Strategic Commissioning Committee (Formal)

13 May 2021, 1 pm – 2.30 pm

via MS Teams Videoconference

Agenda – Part 1

Item	Description	Owner	Action	Format
1.	Welcome and Introductions to the Strategic Commissioning Committee	Chair	Note	Verbal
2.	Apologies for absence	Chair	Note	Verbal
3.	Declarations of Interest relating to items on the agenda	Chair	Note	Verbal
4.	Minutes of the previous formal JCCCGs meeting held on 4 March 2021, matters arising and actions to agree	Chair	Note	Attached
5.	Key Messages	Dr Amanda Doyle	Discuss	Verbal
6.	Quality and Performance Report	Julie Higgins	Discuss	Attached
7.	New Hospitals Programme - Quarter 4 New Hospitals Programme Update	Jerry Hawker/ Rebecca Malin	For information	Attached
8.	Proposal for the development of the Acute Specialised Services workplan for Lancashire and South Cumbria ICS	Nicola Adamson	Discuss	Attached
9.	Special Educational Needs and Disabilities – End of Year Update and Assurance	Debbie Corcoran/ Zoe Richards	Discuss	Attached
10.	Collaborative Commissioning Advisory Group – Terms of Reference	Denis Gizzi	Approve	Attached
11.	Development of Lancashire and South Cumbria Medicines Management Group Recommendations - Clinical Policy Updates	Brent Horrell	Approve	Attached
12.	Any Other Business	Chair	Note	Verbal

The next formal meeting of the Strategic Commissioning Committee for Lancashire and South Cumbria will be held on:-
Thursday 15 July 2021, 1 pm – 3 pm, MS Teams

Subject to ratification at the next meeting

Minutes of a Formal Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs) Held on Thursday, 4 March 2021 via MS Teams

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
Dr Peter Gregory	Chair	NHS West Lancashire CCG
Jerry Hawker	Chief Officer	NHS Morecambe Bay CCG
Paul Kingan	Chief Finance Officer	NHS West Lancashire CCG
Dr Adam Janjua	GP and Chair	NHS Fylde and Wyre CCG
Dr Benjamin Butler-Reid	Executive 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
Andy Curran	Executive Medical Director	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
Lawrence Conway	Chief Executive	South Lakeland District Council
Sue Stevenson	Chief Operating Officer	Healthwatch Cumbria
Beth Goodman	Deputy Director of Commissioning	NHS Blackpool CCG
Neil Greaves	Head of Communications	Lancashire and South Cumbria ICS
In Attendance		
Margaret Williams	Safeguarding Health Executive Lead	NHS Morecambe Bay CCG
Brent Horrell	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU
Roger Parr	Chief Finance Officer	NHS Blackburn with Darwen CCG
Stephanie Betts	Business Affairs Lead	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Affairs Co-ordinator (Minute taker)	Lancashire and South Cumbria ICS
Public Attendees		
6 members of the public were present		

Routine Items of Business	
1.	**Welcome, Introductions and Apologies** **Welcome and Introductions -** The Chair welcomed members to the formal meeting of the Joint Committee of CCGs (JCCCGs) held virtually via Microsoft Teams videoconference. The meeting was held in public; no questions had been raised in advance of the meeting. Apologies had been received from Neil Jack (CEO, Blackpool Council), Dominic Harrison (Director of Public Health, Blackburn with Darwen Borough Council), Katherine Fairclough (CEO, Cumbria County Council) and Andrew Bibby (NHS England/Improvement).
2.	**Declarations of Interests** All members declared an interest in the System Reform agenda item. No other specific declarations of interest were declared. **RESOLVED: That all members and declared an interest in System Reform.**
3.	**Minutes of the Previous Meeting held on Thursday 14 January 2021** The minutes of the previous formal JCCCGs meeting were agreed as an accurate record. **RESOLVED: That the minutes of the meeting held on Thursday 14 January 2021 be approved as a correct record.**
4.	**Key Messages** **Vaccination Programme** – Amanda Doyle (AD) updated that at close of play yesterday, 594,000 vaccine doses had been administered across Lancashire and South Cumbria. Invites had been sent to the over 60's cohort and clinically vulnerable people. 'Catch up' continued for health and social care staff and carers of vulnerable people. An increase in vaccine supply was expected next week; AD was confident that the increased supply could be delivered successfully. Work was underway to encourage communities who may be more hesitant to receive the vaccine, including staff groups, and members of the BAME community, including working closely with faith leaders, Lancashire County Council leaders, Mosques, and other role models. The programme for people in cohorts 1-9 was expected to be completed by the end of March 2021, the national target being 15 April 2021. **Chorley Accident and Emergency –** There had been recent press attention around changes in Chorley A&E department; services would continue to be stepped up again with the aim to open the department for 12 hours per day from next week. **RESOLVED: That members noted the updates on the vaccination programme and Chorley Accident and Emergency.**
5.	**System Reform** Andrew Bennett (AB) spoke to a report updating members on system reform. The government had recently published a white paper 'Integration and innovation; working together to improve health and social care for all'. There were a number of proposals expected from the white paper to put the ICS on statutory footing by April 2022, and build on a number of elements within the paper, ie, collaboration to providers, development in integrated care partnerships, focus on wider health of population , etc. National guidance to guide development work was expected, prior to a full legislation process through Parliament. The work programme had been refined and governance was in place for the Lancashire and South Cumbria approach to system reform, including the creation of an ICS Oversight Group.

The white paper proposes to transfer many functions from CCGs into a statutory ICS NHS body from April 2022. To help move steadily into that direction, each CCG Governing Body had considered proposals to build on the JCCCGs over the next year, re-naming the Committee as the 'Strategic Commissioning Committee' (SCC) to take relevant decisions across Lancashire and South Cumbria. The Committee would continue to meet in public from April 2021 onwards, using the Commissioning Reform Group to maintain oversight of the processes.

The ICP Development Group continued to prioritise ongoing development around ICPs; positive dialogue was taking place along with a process of peer review planned from March into April. Helpful discussion had been held recently with local authority colleagues regarding joint priorities, picking up the care sector, population health, economic regeneration, etc.

A draft Terms of Reference for sub-committees proposed to support the SCC would be brought forward. Earlier today, CCG Chairs discussed a process to identify named leads to enable continuous utilisation of Governing Body members, reflecting lay and clinical roles within the geographical specification. Clear reporting arrangements would be crucial from the SCC back to individual Governing Bodies; arrangements would be made within the next few weeks.

Prior to the paper being presented to CCG Governing Bodies, most CCGs had met with Jerry Hawker (JH) to resolve a number of questions about the new arrangements. Following the meetings with JH, caveats to the paper had been put together. The paper, along with caveats, had been positively accepted by Lancashire and South Cumbria CCG Governing Bodies.

Peter Gregory (PG) reported there were questions from the West Lancashire CCG Governing Body, which are expected to be answered in clarifications from the government over the next few months, ie, how the place is represented at level and structures of sub-committees with representation within. The issue regarding hospital activity with the Merseyside system would have to be worked through.

There was national uncertainty regarding ICPs and formulation; the CCG Chairs had agreed this morning that whilst awaiting national guidance, plans would need to continue to proceed.

Graham Burgess (GB) reported that Pennine Lancashire ICP would have 4 to 5 key interventions that demonstrate benefits of working in an integrated way across Lancashire and South Cumbria. Local governance is taking a lot of interest in their new role.

The Chair summarised that the decision made and carried through Governing Bodies had been very significant in the way the system could collectively manage through 2021/22 and be ready for legislation to operate under the new statutory organisation and ways of working in 2022. Throughout the year, there would be a need to ensure that there is an open line of sight not only from statutory Governing Bodies through to the Strategic Commissioning Committee, but transparency and an open line of sight from the SCC to Governing Bodies.

AB recognised a significant number of opportunities for joint action and priority being led by colleagues in this committee; a further briefing would be provided over the next few months.

Amanda Doyle (AD) highlighted that there was clear detail within the white paper regarding local government issues in that none of the objectives expected to be delivered at place level could be delivered by health alone. There was emphasis on working with local government on matters impacting on the health of the population. Consideration was to be given as to how to make this

relationship work, to advantage our population. Cumbria was currently consulting on changes; however, Lancashire was not consulting at present.

ICP Chairs had started conversation with the Local Government Association (LGA) about how to help with development work at place and system place as legislation moves forward. The LGA could help facilitate some of the conversations required. There was much work to be undertaken to get to the position as defined in the legislation.

Geoff Jolliffe (GJ) highlighted the need for system level conversation around competing interests of Health and Wellbeing Boards and health and care partnerships. Conversations would be required with development work around what concept could be built together as partners on this agenda. True independence would be required to make a decision of population for Lancashire and South Cumbria, as a system.

Sumantra Mukerji (SM) reported that Greater Preston Governing Body had asked for clarity on the following points:-

- Regarding the assurance framework, it had been referenced that in relation to the single point of contact, CCGs would hold statutory responsibility for 2021/2022; it was queried how the CCG would discharge this responsibility
- To ensure a 'voice' was linked to the new arrangements from the Patient and Carer Voice Committee. Further assurance was asked for as to how this would report to the SCC
- The position of public health within the reforms, to ensure key positions currently in place were enhanced
- Assurance in relation to the HR Framework; that this would be in place for staff and how this could be transitioned into new arrangements to ensure clarity and openness.

SM was mindful that it would not be possible to double delegate, therefore, local processes would continue to be required for Primary Care Commissioning Committees and suggested it would be useful to consider these committees to meet in common a few times across the ICS, to enable system wide consideration such as quality contract, to bring uniformity across the system as soon as possible.

AB and Jane Cass (JC) reported that cross-working across boundaries with different ICS' in the North West required acknowledgement with the North West Group; Specialised Commissioning would lead colleagues as to how would evolve. Further work would be required, along with a level of maturity across ICS' in the North West region and the ability to receive some functions within NHS England/Improvement.

Jerry Hawker updated that single point of contact continued to be developed with JC and NHS England, however, it was thought the ambition was for NHS England/Improvement to undertake the assurance approach singly through the SCC, to reduce the amount of work. This would not detract from individual statutory organisations being part of the process.

