indicator	To Evidence	Cost Reduction	Lead Partner	Scope
1. Number of Child Protection (CP) Cases	Successful working with families leading to reduction in numbers of children at risk due to Family Relations improving, Family Problems resolved and Families staying together	Cost associated with CP Cases (across partners)	LCC Children's Services	LCC as a whole
2. Average Length of CP Cases	Successful working with families resolves issues quicker	As above	LCC Children's Services	LCC as a whole
3. Number of repeat CP cases within 1 year and within 2 years	Successful working with families to resolve issues quicker and for longer	Cost associated with CP cases (across partners)	LCC Children's Services	LCC as a whole
4. Number of care proceedings and length of care proceedings	Successful working with families to resolve issues quicker and for longer	Reduced costs associated with court proceedings	LCC Children's Services	Children and young people in cohort
5. Number of children looked after (CLA)	Successful working with families leading to reduction in numbers of children at risk due to family relations improving. Family problems resolved and families staying together	Reduced CLA placement costs, case costs and court costs	LCC Children's Services	LCC as a whole
6. Reduced length of time for CLA	Successful working with families leading to reduction in length of time children and young people are in care	Reduced CLA placement costs	LCC Children's Services	Children and young people in cohort
7. Educational Attendance	Alongside other measures work of the project is having a positive impact on children and parents		LCC Children's Services	Children in the cohort
8. Successful completion of treatment for substance misuse and no re-presentation within 6 months	The project is having a positive impact on substance misuse Compare to historical unplanned discharge Also national indicator broken down into successful completion of treatment for	Reduction in support costs for substance misuse	Public Health / CGL / We are with you	Children and Adults in the cohort

	opiate, non-opiate or alcohol misuse?			
9. Substance Misuse – Improvements in Social functioning Indicators for individuals.	Showing improvements in the following: ● Reduction in substance misuse ● Improvements in psychological wellbeing ● Improvements in physical health ● Improvements in overall quality of life	Improvements relating to substance misuse	Public Health / CGL / We are with you	Adults in the cohort, Regional and National
	Cohort, Regional and National Measures			

10. Number of referrals to mainstream mental health services	Impact on Mental Health Services	Early engagement with mental health services resulting in less overall resources required & less impact on family (inc children).	CCGs	To be recorded through Adult Worker Pages on LCS
11. Mental Health Measures – improvements in depression and anxiety scores for adults	Improved mental health for adults in cohort as a result of embedded mental health workers	Reduction in usage of mental health services	LSCFT / Clinical Psychologists team	Adults with mental health workers in FS
12. No. of Domestic Violence Incidents reported	May subsequently show a reduction in DV incidents or an increase/improvement in reporting	Reduced costs for health, police, probation & CS	Police	Adults in the cohort
13. No. of repeat Domestic Violence Incidents reported	May show that the project is having a positive impact on the repeat incidents of DV	Reduced costs for health, police, probation & CS	Police	Adults in the cohort
	May subsequently show a reduction in DV incidents			

14. Domestic Abuse – successful completion rates of DA programs both victim and perpetrator	DA – successful completion rates of DA programs both victim and perpetrator Shows improved engagement for FS cohort	Improved engagement results in less cost to DA support services	National Probation Service / DA workers	Adults in the cohort
15. Number of referrals to adult worker professionals	Referrals to adult workers and improving behaviours and relationships within the family key to successful implementation of the model	Early engagement with appropriate adult professional results in less resources required & less impact on family (inc children).	Adult workers	To be recorded through Adult Worker Pages on LCS
16. Social workers, Substance Misuse, Mental Health and Domestic Abuse workers caseloads per worker	Split into assessment individual 1:1 Group work Both in terms of numbers and time taken	Gives evidence of workload of adult workers to partners	Public Health / CGL / We are with you	All adult workers in FS teams

5.6 Other Performance Indicators (put forward & potentially available)

Performance Indicator	To Evidence	Cost Reduction	Lead Partner	Scope
Substance Misuse - reduction in substance misuse				
Improvements in did not attend rates for FS cohort alongside number dropped out pre-engagement and number dropped out post engagement	The new FS ways of working improves engagement and results in more efficient services (less wastage)	Reduction in support costs for substance misuse	Public Health / CGL / We are with you	Adults with substance misuse issues in the cohort

Domestic Abuse 3 criminal incidents repeats in 12 months				
Cases going to MARAC (high risk)				

5.7 Performance Indicators to potentially be explored further

Performance Indicator	To Evidence	Cost Reduction	Lead Partner	Scope
Number of A&E Attendances (Separately for Children and Adults)	Potential to show reduction in DV incidents leading to A&E visits & potentially mental health interventions	Costs of A&E (CCGs)	CCGs	Though a national indicator difficult to obtain data for Children and Adults in the cohort
Number of emergency hospital admissions (Separately for Children and Adults)	Potential to show reduction in DV incidents leading to A&E visits & potentially mental health interventions	Costs of emergency admissions (CCGs)	CCGs	Though a national indicator difficult to obtain data for Children and Adults in the cohort
Number of visits made to GP's	Improving health of the cohort for mental health, substance misuse and general health	Reduced usage of GP services – cost reduction to difficult to evidence directly	Clinical Commissioning Groups	Adults and children within the cohort?
Length of Stay for Emergency Hospital Admissions	Impact on Health Services	Reduced usage of emergency unplanned admissions.	CCGs	Lancashire collectible but difficult to obtain data for Children and Adults in the cohort.

5.7 Funding agreements

The timescales for the funding agreements vary but partners undertake to inform the Director of Children's Services / Family Safeguarding of the process and timescales for delivery of business cases for securing the agreement with at least six months' notice prior to the previous funding expiry date**.**

6. Confidentiality

Each Party undertakes to the other that they will keep the contents of this Pledge confidential as between the parties, except to the extent that disclosure is required by law.