RESOLVED: That members:-

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

6.	**Lancashire and South Cumbria Medicines Management Group Recommendations** Andy Curran (AC) introduced the item, confirming that the JCCCGs need to be assured that appropriate reviews had been undertaken with clinical input and appropriate expert evidence considered. Brent Horrell (BH) spoke to a previously circulated paper, updating that 3 local policy positions and 5 NICE technology appraisals had been considered by the Lancashire and South Cumbria Medicines Management Group. Policy positions reviewed were:- - Amiodarone and Dronedarone, for treatment of arrythmias, related to a change in the RAG position in medicine – nearly moving from recommended by a specialist or recommended and initiated by a specialist with further clinical information - The introduction of a new medicine, Semaglutide oral tablets, to be made available for patients unable to receive the injection - Domperidone, for use in stimulating milk supply. Policies were reviewed following the standard process through the Lancashire and South Cumbria Medicines Management Group. Significant clinical support information had been produced, for the Amiodarone and Domperidone, so that when clinicians would be able to deal with any requests appropriately. Significant financial or clinical risk was not expected. 5 NICE technology appraisals were mandated for uptake. 3 were the addition of agents where agents were already available; not expected to have significant impact. 2 would have impact, Liraglutide, which is being approved for use in weight loss services, and galcanezumab, which had been approved by NICE for migraines. Galcanezumab was expected to have a significant cost pressure; the Medicines Management Group would monitor to ensure uptake was in line with estimations. **RESOLVED: That the JCCCGs members 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.**
7.	**Lancashire and South Cumbria Clinical Commissioning Policies for Glucose Monitoring Update** Brent Horrell updated that the paper previously circulated to members related to a pre-existing policy that had been in place since October 2018. Following NHS England guidance, an update to the policy had been made in March 2019. Recent NICE clinical guidelines and NHS England guidance state to expand continuous glucose monitoring and flash glucose monitoring to patients who previously did not have access to this. Funding for 12 months had been aligned and allocated to Blackpool CCG, who would disseminate accordingly to Lancashire and South Cumbria CCGs. Three areas of the policy had been amended relating to patients with Type 1 diabetes where there was access to continuous glucose monitoring for 12 months, in line with NICE guidance, previously, access had been available to flash glucose monitoring. Patients with Type 1 diabetes living with a learning disability would be given access to flash glucose monitoring. A further updated clinical guidance and policy position would be presented to this Committee in the autumn, following a further piece of work over the summer period looking at a few clinical areas of these policy positions.

	Amanda Doyle reminded members that some interventions hold an additional cost, however, some are evidence based on the impact of exacerbations, hospital admissions and long term complications of diabetes, resulting in a significant health benefit, population benefit and financial benefit into the future. **RESOLVED: That the JCCCGs is asked to approve the update for the Policy for the Provision of Continuous Glucose Monitoring and Flash Glucose Monitoring to patients with diabetes mellitus, pending a full review of the policy with Consultation in Autumn 2021.**
8.	**System Quality and Performance Report** Julie Higgins (JH) spoke to a presentation to update members on the quality and performance workstream; the first phase of an accountability framework for the ICS and ICPs to enable the reporting and improvement of health inequalities, performance and quality. Future reports would be standardised at ICP level, focussing on performance improvement; as it moves forward, new integrated reporting methodology from NHS England/Improvement would take this into account. A Quality and Performance Sub Committee was being formed and would ensure operational, tactical, and strategical reporting; the JCCCGs/Strategic Commissioning Committee would receive reporting on future strategic issues. The dashboard demonstrated capabilities of data that could be looked at through the assurance regime, being dynamic and with the ability to look deeper. The report focussed on the NHS constitution indicators by ICP areas using the latest figures in Aristotle. At ICS level, A&E performance reported at 85.6% at the end of January. 18 weeks performance was 58% for providers and 60% for CCGs against a target of 92% at the end of December; an improving position. The Hospital Cell was taking forward focused recovery work and prioritising the Priority 2 (P2) group of patients. 52-week wait was a deteriorating position, with over 7,000 patients waiting more than 52 weeks; Hospital Cell was taking this forward in a structured way. Prioritisation of P2 patients would make recovery of this position more difficult. Cancer 2-week referral was an improving position; the Cancer Alliance/Hospital Cell were taking this forward. Quality summaries had also been included within the report on nosocomial infections, safeguarding and access to mental health. COVID had really affected performance and staff were now focussed on improving this situation. The Chair commented that a lot of work could be undertaken in getting the formatting, frequency, and access to real time. It was noted that all the performance metrics were red. The past 12 months had the impact of a system dealing with COVID, however, the scale of challenge faced in recovery was enormous. Members welcomed the report providing figures on an ICP basis. It was highlighted that CCGs would be required to provide assurance, however, ICP figures could possibly be used. CCGs would continue to have the statutory responsibility and it was understood that elements of the report would continue to evolve. It was suggested to combine some of public health data in relation to mortality and morbidity. Areas of weakness could be worked on with the hospital and CCGs working together on an ICP basis. It was noted that there was a large performance difference in relation to CAMHS services across the footprint. Query was raised whether the benefit of transparency to see improved working in areas and learning conversations were being looked at. Amanda Doyle (AD) reflected that at a weekly regional meeting, Kevin McGee and AD had sight of how the North West benchmarks with other parts of the country and how Lancashire and South Cumbria benchmarks with the North West. The

	North West had more admissions with COVID stretched over a period, resulting in a build-up of elective waits, culminating in time beds would be unavailable. Restoration in the next year would be about clinical priority and the urgency across Lancashire and South Cumbria, not how fast each provider could restore waiting lists and reduce numbers. Lancashire and South Cumbria would need to look at improving cancer waits, increasing diagnostics and getting P2 and P3 patients through the system. All priority patients would need to be seen prior to moving to a different part of the patch, eg, P4 patients. It was envisaged patients would be moved based on clinical priority. Trusts would work together to ensure clinical priority was taken into account. Jane Cass (JC) reflected that this was a transitional year and a solution was being developed as to how to take this forward. Attention would be focussed on what would be expected from CCGs in the next 12 months, compared to from April 2022. Need to get to a position of the regional team speaking to the system once, with steps taken along the way. Consideration to be given to what would be required for a statutory organisation from 2022. In relation to an ICS risk register, Gary Raphael (GR) reported that a paper had been taken to the ICS Board a few months ago, relating to system approach and risk to strategic objectives. The ICS were tasked to develop a risk register to be in place by April 2021, liaising with ICPs and with engagement from the whole system. The risks should be related to strategic objectives, ie, how far behind on waiting lists, what is risk and what action is being taken to resolve in broad terms. GR to liaise with JH regarding bigger risks. Organisational leaders were asked to ensure colleague input was available from all parts of the system. JH continued that a workstream had been agreed that included 3 phases about how to move from current work to a nested ICP/ICS provider collaborative reporting mechanism, to enable knowledge of where issues were in order to understand improvement and enable local areas to interpret how they could help drive improvement. The ambition was to have local indicators and speak with local authorities regarding broader determinants. The new NHS England/Improvement dashboard included a section on health and inequalities JH thanked members for today's discussion and members awareness/concerns of issues; a small team would be working within CCGs and JH would report to them to enable the April report to meet some of the JCCCGs requirements. The Terms of Reference had been drafted for the Quality and Performance Group. Tactical information was being looked at, in order for future reporting along with strategic information. **RESOLVED: That the Joint Committee note the contents of this initial Performance Report and support its development over the next few months.**
9.	**New Hospitals Programme** **a) Update** - Rebecca Malin (RM) provided an update to members on the New Hospitals Programme. The programme had been launched today with internal communications, an external media release, websites, plus letters to stakeholders; communications to increase over the next few months. Jerry Hawker (JH) spoke to a presentation providing the following highlights:- - The programme was about bringing a new opportunity in terms of social and economic value in Lancashire and South Cumbria and all organisations had a part to play in developing the programme of work - The JCCCGs' responsibilities included to endorse and approve a number of stages towards moving to a conclusion of programme, including the case for change, the pre-consultation business case, overseeing the consultation process itself, receiving the consultation business case and ensuring the system meet all requirements within the service change framework

	- CCGs would be required to lead the consultation process in partnership with local authorities, and to take proposals through NHS England planning assurance and delivery service change framework - Prior to 12 May 2021, all documents within the service change framework must be submitted; the JCCCGs would be required to endorse and support this process. To enable this, and seek assurance required, the JCCCGs would be required to meet on the following dates:- • 25 March 2021 (extraordinary meeting) to take members through the process and legal duties that set on the commissioning system, the proposed approach around communications and engagement, to present the Case for Change and to take the JCCCGs through the high level clinical models • 15 April (scheduled JCCCGs meeting) to present clinical models for endorsement • 6 May (extraordinary meeting) to take the Committee through options to endorse/support • 11 May (extraordinary meeting) held in public ahead of submitting the document to NHS England for Checkpoint 1. **a) Case for Change –** RM reported that a draft Case for Change had previously been circulated to all partners for their review and comment over the next period. The Case for Change had been built by looking at other case for change documents across the patch, a series of clinical workshops held throughout autumn/winter, case for change workshops held in January/February with wide representation including patient representatives and governors. Statistics were available around population, however, when linked into deprivation, need to look at why this would mean that the new hospital would make a difference to the population. RM was keen to flip the case for change away from being "deficit" document in order to build on positive features from the programme, eg, improving population health, attracting workforce. Need to demonstrate how models of care could be changed through the New Hospitals Programme. The document would be about hospitals but articulated to be around the whole system. The current condition of estate at Preston and Lancaster is poor, holding the system back as the services are fragmented; this in turn holds back patient flow and is not attractive for workforce. Net zero carbon and digital would be included within the Case for Change. **RESOLVED: That members:-** - **Review the draft Case for Change and consider how to strengthen the case** - **Support to proceed with the extraordinary JCCCGs meetings** - **Note the report and receive a further report at the next meeting.**
10.	**Partnership Pledge for Lancashire Family Safeguarding Model** Margaret Williams (MW) asked Committee members to support the partnership pledge. The Lancashire Family Safeguarding Group had approached the team last November/December for partner support. This is a new way of working with children and families in need, to help prevent children going into care, with families being kept together. It had been developed from an evaluation undertaken in Southern England and is expected to see huge outcome benefits with radical changes in local authorities and partner teams to ensure fully involved, focus on need and appropriate risk to mitigation wrap around. There would be a number of benefits to both populations and workforce. Evaluation on the Southern England work was around retention, recruitment and health and wellbeing.

	It was noted that as this was a Lancashire model, it did not include Blackpool or Blackburn; each have their own models of family engagement. Directors of Children's Services engage and learn from each other in terms of working together, to ensure equity of access and similar services. All areas had strength-based models that work to support families. Lancashire County Council had put this model forward, asking for health organisation pledge to adopt the principles alongside. **RESOLVED: That members:-** - **Agree to support the pledge** - **Agree that Amanda Doyle sign the pledge as Accountable Officer.**
Item for Information	
11.	**All Age Briefing on Mental Health, Learning Disability and Autism Programme** The briefing had been brought to members for information only. Members were asked to email any comments to Andrew Bennett outside of this meeting. **RESOLVED: That the JCCCGs note the briefing.**
Any Other Business	
12.	**Any Other Business** There was no other business.
Date and Time of the Next Informal meeting of the <u>new Strategic Commissioning Committee</u> 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 <u>new Strategic Commissioning Committee</u> for Lancashire and South Cumbria:** Thursday 13 May 2021, 13:00-15:00, MS Teams	

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee

Action Log

Updated 30 April 2021

Item Code	Action	Responsible Lead	Status	Due Date	Progress Update
SCC210415-11	*Quality and Performance Report* Execs to agree 2 or 3 areas of particular concern that the SCC could look at the recommended actions in detail, to add most value to improvement. This would help the committee ensure improvement work agreed had been undertaken.	ICS Execs	Open	May 2021	
SCC210415-07	*Sub-Committees* All sub-committees to the SCC should be up and running by the May round of meetings	Denis Gizzi, Andrew Bennett, Julie Higgins	Open	May 2021	
JCCCG210114-07	*ICS Dermatology* - Further update required.	Gemma Hedge	Open	Spring 2021	On draft June agenda.

Strategic Commissioning Group

Title of Paper	Quality and Performance Report		
Date of Meeting	13th May 2021	Agenda Item	6

Lead Author	Roger Parr	
Contributors		
Purpose of the Report	Please tick as appropriate	
	For Information	√
	For Discussion	√
	For Decision	
Executive Summary	The ICS Quality and Performance work stream continues with 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 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 insight into its constituent parts. 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.	
Recommendations	The Strategic Commissioning Committee is requested to note the contents of this Quality and Performance Report and support its development.	
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 Strategic Commissioning Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Strategic Commissioning 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.*

Strategic Commissioning Committee (SCC) Quality and Performance Report

13th May 2021

1. Introduction

1.1. The ICS has agreed a Quality and Performance (Q&P) work stream that has set out the first phase of an accountability framework for the Integrated Care System (ICS) and Integrated Care Partnerships (ICPs) to enable the reporting and improvement of health inequalities, Performance and Quality.

1.2. This paper from the Q&P work stream attempts to bring together collective oversight for commissioning following feedback from SCC last month and provides a snapshot high level ICS summary. The key next phase will be working to the dynamic reporting mechanism that will be required for the Q&P Group which will report to the SCC.

1.3. The Q&P work stream will need to respond to the new national integrated assurance regime which is expected in Q1. 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 Q&P at ICS level, nested with ICPs. To this end a functions analysis is underway.

1.4. Appended to this report is the dashboard relating to NHS Constitutional targets. These have understandably been impacted by the pandemic, and assurance processes paused, and whilst some of the indicators are attributed to providers, clearly the wider system has responsibility for delivery.

1.5. At the last SCC, 15th April 2021, there was a request for future reports to feature a more in-depth analysis of performance and quality. This month, May 2021, the deep dive that will be discussed relates to Safeguarding.

1.6. The first Sub Committee of Quality and Performance (Q&P) took place on Wednesday 5th May 2021. This committee focused on bringing all CCG/ICP Chairs and Lead GP's for Quality together to consider the Terms of Reference (TOR) for the group, look at the task that needs to be delivered and consider how it wishes to deal with the tactical reports.

1.7. This Q&P meeting considered the deep dive into the Impact of COVID on Safeguarding. Looking at key highlights and actions to be taken. Further escalation of impact is provided into the SCC today, Wednesday 5th May 2021.

1.8. The overall aim of the Q&P is to scrutinise the performance report, consider risk and mitigation and ensure that quality of service delivery is maintained and improved.

1.9. The Q&P will escalate areas of concern into the Strategic Commissioning Committee (SCC) as necessary.

1.10. There will be a forward plan for the Q&P to consider specific agenda's i.e. The chair of the Q&P will write and ask the Chair of the Elective Recovery Board to attend and give assurances on the performance and quality of this agenda.

1.11. This will be forward plan will be flexible so that agenda's that are escalating can be put on the Q&P agenda without delay.

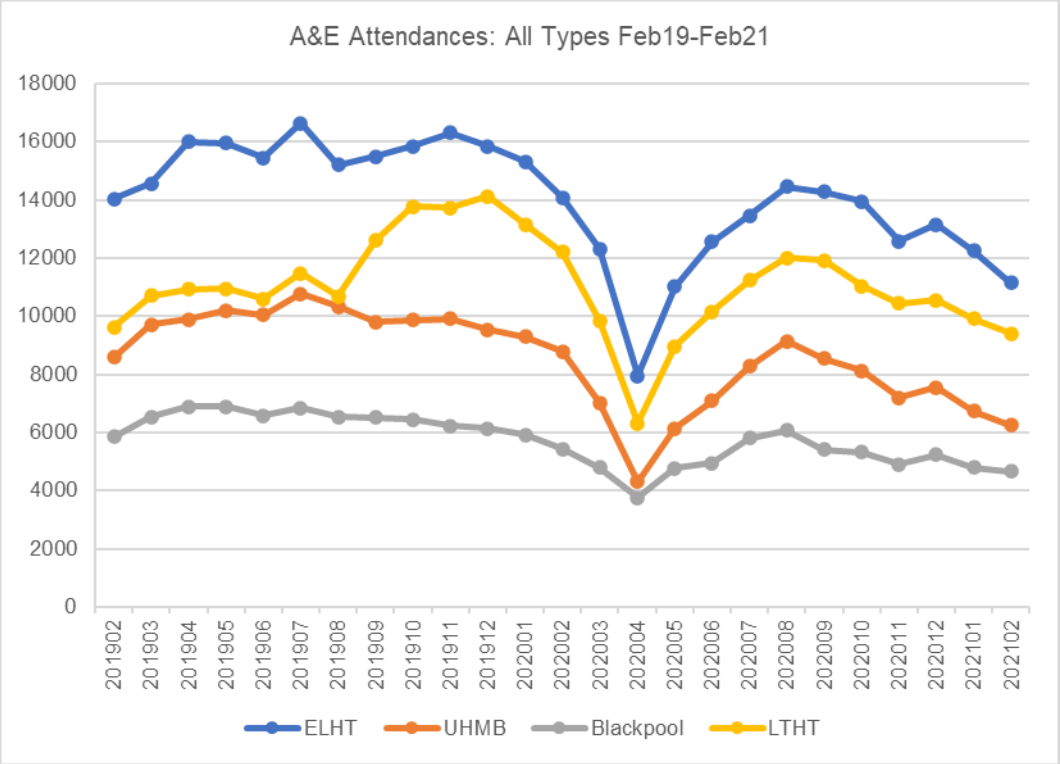
2. Quality & Performance Indicators

This month's report focuses on the following elements of Performance and Quality:

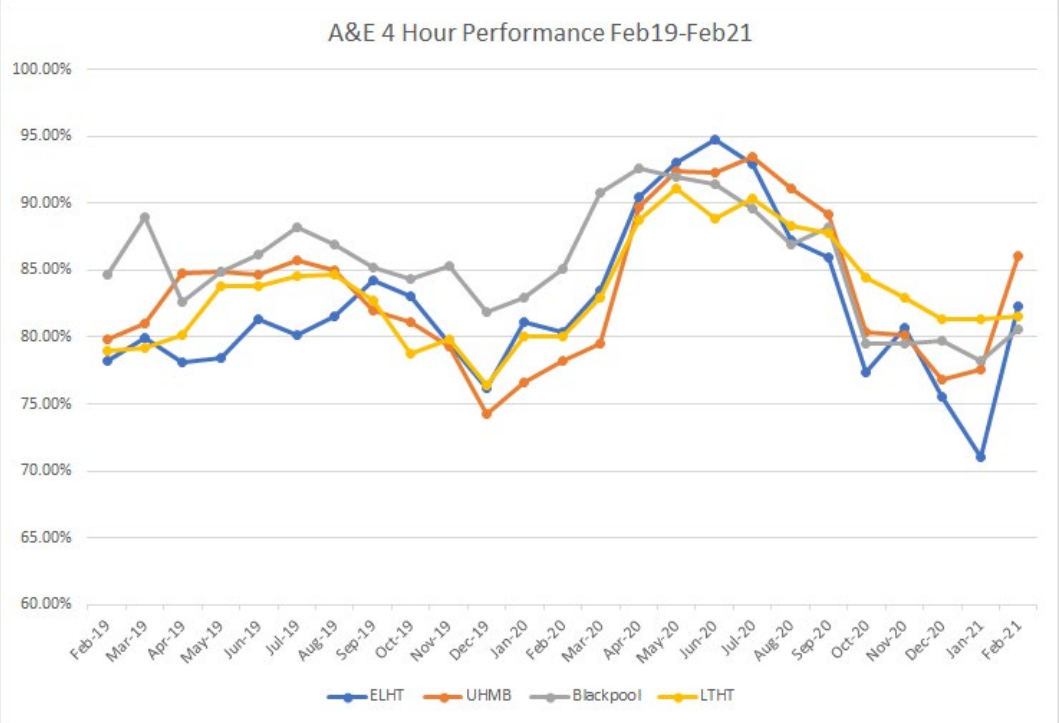
- Urgent Care
- Cancer Services
- Diagnostics
- Elective Care Services
- Nosocomial Infections
- Individual Patient Activity and Continuing Healthcare
- Safeguarding
- CAMHS
- Adult Mental Health and
- Learning Disabilities and Autism
- Appendices
    - Appendix 1: Over 52 week waiters for L&SC CCGs split by Specialty and Provider
    - Appendix 2: Over 52 week waiters for L&SC Providers split by Specialty
    - Appendix 3: ICS Performance Metrics (separate attachment)
    - Appendix 4: ICS Safeguarding Deep Dive (separate attachment)