7. GENERAL

7.1 No forbearance or delay by either party in enforcing its rights will prejudice or restrict the rights of that Party, and no waiver of any such rights or of any breach of any terms will be deemed to be a waiver of any other right or of any later breach.

7.2 No variation of this Agreement will be valid unless recorded in writing and signed by or on behalf of each of the parties to this Agreement.

7.3 If any provision of this Agreement (or part of any provision) is found by any court or other authority of competent jurisdiction to be illegal, the other provisions will remain unaffected and in force.

7.4 Nothing in this Agreement will be construed as constituting or evidencing any partnership, contract of employment or joint venture of any kind between either of the Parties or as authorising Party to act as agent for the other. No Party will have authority to make representations for, act in the name or on behalf of or otherwise to bind any other Party in any way.

7.5 No Party will make any announcement relating to this Agreement or its subject matter without the prior written approval of the other Parties (such approval not to be unreasonably withheld or delayed).

7.6 Each Party will, at the request of the other Parties and its own cost, do (or procure others to do) everything necessary to give the other Parties the full benefit of this Agreement.

7.7 Any termination notice required to be given under this Agreement shall be in writing and shall be delivered personally, or sent by pre-paid first class or recorded delivery or by commercial courier, to each Party required to receive the notice at the addresses specified by the relevant Party by written notice to the other (and if no such address is specified), the address set out at the front of this Agreement.

7.8 Any termination notice shall be deemed to have been duly received:

7.8.1 If delivered personally, when left at the address and for the partnership pledge referred to in this Clause; or

7.8.2 If sent by pre-paid first class post or recorded delivery, at 9.00 a.m. on the second business day after posting; or

7.8.3 If delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

7.9 A notice of termination required to be given under this Agreement shall not be validly given if sent by email or fax.

7.10 Each Party shall bear its own costs and expenses (including legal fees) in relation to the preparation and execution of this Agreement.

7.11 Each Party shall permit or procure permission for any authorised representative of any other Party (including the parties internal auditors and external auditors) to have reasonable access for audit purposes to information, documents, data, systems, the Parties premises or the parties equipment used in the provision of the Project and any information, documents, reports or anything else reasonably required for inspection by the Parties authorised representatives.

7.12 The Parties shall maintain current and accurate records of all work carried out in the provision of the project and shall ensure that these records shall be available for inspection by an authorised representative of all Parties at all reasonable times in accordance with Clause 5.11.

7.13 No person who is not a party to this Agreement shall have any right to enforce any term of this Agreement, which expressly or by implication, confers a benefit on him without the prior consent in writing of all Parties. This Clause does not affect any right or remedy of any person which exists or is available otherwise than pursuant to the Contract (Rights of Third Parties) Act 1999.

7.14 The Parties shall each use reasonable endeavours to resolve any dispute by means of prompt bona fide discussion between the appropriate persons with authority to conclude such disputes within the Parties organisation.

7.15 The Parties acknowledge that the "Parent Recovery Program" is the property of CGL and CGL grants permission to the Partnership to use the Program in order maximise the benefit of this Pledge. It is agreed by the Parties that any intellectual property developed as part of this Partnership Pledge shall belong to all Parties equally unless otherwise agreed in writing. Neither Parties shall acquire the pre-existing intellectual property (IPR) of any other Party throughout the course of this Agreement, unless separately agreed in writing.

8. GOVERNING LAW AND JURISDICTION

a. This Agreement will be governed by and interpreted in accordance with the law of England and Wales.

b. Each Party irrevocably submits to the exclusive jurisdiction of the courts of England and Wales over any claim or matter arising under or in connection with this Agreement.

IN WITNESS whereof the parties have signed this Agreement the day and year first set out above:

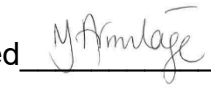
Signed for and on behalf of **LANCASHIRE COUNTY COUNCIL**

Signed 

Name Mrs Angie Ridgwell

Job Title Chief Executive and Director of Resources in Lancashire County Council

Signed for and on behalf of **CHANGE GROW LIVE (CGL)**

Signed 

Name__Nichola Armitage_____

Job
Title__Director_____

Signed for and on behalf of **WE ARE WITHYOU**

Signed_____  _____

Name___Jon Murray_____

Job
Title____Executive Director of Services_____

Signed for and on behalf of **NATIONAL PROBATION SERVICE**

Signed_____

Name_____

Job
Title_____

Signed and on behalf of **LANCASHIRE AND SOUTH CUMBRIA NHS FOUNDATION TRUST (LSCFT)**

Signed___ _

Name___Chris Oliver_____

Job title__Deputy Chief Operating Officer_____

Signed and on behalf of **LANCASHIRE CLINICAL COMMISSIONING GROUPs and ICS Executive**

Signed_____

Name_____

Job title_____

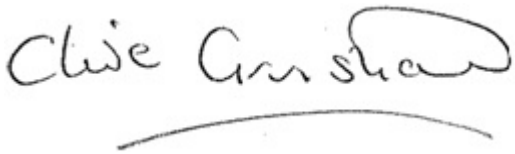
Signed for and on behalf of **LANCASHIRE CONSTABULARY**

Signed_____

Name__~~Neil Drummond~~ JOANNE EDWARDS

Job Title Chief ~~Superintendent~~ Public Protection Unit ACC.