3. Urgent Care

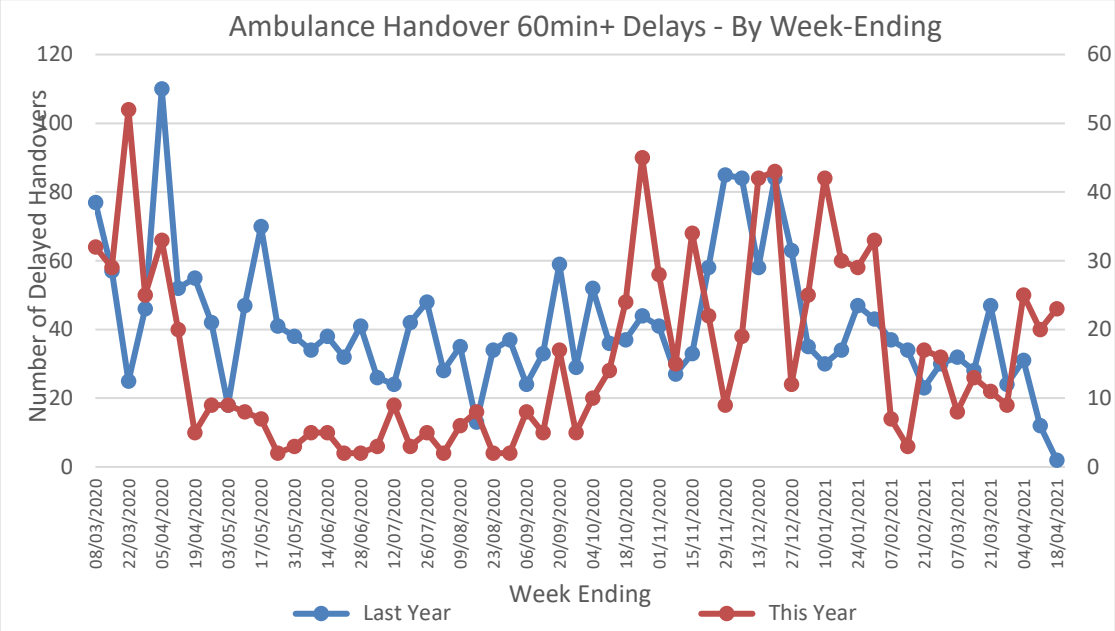
3.1. A&E attendances continue to decrease in February data, however we do know that April has experienced significant increases.



3.2. The ICS is experiencing high occupancy, levels which have a direct impact on flow across the ICS and contribute to the challenging 4 hour performance.



3.3. High occupancy levels can impact on ambulance handover delays, although, improvements continued in February and March, with a slight increase in April.



3.4. We are working to include the triangulation of themes and trends relating to workforce and the causes for the increase in attendances and consequences of increase in respect to patient harm, 12 hour breaches and complaints in future reports.

3.5. **COVID Recovery Performance**

3.5.1. During April, the number of COVID patients in hospital has continued to fall, with significantly low numbers of patients now in our hospitals - 26 COVID positive patients occupying an acute bed, and 3 in critical care beds as of the 23rd of April.

3.5.2. The vaccination programme continues to make a positive impact, with 61% of the ICS population having now had their 1st dose, with a further 22.4% having had their 2nd dose (in line with national targets). Numbers of COVID positive cases continue to reduce, with minimal impact following the return to schools on 8th of March 21 and further easing of lockdown on the 29th of March 21 and 12th of April 21. This is mirroring the number of covid patients in our hospitals.

3.5.3. The reported number of COVID patients in Regulated Care continues to fall. As at the 23rd of April 21 there are currently 18 COVID positive patients in regulated care beds (13 of which on the Fylde Coast). The impact of this improvement means homes have now started to accept new and existing patients back to their normal place of residency, supporting hospital discharges and reducing the number of delays of patients who are medically fit for discharge.

3.6. **Urgent Care Recovery Plan**

3.6.1. Responsibility for the Urgent Care currently sits with the Hospital Cell, who are in the process of working with each trust in order to develop a detailed A&E Recovery Plan for NHS England North West.

3.6.2. The key components of the plan are to include: an assessment of demand, footfall and pressures with an overview of current capacity.

3.6.3. This will facilitate agreement on a final shortlist of initiatives with detailed measurable benefits, including an implementation/ monitoring plan, which will be coordinated via the GOLD hub.

4. Cancer

			Q2			Q3			Q4		
		Target	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Trend
Blackpool Teaching Hospitals	14 Day Target	93.0%	97.4%	96.3%	97.2%	96.2%	97.2%	97.6%	96.0%	97.6%	
	14 Day Target (Breast)	93.0%	94.0%	98.6%	96.1%	97.1%	95.1%	95.3%	94.4%	98.1%	
	62 Day Target	85.0%	82.7%	89.0%	76.7%	75.4%	78.6%	70.0%	72.9%	68.8%	
Lancashire Teaching Hospitals	14 Day Target	93.0%	89.1%	95.7%	96.0%	87.6%	80.5%	74.8%	72.0%	85.2%	
	14 Day Target (Breast)	93.0%	41.9%	87.1%	100.0%	82.8%	30.9%	2.3%	7.1%	38.2%	
	62 Day Target	85.0%	75.3%	70.2%	67.3%	55.8%	54.6%	64.4%	57.4%	53.0%	
East Lancashire Hospitals	14 Day Target	93.0%	91.8%	90.7%	93.0%	95.0%	95.0%	95.7%	94.2%	97.1%	
	14 Day Target (Breast)	93.0%	93.3%	95.7%	95.9%	96.5%	94.3%	88.1%	96.0%	99.3%	
	62 Day Target	85.0%	78.0%	80.5%	70.5%	72.1%	82.6%	72.9%	69.0%	79.0%	
Morecambe Bay Hospitals	14 Day Target	93.0%	81.8%	69.9%	51.3%	59.1%	59.3%	68.2%	56.5%	72.2%	
	14 Day Target (Breast)	93.0%	33.3%	20.0%	0.0%	4.7%	0.0%	4.0%	1.6%	4.2%	
	62 Day Target	85.0%	70.5%	66.9%	60.0%	60.1%	68.3%	67.6%	66.3%	69.1%	

4.1. In line with the national planning letter,[1] the Cancer Alliance is working with local stakeholders on the delivery of two key ambitions:

- To return the number of people waiting for longer than 62 days to February 2020 levels (or to the national average in February 2020 where this is lower) and
- To meet the increased level of referrals and treatment required to address the shortfall

4.2. At present, timescales have not been set nationally for the sustainable delivery of all cancer targets. The focus of the national draft planning submission on the 6th May 2021 is to agree ICS level trajectories for 62-day backlog reduction, cancer treatment volumes and two-week wait referrals. The Midlands and Lancashire CSU are supporting the Cancer Alliance in developing baseline data and commissioner / provider level trajectories. Charts to show progress against these ambitions will be included in future reports.

4.3. Stakeholders within the Cancer Alliance are however working hard to improve overall cancer target performance and where possible reduce variation across the ICS. The key areas of risk remain access to diagnostics such as Endoscopy and Radiology, outpatient capacity for first appointments, service and workforce pressures with Breast services, surgical capacity and wider workforce issues. Demand levels are also continuing to increase as national social and lockdown restrictions are eased.

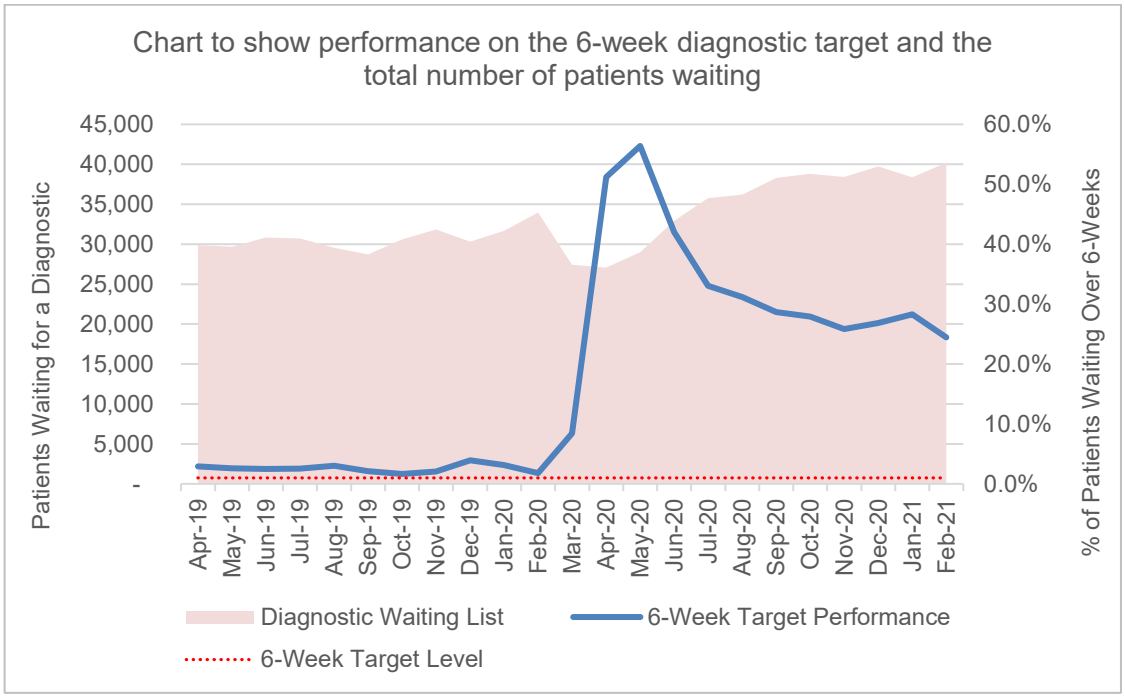
[1] https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-nhs-operational-planning-and-contracting-guidance.pdf

4.4. The key actions led by the Cancer Alliance include:

- The development of capacity and activity plans for 2021-22 with local acute providers
- The development of planning commitments for submission nationally via the elective Care Recovery Group
- Ongoing delivery of the Endoscopy recovery actions and implementation of provider actions plans
- Engagement in the Community Diagnostic Hubs (CDH) programme to ensure capacity can be increased in year
- Delivery of Increased surgical and diagnostic procedures, overseen by the ongoing surgical hub arrangements
- Implementation of the Rapid Diagnostic Pathways within each ICP and investment / actions to review key high volume pathways
- The launch of the Breast Services Collaborative. This group met on the 23rd of April 2021 is quantifying capacity needs for the ICS going forward.
- Ongoing delivery of the wider Cancer Alliance work programme that includes PCN support, the re-mobilisation of screening, patient engagement and the development of further collaborative groups e.g. Urology.