Signed for and on behalf of **THE POLICE AND CRIME COMMISSIONER FOR LANCASHIRE**



Signed____ _____

Name Clive Grunshaw_____

Job Title___Police and Crime Commissioner for Lancashire_____

Healthier Lancashire & South Cumbria

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Title of Paper	All-Age Briefing on Mental Health, Learning Disability and Autism Programme		
Date of Meeting	4 March 2021	Agenda Item	11

Lead Author	Sally Nightingale and Fleur Carney				
Contributors	Michael Connell, Helen Rimmer and Sophie Valinakis				
Purpose of the Report	Please tick as appropriate				
	For Information	Yes			
	For Discussion				
	For Decision				
Executive Summary	This report presents the key strategic deliverables for the All-Age Mental Health and Learning Disability and Autism programme for 2020/21, progress against these key strategic deliverables, and the programme plans for 2021/22.				
Recommendations	The Joint Committee of CCGs is asked to: 1. Note this report from the All-Age Mental Health and Learning Disability and Autism Programme 2. Note the progress made against the key strategic deliverables for 2020/21. 3. Note the programme plans for 2021/22.				
Next Steps	A report detailing the key strategic deliverables for 2021/22 will be brought to a future Joint Committee of CCGs meeting.				
Is this a level 1 or Level 2 decision?	Level 1		Level 2		
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable		
Patient and Public Engagement Completed	Yes	No	Not Applicable		
Financial Implications	Yes	No	Not Applicable		
Risk Identified	Yes		No		
If Yes : Risk					
Report Authorised by:	Peter Tinson				

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

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

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

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

All-Age Briefing on Mental Health, Learning Disability and Autism Programme

1. Introduction

1.1 The purpose of this report is to provide the Joint Committee of CCGs with an update of the the key strategic deliverables for the All-Age Mental Health and Learning Disability and Autism programme for 2020/21, progress against these key strategic deliverables, and the programme plans for 2021/22. This report asks the Joint Committee to note the progress made against the key strategic deliverables for 2020/21 and to note the programme plans for 2021/22.

2. Programme Scope

2.1 The All-Age Mental Health and Learning Disability and Autism programme is a priority programme of the Healthier Lancashire & South Cumbria (HL&SC) Integrated Care System (ICS) and whilst the programme is delivered within the context of Adult and Older Adult Mental Health, Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) and Learning Disability and Autism, the programme works collaboratively to deliver sustainability and transformation across the ICS.

2.2 The Adult and Older Adult Mental Health programme encompasses a broad remit covering at scale commissioning of mental health services, system strategy and planning, quality improvement and assurance, and contract management. The Adult and Older Adult Mental Health work programme is an ambitious programme of work that aims to improve mental health services and deliver the national programmes of work, in the context of significant operational pressures and demographic challenges.

2.3 The scope of the CYPEWMH programme is to improve the resilience, emotional wellbeing and mental health of children and young people, especially those who are at increased risk due to their vulnerability, such as those within and on the 'edge of care', making it easier for them and their families to access help and support when they need it whilst improving the standard of mental health services across Lancashire and South Cumbria.

2.4 The scope of the Learning Disability and Autism programme encompasses a broad remit covering at scale commissioning of Learning Disability and Autism services, system strategy and planning, quality improvement and assurance, and contract management. As System leaders we aim to ensure all people with Learning Disabilities and/or Autism: feel valued, have a full and meaningful life, and receive person-centered support and care when they need it. We collaboratively commission services to keep people well with proactive care in the community. We ensure that reasonable adjustments are made so that wider NHS services can support, listen to, and help improve the health and wellbeing of people with learning disabilities and autism, and their families.

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3. Key Strategic Deliverables for the All-Age Mental Health and Learning Disability and Autism Programme for 2020/21

3.1 Each of the Adult and Older Adult Mental Health, CYPEWMH and Learning Disability and Autism elements which make up the programme had key strategic deliverables agreed for 2020/21. These can be seen in Appendix 1.

4. Progress against Key strategic deliverables

4.1 Since April 2020, a Command-and-Control system was introduced within the L&SC ICS in response to the pandemic. the operational response is being led by the Mental Health, Learning Disability and Autism Sub Cell which the All-Age Mental Health and Learning Disability and Autism Programme feeds in to.

4.2 Throughout the COVID 19 pandemic, many mental health and learning disability and autism services providing support continued to operate with face-to-face contacts where needed, but also making increased use of technology.

4.3 Adult and Older Adult Mental Health

4.3.1 Early Intervention to Psychosis (EIP)

4.3.2 Individual Placement and Support (IPS) employment support has been fully integrated into the EIP pathway. The first workforce group took place on the 18 December 2020 and there were some positive statistics reported especially looking at first contacts into the service. The IPS team are now able to use RiO (an electronic care record system) which means that the EIP teams and the IPS teams can now work together optimally.

4.3.3 Psychology Workforce Project

4.3.4 There has been 50 Trainee Associate Psychological Practitioners (TAPPs) recruited across Lancashire, South Cumbria, Cheshire and Mersey and these roles commenced on the 11 January 2021. UCLan are providing training and support for these roles and once the training has been completed the TAPPs will receive a Postgraduate Diploma Associate Psychology Practitioner (PGDip APP) which will mean that they can work at band 5 level. The service specific TAPPs are now in post however the Primary Care posts have been delayed slightly due to the COVID-19 vaccination roll out. There has been an extremely positive response across the system regarding the deployment of the TAPPS. The final report is in the process of being produced and once completed will be shared across the system.

4.3.5 Mental Health Rehabilitation

4.3.6 A Mental Health Rehabilitation Commissioning Review was presented to Mental Health System Improvement Board (MHSIB) on the 4 March 2020. The presentation proposed a long-term plan for a redesigned rehab pathway to be procured and implemented by 2022/23, with an interim pilot commencing in 2020/21 to test and evaluate the proposed new pathway. This work was supported by MHSIB with further updates on the

establishment of the pilot presented to CCB in March, April and May 2020, as well as to the Out of Hospital Cell in January 2021, which included an interim evaluation. The interim evaluation highlighted a number of successful areas of the work so far and a full evaluation of the pilot is planned to be conducted in May 2021.

4.3.7 **National Bids**

4.3.8 **Community Transformation**

4.3.9 A community transformation bid has been developed and submitted in draft form to the NHSE/I national team for sign off and approval for funds to be released. The proposal aims to facilitate and enhance integrated multi agency teams across local communities to better meet the needs of patients and their carers. The key next step is to develop a multi-agency steering group to support implementation and delivery.

4.3.10 **Crisis Transformation**

4.3.11 The Crisis Transformation Bid for 2020/21 to 2023/24 was successful and will be used to sustain our crisis house and crisis cafe provision with increased staffing levels and data collection.

4.3.12 In addition this funding will be used to fund our 24/7 crisis line, recruit additional peer support workers and extend our suicide prevention program. All of these initiatives are in line with the stated aim of establishing non-clinical de-escalation and guided self-help services for people experiencing mental health crisis.

4.3.13 **Workforce**

4.3.14 The mental health workforce group is being revitalised to provide a wider perspective on both current and future workforce requirements. A key function will be to act as an interface between individual areas and programmes, training providers and national agencies such as Health Education England. It will endeavor to achieve balance between supply and demand, growing supply where required and ensure that we minimise cycling of staff from one service to another.

4.4 **Children and Young People's Emotional Wellbeing and Mental Health**

4.4.1 Whilst the CYPEWMH programme was paused at the start of the COVID pandemic, some elements of the THRIVE redesign have been brought forward as a consequence of and as part of the response to the COVID-19 pandemic.

4.4.2 The Lancashire and South Cumbria Healthy Young Minds Website has been expanded to include COVID-19 specific resources alongside the planned launch of information, advice and resources to support children, young people, parents/carers and professionals, identify and manage emotional wellbeing and mental health issues.

4.4.3 Self-referrals by children and young people to the Child and Adolescent Mental Health Services (CAMHS) across Lancashire and South Cumbria have been implemented, with access via the Healthy Young Minds website.

4.4.4 The All-Age Mental Health Crisis Line is now available 24 hours a day, 7 days a week, and staffed by trained mental health professionals who can provide assessment and referrals to appropriate services.

4.4.5 Child and Adolescent Mental Health Services (CAMHS) 0-19 service provision, to address the issue of older adolescents who have previously had to access adult services, has been fully implemented across Lancashire and South Cumbria.

4.4.6 The evaluation of the final THRIVE Redesign Clinical Model, Transition & Implementation plan and Financial Modelling Template planned initially for April 2020 and subsequently for July 2020 were delayed. These were evaluated by the evaluation panel on 16 September 2020. The final report was presented at the Collaborative Commissioning Board (CCB) on 13 October 2020 and received approval at the Joint Committee of Clinical Commissioning Groups (JCCCG) on 5 November 2020.

4.4.7 A CAMHS Investment plan is in development with finance colleagues from the Provider Trusts and Lead CCGs collaboratively. System leaders meet weekly, NICHE consulting have been commissioned to undertake a Capacity and Demand analysis for CAMHS. The investment plan will be presented to both the Provider Board in March 2021 and JCCCG in April 2021.

4.4.8 A review of the THRIVE Single Point of Access (SPoA) and Initial Response Service (IRS) models is being progressed, to assess if the development of a SPoA for all age is an option, understand what can be delivered across each ICP taking into account the different providers of CAMHS across Lancashire and South Cumbria and review options of delivering urgent and routine mental health support for all age. A Project Initiation Document is in development and 5 Integrated Care Partnership (ICP) engagement workshops have been delivered to gain an in-principle decision to explore in more detail the delivery of an All Age Mental Health Point of Access.

4.4.9 A review of objectives within the CYPEWMH Transformation plan has taken place and expected deliverables in the short term (31 March 2021) can be seen within Appendix 2.

4.5 Learning Disability and Autism

4.5.1 Whilst the emerging COVID related responses have been prioritised, the Learning Disabilities and Autism Programme has continued to deliver the programme priorities for 2020/21. Much progress has been made against our strategic developments across the ICS. A redesign is to be implemented of governance and financial arrangements in line with the developments locally within the Integrated Health and Social Care System wide collaborative commissioning arrangements and Funding Transfer Agreement (FTA) Pathway Fund process being implemented nationally to meet the needs of people with a learning disability and/or autism.

4.5.2 Reducing reliance on inpatient settings/beds (for adult and CYP). There has been increased investment in Learning Disability intensive support with the establishment of an Intensive Support Team (IST) which will enable more people to receive personalised care in the community, closer to home, and reduce preventable admissions to inpatient services. As a system community health services investment has grown to deliver a seven-day specialist multidisciplinary intensive support service for young people and adults. In addition, we have increased investment in services for Autistic Adults (16+) and established an Autism Outreach Service. Additional CCG investment in Community Learning Disability Health Teams has enabled LSCFT to address gaps in Community Health Teams across the ICP Learning Disability Teams.

4.5.3 Development of our community infrastructure and services. Lancashire and South Cumbria ICS is a national pilot site for the Keyworker Function, a multi-agency partnership approach to support children, young people, families/carers with the implementation of a Key Worker for children and young people who are in patients or at risk of a Mental Health of Learning Disability Hospital admission. The approach chosen includes the co-delivery of comprehensive training to strategic leaders, commissioners, and frontline colleagues, and the development of strategic and operational understanding of the keyworking function, in addition to the implementation of identified Key Workers for children young people and their families/carers. Work has progressed to ensure children and young people with a learning disability, autism or both with the most complex needs will have a designated key worker. Initially services will be provided to children and young people who are inpatients or at risk of being admitted to hospital.

4.5.4 Accommodation and Support. The Learning Disabilities and Autism programme has built on support to oversee the provision of suitable homes for people with a learning disability and / or autism across the ICS, working closely with Local Authority partners. Undertaking a Needs Assessment to strategically plan ongoing care and accommodation needs for the current in-patients. We are also developing a new model for crisis support and accommodation, with a proposal to utilise the Community Discharge Grant issued to Local Authorities for the revenue funding. The Programme continues to ensure improved quality of inpatient settings via Host Commissioner and Oversight Visit arrangements.