5. Diagnostics

5.1. As noted above, access to diagnostic tests is a key component of delivering timely Cancer and Elective pathways. The chart below shows ICS performance on the 6-week diagnostic target along with the number of patients waiting for a diagnostic test. Prior to the COVID pandemic, ICS level delivery was slightly above the target of 99% of patients waiting within 6-weeks.



5.2. Performance has deteriorated significantly since March 2020 due to the impact of new COVID-19 Infection Prevention rules designed to slow the rate of nosocomial infection. The majority of diagnostic services are currently delivering a lower level of capacity due to the increased requirement for PPE and cleaning between patients.

5.3. The acute providers are currently reporting waiting list growth in four key areas: Magnetic Resonance Imaging (MRI), Cystoscopy, Echocardiography and Urodynamics. MRI and Cystoscopy waiting lists currently have the highest proportion of patients waiting over 13 weeks for a test.

5.4. The table below summarises the proportion of Lancashire and South Cumbria (L&SC) patients waiting over 6 weeks by ICS Trust, highlighting both the significant variation across the ICS and the high levels of pressure in Endoscopy services. The arrow next to the percentage figure indicates fewer patients are waiting over 6 weeks compared to the previous month.

	% of patients waiting over 6 weeks (February 21)		
Provider	Endoscopy	Non Endoscopy	All Diagnostic Tests
Blackpool Teaching Hospitals	55% ↓	11% ↓	23% ↓
East Lancashire Hospitals	34% ↓	15% ↓	18% ↓
Lancashire Teaching Hospitals	58% ↓	41% ↓	41% ↓
Morecambe Bay Hospitals	13% ↓	3% ↓	4% ↓

5.5. The Elective Care Recovery Group (ECRG) is tasked on behalf of the ICS to collate and develop plans for 2021-22 and to oversee the submission of our elective and diagnostic planning commitments. Key actions include:

- Acute hospitals implementing sub-contracts with the Independent sector to secure additional diagnostic capacity, including mobile Endoscopy provision
- Successfully securing Adapt & Adopt capital allocations and purchasing three new CT scanners.
- East Lancashire Hospitals Trust (ELHT), University Hospitals of Morecambe Bay Trust (UHMB) and Blackpool Teaching Hospitals Trust (BTH) have agreed to site and staff these scanners which will operate 12hrs/7days a week, subject to the availability of recurrent funding
- The planned go live dates are in April/May of 2021 with an estimated 90+ additional CT scans per day available to the system.
- Actions in train to establish the Provider Collaborative Diagnostics Imaging Network and the implementation of Community Diagnostic Hubs over the next 5 years. Close working with key stakeholders and ECRG will be required to deliver this.
- Modelling of future demand and capacity are being undertaken as part of the regional planning process and to inform ICS level bids for the national funding to support elective recovery.
- Providers developing efficiency and local improvement plans in line with the national planning guidance on moving to top quartile performance.

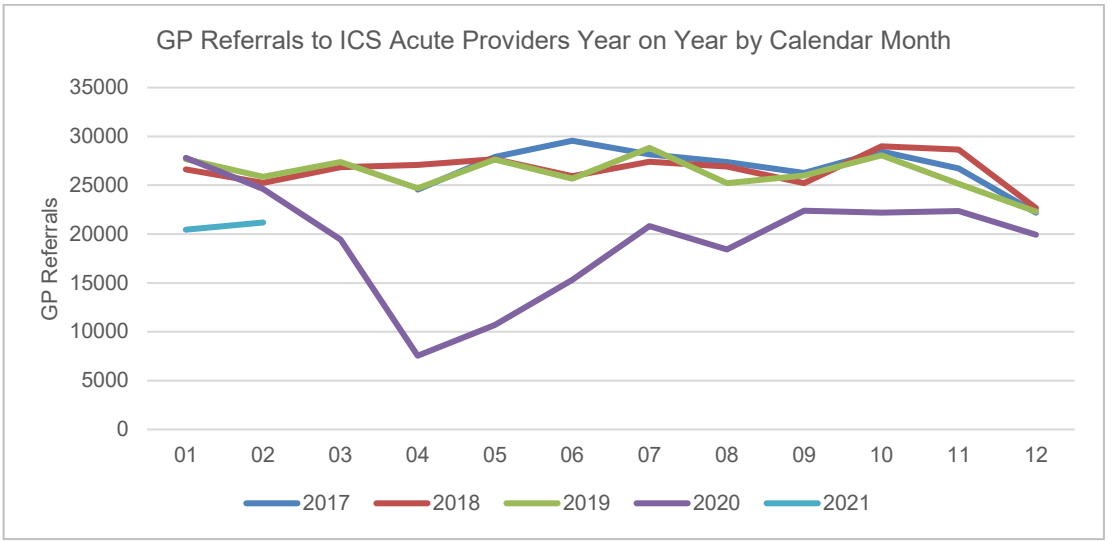
5.6. Detailed test level trajectories are being developed by the ECRG for inclusion in the draft planning return on the 6th May 2021.

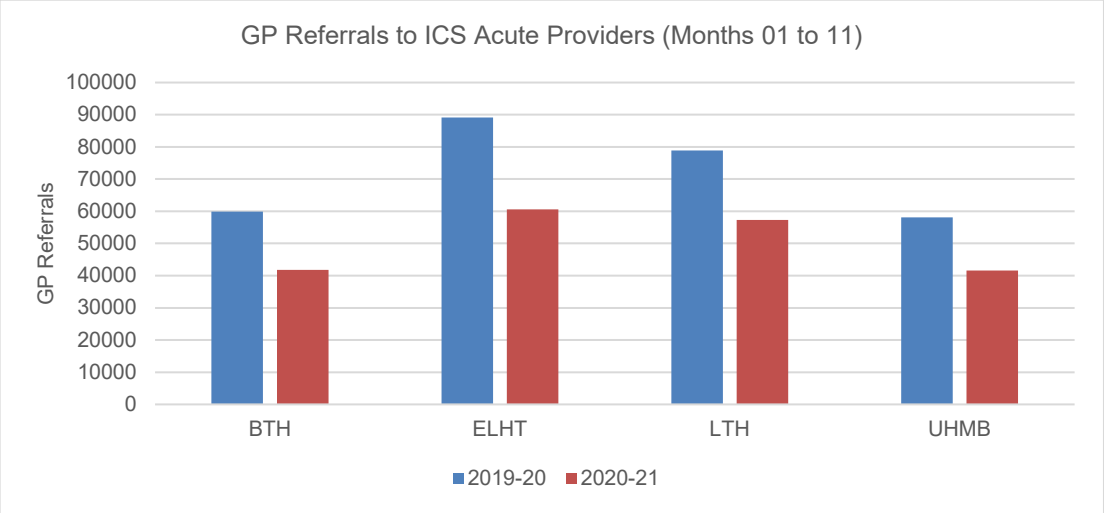
5.7. Morecambe Bay CCG have noted an increase in the number of incidents where there is a treatment or diagnostic delay. The CCG are currently undertaking a deeper dive of the information to determine which treatment pathways are affected.

6. Elective Care Services

6.1. Service Demand

6.1.1. As noted in previous reports, the patterns of demand to our elective services changed significantly as result of COVID-19. The charts below shows GP referrals to the four main ICS acute hospitals. Whilst still below previous years referral levels there is an upward trend towards recovery.





6.1.2. Referral rates have increased since the start of the pandemic in 2020 because of national awareness campaigns and growing public confidence, however GP referrals during 2021 remain below previous levels. It is anticipated that a proportion of the 'suppressed demand', i.e. referrals not received as expected, will present in the current financial year leading to above average demand pressures. The ICS is working to a demand estimate of 120%.

6.1.3. The Elective Care Recovery Group is tasked on behalf of the ICS to collate and develop plans for 2021-22 and to oversee the submission of our elective planning commitments. Each acute provider, through discussions with their local CCG, has submitted estimated demand plans for each service.

6.1.4. Work is ongoing to track the changes in demand by speciality and population group to ensure that recovery actions are equitable and that low presenting patient groups are targeted for support. In line with the planning guidance, specific consideration will be given to variation in access by ethnicity and deprivation.

6.2. Elective Activity Levels

6.2.1. The national planning letter received on the 25th of March 2021 sets clear activity targets for the first half of the financial year. From April 2021, Integrated Care Systems must deliver 70%, of the elective activity levels reported in 2019-20 with a five-percentage point increase in delivery in subsequent months to 85% from July 2021.

6.2.2. The tables below summarise the elective activity levels commissioned by the ICS from all providers in February 2021. During the first half of 2021-22, the ICS will be judged on its monthly activity levels rather than the cumulative annual position.

ICS 2020-21 Elective and Outpatient restoration levels – All Trusts

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Cumulative
IP and DC Activity (% of 2019-20 activity levels which have been restored)												
L&SC	26%	30%	45%	56%	63%	75%	76%	77%	86%	69%	74%	**62%**
Outpatient Activity (% of 2019-20 activity levels which have been restored)												
L&SC	56%	60%	87%	80%	87%	97%	87%	93%	99%	80%	90%	**83%**

ICS Elective and Outpatient restoration levels by Trust

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Cumulative
IP and DC Activity (% of 2019-20 activity levels which have been restored)												
BTH %	30%	33%	48%	61%	68%	82%	75%	84%	95%	74%	79%	**66%**
ELHT %	27%	32%	51%	63%	65%	85%	84%	82%	86%	71%	76%	**66%**
UHMB %	22%	23%	34%	48%	57%	63%	75%	79%	85%	68%	67%	**57%**
LTH %	26%	32%	46%	51%	60%	68%	69%	67%	79%	65%	71%	**58%**
Outpatient Activity (% of 2019-20 activity levels which have been restored)												
BTH %	48%	52%	80%	82%	92%	99%	86%	97%	102%	82%	97%	**83%**
ELHT %	64%	67%	93%	81%	87%	98%	90%	94%	98%	84%	95%	**86%**
UHMB %	40%	51%	77%	71%	76%	89%	77%	82%	92%	79%	88%	**74%**
LTH %	61%	63%	91%	84%	91%	99%	90%	94%	102%	77%	82%	**85%**

6.2.3. The tables above shows that in February 2021 the ICS had restored both outpatient and elective activity levels to the 70% threshold in all providers apart from admitted patients at UHMB. Local monitoring indicates that these levels have been maintained during March 2021.