4.5.7 Reducing Health inequalities (including development of Annual Health Checks (AHC) uptake and LeDeR). We continue to deliver the Learning Disabilities Mortality Review Programme (LeDeR), to make improvements to the lives of people with a learning disability as a result of learning taken from LeDeR reviews. As a system we have developed robust plans to ensure that all reviews are allocated within three months and completed within six months of the notification of death to the local area. We have established the ICS Reducing Heath Inequalities Group. This group is responsible for the Health Inequalities workplan including managing deterioration in health, increasing the uptake and quality of Annual Health Checks and implementing the LeDeR learning into action to improve services, reduce health inequalities and address premature mortality. A pilot Health Facilitation Team has been established aligned to LSCFT Community Learning Disability Teams to support PCNs with AHC uptake.

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5. Long Term Plan

5.1 The ICS continues to monitor the deliverables in the Long-Term Plan and these can be found in Appendix 3 along with assurance statements which reinforce the progress that is being made.

6. Winter Planning

6.1 A bid for several schemes was submitted to NHS England in December 2020 for non-recurrent Winter Pressures funding to be allocated to Lancashire and South Cumbria. The development of the schemes was led by commissioners, in collaboration with Providers, and a number of these have now been successfully awarded and allocated to the ICS and ICPs. Successful schemes include, the expansion of A&E Liaison, extended in-hours peer support in Lancaster and Morecambe, the development of a Community Hub in West Lancashire, CYP waiting times initiative and expanding the CYP element of the All-Age Eating Disorder service.

6.2 In addition, the ICS was also given the opportunity to bid for further additional funding to support discharges over the winter period. The development of a bid against this funding was facilitated by Lancashire and South Cumbria NHS Foundation Trust's Chief Operating Officer, Chris Oliver, with Morecambe Bay CCG representing commissioners. Again, several schemes were agreed and supported including the commissioning of substance misuse 'detox' beds, additional support for service users with no fixed abode and the expansion of Social Work capacity.

7. System Reform

7.1 Prior to March 2020, the Lancashire & South Cumbria ICS had developed ambitious plans to respond to the health and wellbeing challenges faced by local communities and make best use of its resources (people, services, buildings, knowledge). The coronavirus pandemic, however, has created an imperative for further system reform, to enable the ICS to demonstrate stronger capabilities to address health inequalities, support our teams working to restore health and care services and contribute to regional strategies for economic, social and environmental recovery.

7.2 The recently published consultation document from NHS England and Improvement focuses on the next phase of development for 'Integrating Care' which provides further clarity and intended direction of travel subject to legislative and parliamentary approvals. A key component of our proposed system reform plan is a continued focus on Mental Health, Learning Disability and Autism services. There has been good progress and focus as a system during the pandemic with many examples of system working which has accelerated the reform plans and allowed for wider partner engagement in this priority area.

7.3 The ICS therefore intends to develop a System Reform Plan to set out the collective intention for system reform as it applies to Mental Health, Learning Disability and Autism. This will build on the positive work which has taken place in the system over the last 12 months, including the collaborative responses of partners during the pandemic, the

development of the Provider Collaboration Board and the direction of commissioning reform.

7.4 A key element of the developing Plan will be the full engagement of partners to shape and direct it. This will allow a broad range of inputs in response to both the national policy and local experiences. An external organisation: Moorhouse Consulting; has therefore been commissioned to support co-design of the Plan. Initial engagement is intended to be completed by the end of January 2021 and will include a broad range of stakeholders, including providers, commissioners, local authorities and the Voluntary, Community and Faith Sector (VCFS), with further milestones to be agreed.

8. Financial Planning

8.1 A System Business Planning Group has been established within the sub cell governance framework. This includes financial planning and will facilitate efficient and effective management of our finances to maximise value for money from our current investments in services and help us to prioritise any increase in MHIS and/or Transformation funding, and implementation of this as required (including workforce considerations).

9. Programme Plans 2021/22

9.1 It is recognised that the landscape has changed significantly and, reflecting on the new reality and emerging evidence on the impact of COVID.

9.2 Adult and Older Adult Mental Health

9.2.1 A 2021/22 Programme Plan for Adult and Older Adult Mental Health will be developed following the completion of the System Reform work outlined in Section 7.

9.3 Children and Young People's Emotional Wellbeing and Mental Health

9.3.1 There is no national expectation to refresh CYPEWMH Local Transformation Plans. Going forward, a system CYPEWMH Strategic Plan is expected to be developed alongside ICS plans by the end of September 2021. This regional approach differs to some other regions and reference to 'CYP Local Transformation Plans' in Claire Murdoch's recent letter applies to those regions where they are refreshing CYP Local Transformation Plans.

9.3.2 National CYPEWMH Key Lines of Enquiry (KLOE) (based on previous KLOE for CYPEWMH Local Transformation Plans) have been revised into a guidance document to support systems when considering recovery and restoration, strategic CYPEWMH plans, and delivery of the future ambitions as set out in the NHS Long Term Plan.

9.3.3 The CYPEWMH PMO team are developing a proposal and timeframe to deliver a system CYPEWMH Strategic Plan and will engage with stakeholders to complete this.

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9.4 **Learning Disability and Autism**

9.4.1 The Learning Disabilities and Autism Programme Plan for 2021/22 is being developed following the completion of the system consultation and community service benchmarking exercises completed in January 2021. Progress against programme delivery has been benchmarked for 20/21 and key strategic priorities for 2021/22 have been co-produced. The co-production of the key strategic priorities will inform a light touch 3-year planning process for Learning Disabilities and Autism issued by the NHSE Regional Team for completion by 12th March 2021. As a Programme, the key ambitions as set out in the NHS Long Term Plan.will continue to be delivered.