6.2.4. It is important to note that a significant proportion of the activity delivered in quarter 4 and planned for the first half of 2021-22 will be delivered by the Independent Sector. This is in line with national guidance. During 2019-20, CCGs spent circa. £70M on Independent Sector capacity, this equates to 14% of the total elective care spend. The Elective Care Recovery Group and ICS Planned Care Commissioners have implemented six-month contracts from April 2021 with activity plans set at the 2019-20 activity level.

6.2.5. To illustrate the pace of restoration being different between the individual providers within the ICS, the table below breaks down February's performance. The RAG rating illustrates the variation between the local acute providers by point of delivery. This data includes sub-contracted IS capacity.

February 2021 (SUS Data)	ICS Position	BTH	ELHT	LTH	UHMB
First Appointments	89%	89%	94%	74%	96%
Outpatient Follow Up	88%	99%	93%	83%	81%
Day Case (DC)	75%	82%	76%	70%	71%
Elective (EL)	62%	59%	73%	78%	38%

6.2.6. To maintain delivery of the national planning requirements and to secure funding for recovery the ICS will need to increase activity levels month on month. The additional activity will need to be delivered within the NHS acute providers, particularly overnight elective admissions.

6.2.7. Capacity within the independent sector is limited and increasing independent sector usage will both increase financial over performance and potentially require patients to travel to out of area providers, impacting on patient experience and potentially equity of access.

6.2.8. Elective recovery actions will also need to address the variation between providers, particularly in relation to elective (overnight) episodes. Independent Sector providers are only able to deliver treatments below a set threshold of risk, above this threshold treatments need to be delivered at sites with ready access to ICU and other urgent acute facilities. Achieving the surgical activity targets through the acceleration of Day Case activity alone risks creating further inequity.

6.2.9. The Elective Care Recovery Group are leading on the development of elective restoration plans. These plans include:

Elective Hub	• Transformation Actions including: A&A Theatres: 24 hr Joints, Consistent IPC, standardisation of lists, Theatre Lite, Maximising Day Case activity • Establishing surgical hubs • Co-ordinated waiting list (inc. IS) & protocol to determine system wide priorities • Oversight clinical validation of waiting lists • Managed system view of EBIs & implementation of clinical policies • System wide surgical prioritisation committee
Outpatients	• Increased use of Patient Initiated Follow Ups (PIFUs) • Increased use of Advice and Guidance • Increased volume of Virtual Consultations • Clinical pathway redesign: MSK & dermatology to reduce attendances
Diagnostic Imaging	• Securing additional imaging capacity • Establishing Provider Collaborative Diagnostics Imaging Network • Implementing Community Diagnostic Hubs
Diagnostics Endoscopy	• Establishing Endoscopy Hub and manage at system level Mobile scanner utilisation rates • Workforce capacity, staffing models & skills

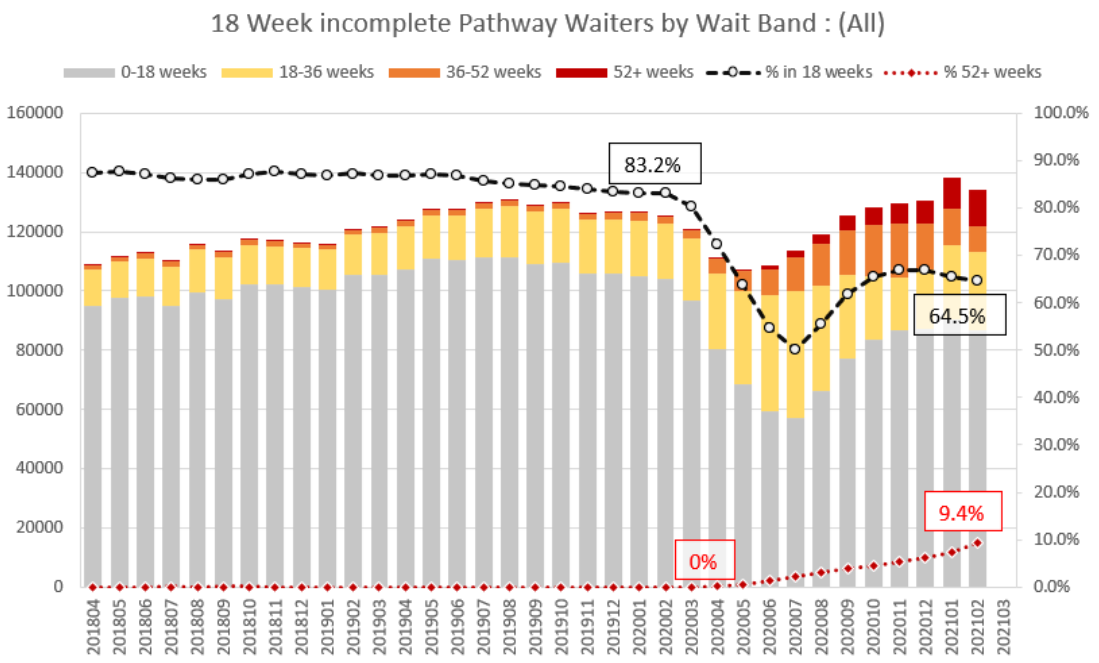
Independent Sector	• Contract negotiation, mobilisation & monitoring CCGs & Trusts • Referral & demand management, triage, clinical prioritisation & use of eRS • IS NHS patients incorporated into single system waiting list
Critical Care	Project plan to address; • Efficient use of critical care beds/ enhanced care within the estate • Workforce : staffing models, attrition, education, well being & skill sets • Patient pathways and interdependencies • Effective and efficient system working

6.3. Patient Experience: The 18 Week Target

6.3.1. There are 3 key measures associated with referral to treatment times:

- The number of patients waiting to start treatment (incomplete pathways)
- The % of patients currently waiting up to 18 weeks to start treatment (Target 92%)
- The number and % of patients currently waiting 52+ weeks to start treatment (Target 0%)

6.3.2. The chart below shows the ICS performance (aggregated for the 8 x CCGs) against these 3 measures. Prior to the COVID pandemic, the total number of patients waiting to start treatment had stabilised and was showing signs that it was starting to reduce. In January 2020 the total number of patients waiting to start treatment was 125,065 and although the 18-week standard was not being met (83.2%), there were only 5 patients waiting over 52-week (<0.01%).



6.3.3. The drop in the number of patients waiting to start treatment in March and April 2020 can be linked to a dramatic reduction in the volume of GP referrals as the pandemic started to take hold. Although planned activity also reduced, this was not to the same degree as referrals, with a shift of activity away from face to face to virtual outpatient clinics. However, the overall reduction in clinical capacity and prioritisation of urgent / cancer cases has meant that a greater proportion of patients were having to wait longer for routine treatment. From June 2020, the number of patients waiting has started to

increase, with significant increases in patients waiting longer, especially in excess of 52 weeks.

6.3.4. As of February 2021, the total number of patients waiting to start treatment was 138,121, performance against the 18-week standard was 64.5%, and there were 12,560 over 52-week waiters (9.4%).

6.3.5. For completeness[2], West Lancashire (WL) CCGs main acute hospital provider, Southport & Ormskirk Hospitals Trust was at 83% under 18 weeks as of February 2021.

6.3.6. The following table shows the variation in numbers of patients waiting to start treatment and the % waiting 18 weeks and 52+ weeks at the end of February. There is significant variation between CCGs which will be linked to differences in the position of the main providers and specialties. In terms of the volumes of longer waiter patients then there appears to be a greater pressure in the Fylde Coast and Morecambe Bay.

CCG	0-18 weeks	18-36 weeks	36-52 weeks	52+ weeks	Total	% in 18 weeks	% 52+ weeks
Blackburn with Darwen CCG	8015	1825	476	668	10984	73.0%	6.1%
Blackpool CCG	8325	2749	988	1786	13848	60.1%	12.9%
Chorley & South Ribble CCG	9374	3298	1241	1740	15653	59.9%	11.1%
East Lancashire CCG	18365	4366	1028	1581	25340	72.5%	6.2%
Fylde & Wyre CCG	8947	3000	1049	1732	14728	60.7%	11.8%
Greater Preston CCG	11790	3853	1377	1865	18885	62.4%	9.9%
Morecambe Bay CCG	16108	6049	2058	2728	26943	59.8%	10.1%
West Lancashire CCG	5693	1357	360	460	7870	72.3%	5.8%
February Total	**86617**	**26497**	**8577**	**12560**	**134251**	**64.5%**	**9.4%**
January Total	**90458**	**24887**	**12639**	**10137**	**138121**	**65.5%**	**7.3%**
Difference	-3841	-1,610	-4062	+2423	-3870	-1.0%	2.1%

6.3.7. Three-quarters of all over 52-week waiters for the CCGs are at the four main providers in the ICS, with 39.6% at LTHT (See Appendix 1). Four specialties account for 64% of all (11,695) long waiters (as at the end of March 2021):

- Trauma & Orthopaedics: 2,946 (25.2%)
- General Surgery: 2,070 (17.7%)
- ENT: 1,402 (12.0%)
- Ophthalmology: 1,076 (9.2%)

[2] This is for information only as WLCCG are not the lead commissioners and assurance sits within Cheshire & Mersey (C&M). Concerns are escalated into C&M QSG via Southport & Formby CCG as lead commissioners.

6.3.8. When a provider view is taken (Appendix 2) then Oral Surgery is reported to have the greatest number of 52+ week waiters (2,451) with nearly three-quarters (73.8%) of these waiting at LTHT. Oral surgery is commissioned by NHS England and as such these waiters appear in provider totals, but not CCG figures.

6.3.9. The number of 52-week breaches continues to increase and this upward trend is also being seen on a local and national level. It should be recognised that the 52-week position is expected to deteriorate further as a result of the National Clinical Prioritisation Programme where all patients are being clinically validated by their lead consultant and given a specific priority code.