10. Conclusion

10.1 The All-Age Briefing on Mental Health, Learning Disability and Autism Programme provides the JCCCG with an overview of the scope of each element of the programme along with progress against deliverables during 2020/21 whilst working within a COVID-pandemic environment and the plans in place to agree deliverables for 2021/22.

10.2 The deliverables for the All-Age Mental Health, Learning Disability and Autism Programme will be presented to the JCCCG when developed for approval.

11. Recommendations

11.1 The Joint Committee of CCGs is requested to:

1. Note this report from the All-Age Mental Health and Learning Disability and Autism Programme
2. Note the progress made against the key strategic deliverables for 2020/21.
3. Note the programme plans for 2021/22

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All-Age Briefing on Mental Health, Learning Disability and Autism Programme

Appendix 1

Key Strategic Deliverables for the All-Age Mental Health and Learning Disability and Autism Programme for 2020/21

Adult and Older Adult Mental Health Key Strategic Deliverables
The ICS System has agreed the following priority areas for the Adult and Older Adult Mental Health Programme (expansion of IAPT services remains a national target, however Lancashire and South Cumbria has delayed achievement of this target): • Enhanced Bed Management • Crisis and Home Treatment Teams (24/7) all areas • Hospital Liaison Teams • Community Mental Health Teams (increase in peer support / substance) • Alternative to Admissions (Crisis Cafes) • Rehabilitation Inpatient Capacity (In our ICS footprint) • Development of robust the mental health and substance misuse urgent care pathways • Extend the reach of the perinatal team • Expand digital solutions to within crisis care pathways In addition, there are also a number of wider system programme priorities that need to be addressed: • Development of a 4-year Investment / Disinvestment Plan (linked to MHIS standard) • Development of MH Strategy • Agreed protocols within Mental Health / Substance Misuse services for ways of working • Commissioning Reform • Review of Suicide and Real Time surveillance programme of work The programme has also identified seven longer term objectives, which are as follows: Objective 1: Build resilient community services with a focus on early intervention and prevention that are responsive to health and social care needs. Objective 2: Improving access to mental health services (Build robust crisis intervention services including a range of alternatives that provide a greater focus on upstream support / Ensure that we have no unnecessary admissions to in-patient beds and less emphasis on beds as a treatment of choice)

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Objective 3: Work with our local third sector and independent providers to broaden the experience and skills made available to our residents

Objective 4: Enable individuals, their families and carers to develop resilience in their communities and provide locally facing support that is flexible and working for the individual in their own environment

Objective 5: That we have no preventable deaths, including from suicide and that we reduce the stigma from identifying early with suicidal ideology

Objective 6: That we have an equipped and well trained mental health aware workforce

Objective 7: Ensure that we have one strategic commissioning approach and aligned finance strategy for mental health services across the ICS / ICP with outcome-based contracts with our providers

Children and Young People's Emotional Wellbeing and Mental Health (CYPEWMH) Key Strategic Deliverables

CYPEWMH objectives can be grouped under 3 priority statements:

Redesign Child and Adolescent Mental Health Services (CAMHS) in line with the THRIVE model, including mobilisation once approved: Specific objectives linked to this area of work include objectives 1, 2, 8, 9, 11, 12, 19 and 20

To provide access to online information and self-help materials that are meaningful to children and young people; parents and carers; and professional via our Healthy Young Minds Website: Specific objectives linked to this area of work include objectives 3, 4, 5, 6, 7, 14

To deliver support to children, young people, parents and carers at a time of crisis and in the most appropriate place to meet their needs: Specific objectives linked to this area of work include objectives 8, 9, 10, 13, 15, 16, 17, 18

Learning Disabilities and Autism Programme Key Strategic Deliverables (2020/21):

1) Completing Care and Treatment Review (CTRs) /CETRS for Adults & under 18 years

2) Primary Care – increasing Annual Health Checks

3) Learning Disabilities Mortality Review (LeDeR) - complete all LeDeR reviews and share learning and inform improvements in future practice.

4) Children & Young People - implementation of Long-Term Plan Children and Young People's Keyworking Function pilot, align Transforming Care Programme (TCP) Plan

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with SEND (Special Educational Needs and Disabilities), Mental Health, transformation plans & Integrated Personalised Care.

5) Housing – Care and Accommodation - creating a Housing Plan (covering the period to 2023/24 which identifies gaps in provision to meet forecast demands and develop a pipeline of care and accommodation options.

6) Dynamic Support Database - collaborative approach across ICS, operational, and jointly owned by CCGs and Local Authorities for people under 18 years and over 18 years.

7) STOMP/STAMP - pilot site across Pennine Lancashire, implement pilot learning, increase medication reviews i.e., through CTRs.

8) Use of 12-point discharge plan - evidence of assurance process with CCGs /TCPs including use of 12-point discharge plan.

9) Reducing Inpatients - admissions & discharges, re-admissions, length of stay, out of area patients

10) Develop Autism Only Services.

11) Implement Community Services - increase sustainment of capable, environments within the local community, reduce reliance on restrictive practices, reduction the use of inpatient services and reduce out-of-area and/or residential placements.

12) Development of LSC inpatient beds - assessment and treatment (Learning Disability, Autistic Spectrum Disorder (ASD) only, Ministry of Justice (MOJ) restricted, complex individual packages of care.

13) Strategic Commissioning - sustainable finance plan – including NHS LA budget alignment and collaborative commissioning functions, needs assessment, a CCG / Specialised Commissioning strategic commissioning plan, governance arrangements, quality oversight in place for all people placed out of area.