6.3.10. Recovery trajectories will be produced as part of the recovery plan development, led by the Elective Care Recovery Group. Local CCGs are working with Acute Trusts to track and mitigate potential risks and harm to patients and address opportunities for demand reduction where possible. For instance, Blackpool, Fylde and Wyre CCG are doing a piece of work which requests timelines for each patient, together with assurance that no harm had been caused due to the long wait.

6.3.11. NHSE have advised there will be increased emphasis on anyone waiting 104 weeks or more. The Central Lancashire CCGs currently have one patient and Fylde Coast CCGs have 13 patients waiting over 104 weeks and assurance has been sought to ensure that no harm has been caused as a result of the long waits. Ongoing monitoring and assurance will continue.

6.3.12.

7. Nosocomial Infections

7.1. The incidence of COVID-19 within the hospital and community has reduced significantly and this has been a sustained downward trajectory from previous months. This is primarily due to lockdown restrictions and the roll out of the vaccination programme for priority groups 1-9. Overall, this has contributed to a decrease in nosocomial infections being reported across all care settings.

7.2. Across the acute trusts visiting restrictions have remained in place. This is impacting on patient and family experience despite multiple mitigating actions. A national guidance document has been issued and consideration of the implementation of this will be undertaken regionally, with the aim of implementing a consistent approach to reintroducing visiting at the appropriate time. All trusts have exceptions in place for:

- A patient receiving end of life care
- A patient is a child or neonate. The visitor must be a parent or designated carer
- They are partner or birthing partner accompanying a woman in labour
- To support someone with a mental health issue such as dementia, a learning disability or autism where not being present would cause the patient to be distressed

7.3. ELHT are currently undertaking a pilot on select wards across sites where patients can have one visitor per day for 1 hour. This is being evaluated regularly, with initial feedback being positive and to date this has not impacted on the increase in infection rates.

7.4. Phase 3 of the asymptomatic staff testing started in April 2021 with the roll-out of LAMP (loop-mediated isothermal amplification) tests. With this being a simpler test to undertake, and supported with a national digital solution, it is anticipated this will lead to a greater level of compliance.

7.5. Regulated Care have continued to see a significant decrease in the number of outbreaks being reported across the sector. The Regulated Care Cells have reduced their meetings frequency to once a week but continue to monitor incidents closely.

7.6. CCGs are continuing to work in partnership with local authorities to promote and disseminate information of COVID Vaccine Programme to care home managers and care staff to increase uptake across the workforce. In addition, local authorities have completed calls to homes with low staff uptake of the vaccine and follow up calls will be undertaken if required.

7.7. Recently, national guidance regarding the completion of nosocomial death investigations which is to take the form of a modified Structured Judgement Review (SJR) has been published. All Trusts are currently reviewing the guidance and an implementation plan is being currently developed.

8. Individual Patient Activity (IPA) and Continuing Healthcare (CHC)

8.1. The core IPA/CHC service is still experiencing increased levels of activity as a result of the ongoing COVID 19 Scheme 2, six week Discharge to Assess requirement but are supporting all the discharge pathways as required and monitoring and reporting on breaches. This is however inevitably having an impact of the services ability to handle incoming non discharge referrals and essential review activity.

8.2. With regards to deferred assessments a revised trajectory for eligibility assessments that were deferred when the NHS CHC National Framework was stood down (April to August 2020) due to the pandemic has been submitted taking the project to the end of April 2021. As at 28th April 2021 the project is slightly behind planned trajectory but there are now only 75 cases remaining to be completed. Whilst the project has gone beyond the 31st March 2021 date required by NHSE nationally it is still a significant achievement by all stakeholders considering the 2700+ cases that needed addressing and also considering the numerous barriers to completion that have been faced.

8.3. The project to address the legacy Incomplete Referrals (ICR) will also pick up pace after the COVID-19 deferred work is completed at the beginning of May 2021.

8.4. The programmes senior responsible officer and commissioning lead have weekly meetings and regular touch points with NHSE&I CHC regional team to give assurance on the delivery of the projects.

9. Safeguarding

9.1. The L&SC safeguarding system reforms continue to progress. All Designated Nurses/professionals have now agreed ICS portfolio leadership areas. Safeguarding teams are working on the portfolio areas such as: Neglect, Domestic Abuse and System Reform, Service Change, Workforce and Assurance. Designated professionals continue to ensure that their respective CCG statutory responsibilities are maintained. Pennine CCGs are leading on the Contextual safeguarding portfolio

for the ICS footprint, and have developed with partners a contextual safeguarding strategy and draft delivery plan.

9.2. Across the ICS, there is risk in respect of the increase in unregulated placements for Looked After Children (LAC) and children placed in these with significantly high risk taking behaviours. This has been raised at a National Level and work is being undertaken across the ICS to address this through the LAC Professionals Network, including linkage with CQC and Ofsted to seek assurance and strengthen notification processes.

9.3. There is emerging concern in respect of the increase in demand and complexity of children presenting with mental health difficulties to Acute Providers within the L&SC area; this has been raised through the ICS Safeguarding System and across the Children and Young People Partnership Boards. Designate Nurses are looking to work with providers and partners across the system to address these challenges.

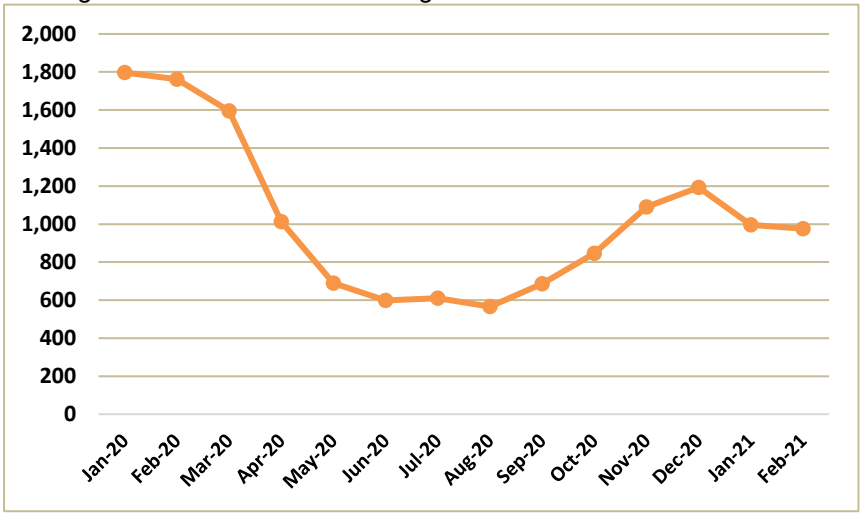
9.4. Within Pennine Lancashire, a safeguarding practitioner is leading on development work with LA partners in relation to children educated from home, and this has been recognised as good practice across the ICS.

9.5. The fragility of the Regulated Care Sector continues to be closely monitored across the ICS. Quality concerns surrounding the Regulated Care Sector is anticipated to increase as we move into the 'Recovery & Restoration' phase, as footfall increases within these settings. The CQC have highlighted an increase in Whistleblowing – relating to IPC, Staffing and Lack of Leadership. Financial viability of this sector remains a concern. All agencies across the system are ensuring wrap around support is available where required.

10. Children and Adolescent Mental Health Services (CAMHS)

10.1. <u>Waiting Lists</u>

Waiting Times - No. of CYPs waiting to be seen



National Target – N/A
Local Target – N/A

10.1.1. **February 2021 Position** Overall, there has been a 2% decrease in the number of CYPs waiting for treatment, from 995 (Jan'21) to 975 (Feb'21)

10.1.2. **Blackpool Teaching Hospital** have seen a decrease in the number of CYPs waiting for treatment compared to the previous month, from 592 (Jan'21) to 528 (Feb'21).

10.1.3. **East Lancashire Hospital Trust** have seen an increase in the number of CYPs waiting for treatment compared to the previous month, from 56 (Jan'21) to 68 (Feb'21).

10.1.4. **Lancashire & South Cumbria Foundation Trust** have seen an increase in the number of CYPs waiting for treatment compared to the previous month, from 347 (Jan'21) to 379 (Feb'21).

10.2. Access

% of CYP accessing treatment by NHS funded community services (at least two contacts) - Latest Prevalence Position 19/20

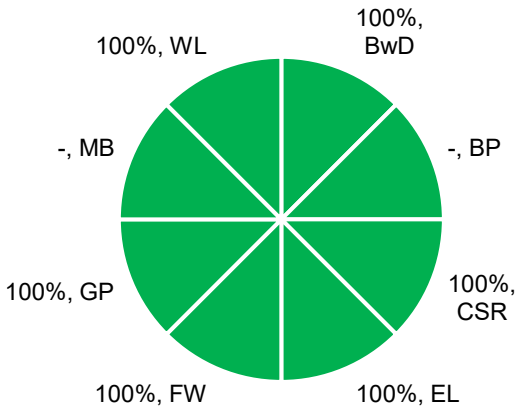
	Feb'20 -Jan'21 National Data (All Providers)		
	12 Month National Rolling Position	Prevalence	% Achieved
Blackburn with Darwen CCG	1,640	3,871	42%
Blackpool CCG	1,640	2,952	56%
Chorley & South Ribble CCG	1,740	3,227	54%
East Lancashire CCG	3,160	8,115	39%
Fylde & Wyre CCG	1,680	2,702	62%
Greater Preston CCG	1,435	3,975	36%
Morecambe Bay CCG	2,785	6,084	46%
West Lancashire CCG	1,090	2,040	53%
Lancashire & South Cumbria Total	15,170	32,966	46%

The 12-month rolling position (January 2020 – February 2021) demonstrates L&SC is achieving a 46% target overall which continues to exceed the National target of 35%, no change on the previous 12-month rolling position, bringing L&SC only 6% below the local planned 2020/21 target of 52%.