14) Implement NHS Improvement Standards - understand from NHS providers key areas of challenges are around:
    a) respecting & protecting rights.
    b) Inclusion & engagement.
    c) Workforce.
    d) Specialist Services.

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Appendix 2

Children and Young People's Emotional Wellbeing and Mental Health Programme

Transformation Plan Deliverables (by 31st March 21)	
Objective No.	**Objective**
1 & 2	All Primary Mental Health workers will be trained to deliver the 'schools mental health first aid' one day course and each CCG area will have delivered a minimum of four 'Mental Health First Aid' courses per year
4 & 5	Mental Health support within education settings in line with the 2019-20 Trailblazer programme will be delivered in MB and Pennine
7	'Healthy Young Minds' website offers information, advice, self-help, care pathways and self-referral for children and young people, parents and carers and professionals
8	LSC CAMHS Clinical Model has been redesigned in line with THRIVE
10	There is a consistent 'Out of Hours' provision across LSC
11	LSC CAMHS services are accepting referrals up to 18th birthday and are continuing to work with young people up to 19th birthday if appropriate and necessary
15	The 'all age' eating disorder service model has been implemented in South Cumbria
17	Families and carers who are caring for children and young people in crisis are supported through access to appropriate crisis training packages
20	Key performance indicators, incorporating the Mental Health Standard Data Set (MHSDS), national transition CQUIN, and CAMHS outcome measures, are monitored and challenged via the Performance Management Group and reported monthly to the Partnership Board with recommendations for action

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Appendix 3

NHS Long Term Plan Assurance Statements

Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
Perinatal Mental Health*	PMH 1	Increased access to services* to include a further 24,000 women by 2023/24		Organisations across the ICS have been working collaboratively to overcome some of the recruitment challenges for this service. This has meant that achievements of some targets have been deferred and available funding has been reprioritised to support challenged service areas including our urgent care pathway. ICS execs (including MH lead commissioners and LSCFT execs) have agreed planning submissions are to be amended to reflect delivery of all the LTP expectations and a paper was prepared for JCCCG for consideration on 03/09/20 where funding was approved.
	PMH 2	Offer of psychological therapies to include wider family and carer intervention		
	PMH 3	Father/partner support for those in services		
	PMH 4	Closer links from perinatal mental health services into maternity settings		
Children & Young People*	CYP 1	Increased access to CYP services		Access targets met currently.

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
	CYP 2	Increased investments in Eating Disorder services*		It is recognised there has been under investment in the Eating Disorder service in line with LTP expectations. ICS execs (including MH lead commissioners and LSCFT execs) have agreed planning submissions are to be amended to reflect delivery of all the LTP expectations and a paper was prepared for JCCCG for consideration on 03/09/20 where funding was approved.
	CYP 3	Extension of pathways from 0-25 (0-18 previously)		Lancashire & South Cumbria have standardised the offer with CAMHS services accepting referrals up to 18th birthday (19 years for completion of packages of care). Increase up to 25 is not due until 2023/24.
	CYP 4	Mental Health Support Teams (MHSTs) to cover between a quarter and fifth of the country by 2023/24		Success in gaining funding for Trailblazer projects in Pennine & Fylde Coast.
	CYP 5	Crisis support being available for those young people in crisis 24/7		THRIVE redesign addresses 24/7 crisis with planned mobilisation and implementation of RAIS in Q4.

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
	CYP 6	CYP Eating Disorders Urgent Referral Waiting Time		Revised pathways at monitoring in place, with recent monthly compliance and confidence that rolling averages are on trajectory to become compliant.
	CYP 7	CYP Eating Disorders Urgent Routine Waiting Time		Revised pathways at monitoring in place, with regular monthly compliance lifting rolling averages into sustained compliance.
IAPT: Recovery & Access to Psychological Therapies*	IAPT 1	By 2023/24 an additional 380,000 people per year will be able to access NICE-approved IAPT services including access to online therapies		Projected to achieve the locally agreed target recognising the one-year deferral in achieving the national 25% target. Increased use of online delivery has facilitated achievement of the national access and recovery targets. Training numbers increased.
	IAPT 2	Maintain the IAPT RTT rates (75% RTT within 6 weeks; and 95% RTT within 18 weeks)		RTT met but caution needed due to reduced demand during Covid-19. Covid suppressed and Covid-generated demand will bring pressure on RTT rates.
	IAPT 3	Maintain the IAPT recovery rate (50%)		

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
	IAPT 4	All areas to have an IAPT-Long Term Conditions (LTC) service in place		Long-Term Conditions service in place in all localities.
Community Mental Health	CM H1	New Offer for Community Mental Health provision		Lancashire & South Cumbria are not in the earlier adopter phase.
	CM H2	Focus on those with complex needs		
	CM H3	Continue trajectories on Physical Health Checks for people with SMI and by 2023/2024 a further 110,000 per annum		12 month rolling target significantly impacted by Covid & the move of the vast majority of primary care services online. Trust is working collaboratively with partner organisations and regional colleagues from NHSE&I and the SCN to maximise achievement.
	CM H4	Continued support for individual placement and support		IPS services are being introduced across the ICS during September 2020 provided by Blackpool Council who have significant experience in delivering employment support services. The initial service offer will be co-located with EIP services across the ICS.
	CM H5	EIP: achieve 60% of EIP Activity Standard by 2020/21		National Improvement Team recommendations being implemented, with improvements in activity evident. Family support / IPS identified as required for NICE concordance. MHIS and other funding will enable the development of family support interventions.
	CM H6	EIP: Achieve 60% Level EIP NICE-concordance by 2020/21		

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
Crisis	CR1	100% coverage of 24/7 adult Crisis Resolution and Home Treatment Teams (CRHTTs) operating in line with best practice by 2020/21		Home Treatment Teams expanded to meet CORE standards across ICS.
	CR2	100% STP coverage of Liaison Mental Health teams meeting the needs of all ages		MHLTs expanded to CORE 24 standard in all Emergency Departments with all-age Liaison Teams.
	CR3	Flexible Ambition by 2023/24: Invest in crisis alternatives		Crisis Houses, Crisis Cafes, Crisis Helpline, Bed Capacity Review, Support Workers based in EDs all delivered collaboratively with third sector partners.
	CR4	Flexible Ambition by 2023/24: Improve mental health response provided by the ambulance service		Mental Health Nurses embedded in Ambulance Control Centre. Business case made to extend IRS model to include Street Triage.
	CR5	Flexible Ambition by 2023/24: Access via NHS 111 to urgent mental health care		Collaborative work is currently underway to implement NHS111 – First – Initially Fylde coast area commenced Aug 20. It will then be rolled out to Pennine Lancs - Oct 20 and Morecambe Bay & Central before 1st Dec.

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
	CR6	50% of Liaison Mental Health Teams achieving 'core 24' standard		MHLTs expanded to CORE 24 standard in all Emergency Departments.
	CR7	Sustain 24/7, open access, all-age crisis lines, and continue to improve operation of the telephony infrastructure to implement a single point of access for the local mental health system. This should be with a view to integrating the crisis line function with NHS 111.		Crisis Lines established May 2020.
Therapeutic Acute	TA1	Flexible Ambition by 2023/24: Improving therapeutic support in adult mental health inpatient care		Variable levels of psychology and Occupational Therapy input into wards, with audit identifying greater efficiency on those wards with higher input.
	TA2	Eliminate OAPs for adult acute care		Enforced bed closures in remaining dormitory units has resulted in increased numbers in out of area placements. Analysis has shown that actions being undertaken are resulting in ongoing underlying

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
				reductions once these closed beds are factored in. Estates options are being evaluated to provide a long-term solution to this issue.
Dementia	IDC 1	Maintain the dementia diagnosis rate of two thirds (66.7%) of prevalence and improve post diagnostic care		DDR achieved in all CCGs. RITT teams have been recognised nationally as examples of good practice and offer strong support to care homes alongside our specialist inpatient facilities which have been described as state of the art.
Suicide Prevention & Support*	SPS 1	Suicide Prevention Quality Improvement Programme		The ICS's Real Time Surveillance system has been recognised as an exemplar of good practice in this area of work. Support is being shared with neighbouring areas to develop similar systems. Bereavement support is now available in all five ICP areas.
	SPS 2	Safety Improvement programme		
	SPS 3	Bereavement support		
Problem Gambling	PG1	ICS not in Key Priority Area		ICS not in Key Priority Area.
Rough Sleepers	RS1	£30million to provide better access to specialist mental health support to work alongside outreach services		Although Lancashire & South Cumbria is not one of the areas selected for the national programme, each ICP has undertaken significant amounts of work to support this patient cohort, particularly aligned to the pandemic.
Provider Collaboratives	PC1	Trial new models of care within the secure		Plans in place for 2021 implementation.

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
		care pathways in selected areas		
	PC2	All appropriate specialised mental health services, and learning disability and autism services to be managed through NHS-led provider collaboratives; NHS-led collaboratives will become the rolling-out specialist community forensic care		Positive conversations and planning locally.
Digital Mental Health	DM H1	Build digital leadership and digital workforce, identify specific areas for focused investment. Use GDE blueprints to inform development		LSCFT have appointed Board-level Digital Executive. Strong ICS Digital Leadership. GDE Programme in place.
	DM H2	Every person with diagnosed mental health problems will be able to access their care plans,		Positive developments with staff digital, and work to be done on patient digital access. Digital Care Plan sharing in place between agencies.

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
		All community staff will have access to mobile digital services, Local NHS.uk service directory includes crisis services		
Mental Health Data Quality	DQ1	All providers to be achieving Data Quality Maturity Index (DQMI) score on or above 95%		
	DQ2	100% of mental health providers to achieve and maintain a score of 95%, or above, in the MHSDS Data Quality Maturity Index from 2020/21		Currently at 92% compliance with further progress to follow RiO roll out in November.
	DQ3	100% of NHS mental health providers to submit patient-level costing information by 2020/21		PLICS structure in place within LSCFT.

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Programme	Ref	2020/21 Deliverable	RAG Rating	Assurance Statement
Advancing Health Equalities	AHE 1	All STPs must set out how they will reduce health inequalities by 2023/24 as per Q2-Q4 planning letter requirements		Meeting the diverse needs of the people of Lancashire and South Cumbria and reducing the health inequalities that exist are at the heart of the action both currently in train, and those planned, across the system. Key actions include diversifying the range of services on offer to meet a wide range of needs and widening the range of providers commissioned to deliver them from across all sectors. We are also extending the range and depth of prevention services. A key tool to deliver this ambition is enhanced use of technology in many guises including as a treatment tool, to provide information and to share records in real time across all relevant system partners. This will also facilitate whole system and whole person monitoring rather than the information silos we currently experience.
MHIS	IS1	100% of systems achieve the Mental Health Investment Standard from 2020/21		Met in all CCGs.
Workforce	W1	Workforce plans are sufficient to deliver the ambition of the plan as per Q2-Q4 planning letter requirements		Recruitment market is a key challenge for L&SC
Learning Disabilities & Autism	LDA 1	Ensuring people with LD/Autism		Significant new investment (c£4m) agreed. Inpatient planning developed,

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		receive person centred support enabling people to live happier, healthier and longer lives		but capital investment confirmation required.
	LDA 2	Enabling the planned discharge of people who have been in long stay hospital places into appropriate community provision.		
	LDA 3	Ensure admissions into inpatient beds are appropriate and create a culture of 'Home First'.		
	LDA 4	Ensure that children transitioning into adulthood are supported by services that meet their needs including housing and community provision.		