10.3. Eating Disorders

CYP – Eating Disorders		Performance Data								
Measure	CCG/ICP	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21	Sparkline
% of CYP with eating disorders (ED) seen within 1 week (urgent)	**L&SC**	**85%**	**90%**	**100%**	**100%**	**100%**	**100%**	**100%**		
	Blackburn with Darwen CCG	100%	-	-	100%	-	-	-		
	East Lancashire CCG	83%	80%	100%	100%	100%	-	100%		
	Blackpool CCG	-	-	-	-	100%	100%	100%		
	Fylde and Wyre CCG	100%	-	100%	-	-	100%	100%		
	Chorley and South Ribble CCG	100%	100%	100%	100%	100%	-	100%		
	Greater Preston CCG	0%	-	-	-	-	100%	-		
	MBCCG/**Bay Partnership**	-	**100%**	-	-	-	-	**100%**		
	West Lancashire CCG/**West Lancashire WCP**	-	**100%**	-	**100%**	**100%**	100%	-		
% of CYP with eating disorders (ED) seen within 4 weeks (routine)	**L&SC**	**70.9%**	**95.5%**	**96.2%**	**100.0%**	**98.3%**	**98.7%**	**94.6%**		
	Blackburn with Darwen CCG	75.0%	75.0%	66.7%	100.0%	100.0%	100.0%	71.4%		
	East Lancashire CCG	41.7%	85.7%	90.0%	100.0%	100.0%	92.3%	83.3%		
	Blackpool CCG	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
	Fylde and Wyre CCG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
	Chorley and South Ribble CCG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
	Greater Preston CCG	87.5%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%		
	MBCCG/**Bay Partnership**	**83.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		
	West Lancashire CCG/**West Lancashire WCP**	**33.3%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**		

% of CYP with Eating Disorders seen within 1 week (Urgent) Q3

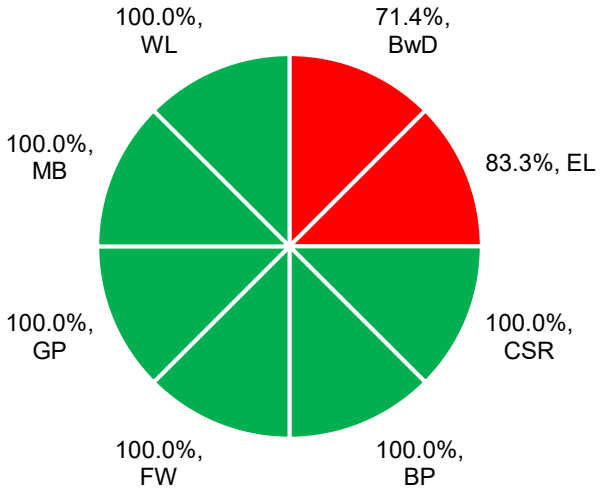


Performance based on NHSE published data is showing L&SC achieving 100% for Quarter 3 and Q3 Rolling 12-month position.

National Target – 95%
Local Target – N/A

No patient need for CCGs with N/A reported against them

% of CYP with Eating Disorders seen within 4 weeks (Routine) Q3



Performance based on NHSE published data is showing L&SC achieving target for Quarter 3 and the rolling 12-month position. Also, all CCGs have achieved target in quarter 3 20/21 position with the exception of Blackburn with Darwen CCG & East Lancashire CCG this was due to team capacity. Blackburn with Darwen CCG has not achieved target for rolling 12-month position which is again due to team capacity.

National Target – 95%
Local Target – N/A

10.4. West Lancs CCG launched a new single point of access for talking therapies from 1st of November 2020. This now sees all referrals for talking therapies going via one single point of access. This new pilot has improved patient choice and made access to talking therapies easier and more straightforward. It is expected that this model will improve both access and recovery rates of people attending the service. Other areas of the ICS, as well as NHSEI will monitor the model closely with a view to replicating in other areas. It is expected that the pilot will continue to March 2022 and be evaluated throughout. In March and April 2021, West Lancs CCG have started to see an increase in demand with the team meeting access targets. There had generally been a national reduction in people wanting talking therapies during the pandemic.

10.5. <u>Early Intervention to Psychosis</u>
LSCFT's local data Month 11 EIP report provided below. LSCFT have achieved the 60%. There is no exception reporting required.

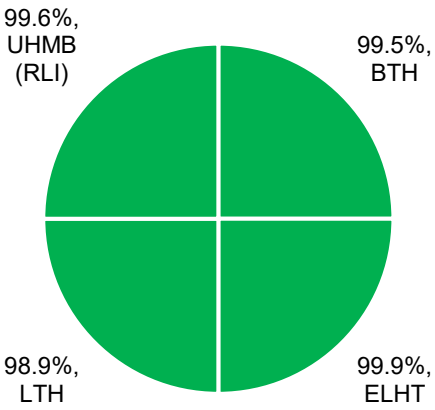
% of people who started treatment within 2 weeks of referral

EIP 2 week wait - CCG Position	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
NHS Blackburn with Darwen CCG													
Numerator	5	4	4	5	1	4	6	6	3	2	5	1	4
Denominator	6	5	7	7	1	4	8	7	7	4	8	3	4
Performance %	83.3%	80.0%	57.1%	71.4%	100.0%	100.0%	75.0%	85.7%	42.9%	50.0%	62.5%	33.3%	100.0%
NHS Blackpool CCG													
Numerator	2	5	4	6	7	3	3	2	0	2	2	3	4
Denominator	4	7	5	6	9	7	5	6	2	3	2	4	5
Performance %	50.0%	71.4%	80.0%	100.0%	77.8%	42.9%	60.0%	33.3%	0.0%	66.7%	100.0%	75.0%	80.0%
NHS Chorley and South Ribble CCG													
Numerator	3	5	5	1	2	6	5	1	2	3	3	1	2
Denominator	3	7	8	2	2	9	6	2	2	3	3	2	3
Performance %	100.0%	71.4%	62.5%	50.0%	100.0%	66.7%	83.3%	50.0%	100.0%	100.0%	100.0%	50.0%	66.7%
NHS East Lancashire CCG													
Numerator	5	5	7	2	6	7	2	6	4	5	6	5	3
Denominator	6	8	10	2	7	8	5	6	5	12	9	6	3
Performance %	83.3%	62.5%	70.0%	100.0%	85.7%	87.5%	40.0%	100.0%	80.0%	41.7%	66.7%	83.3%	100.0%
NHS Fylde & Wyre CCG													
Numerator	2	2	1	3	1	1	2	2	3	1	1	7	3
Denominator	2	3	1	3	2	1	2	5	4	2	2	10	5
Performance %	100.0%	66.7%	100.0%	100.0%	50.0%	100.0%	100.0%	40.0%	75.0%	50.0%	50.0%	70.0%	60.0%
NHS Greater Preston CCG													
Numerator	5	2	6	2	7	8	4	3	7	5	3	7	2
Denominator	6	6	6	4	7	10	4	4	7	5	3	7	2
Performance %	83.3%	33.3%	100.0%	50.0%	100.0%	80.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%
NHS Morecambe Bay CCG													
Numerator	0	1	0	4	0	2	3	4	3	6	1	3	1
Denominator	2	2	1	4	0	2	3	4	5	6	3	3	1
Performance %	0.0%	50.0%	0.0%	100.0%		100.0%	100.0%	100.0%	60.0%	100.0%	33.3%	100.0%	100.0%
NHS West Lancashire CCG													
Numerator	0	0	2	2	1	0	1	1	2	1	1	5	2
Denominator	1	0	3	4	2	0	1	1	3	1	1	5	2
Performance %	0.0%	-	66.7%	50.0%	50.0%		100.0%	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%
Out of area													
Numerator	0	0	0	2	2	0	0	1	0	1	2	1	1
Denominator	0	1	1	2	2	0	0	1	1	2	2	2	1
Performance %	-	0.0%	0.0%	100.0%	100.0%			100.0%	0.0%	50.0%	100.0%	50.0%	100.0%
Total Figure - 8 CCGs													
Numerator	22	24	29	25	25	31	26	25	24	25	22	32	21
Denominator	30	38	41	32	30	41	34	35	35	36	31	40	25
Performance %	73.3%	63.2%	70.7%	78.1%	83.3%	75.6%	76.5%	71.4%	68.6%	69.4%	71.0%	80.0%	84.0%

11. Adult Mental Health

11.1. Urgent Care

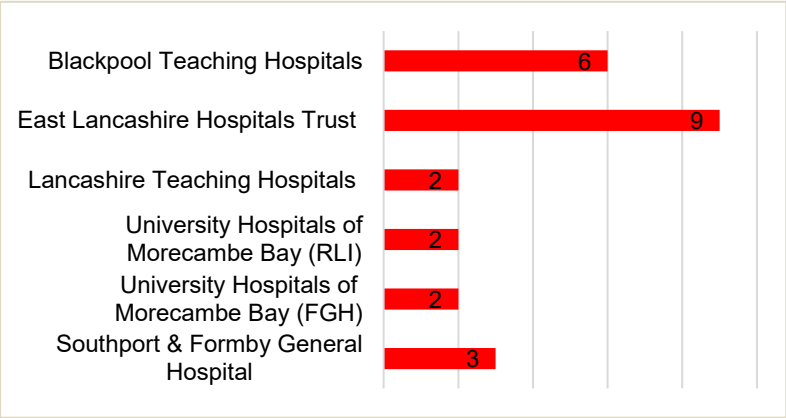
Mental Health A&E 4-hour Compliance in Q3



All Trusts have met the 4-hour compliance target in Q3. With significantly high levels of demand for MHLT in A&E and on the wards the maintenance of performance is encouraging regarding sustainability.

National Target – 95%
Local Target – 95%

Mental Health A&E 12-hour breaches in Q3

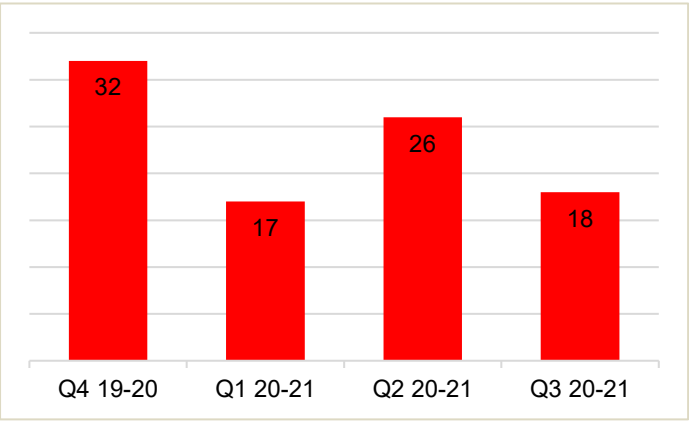


The total number of 12-hour breaches in Q3 were 24 which is a reduction from 46 in Q2. The improvements to the urgent care pathway continue to be sustained, despite the continued increase in demand for MH activity within A&E departments.

National Target – 0
Local Target – 0

11.2. Mental Health Detentions

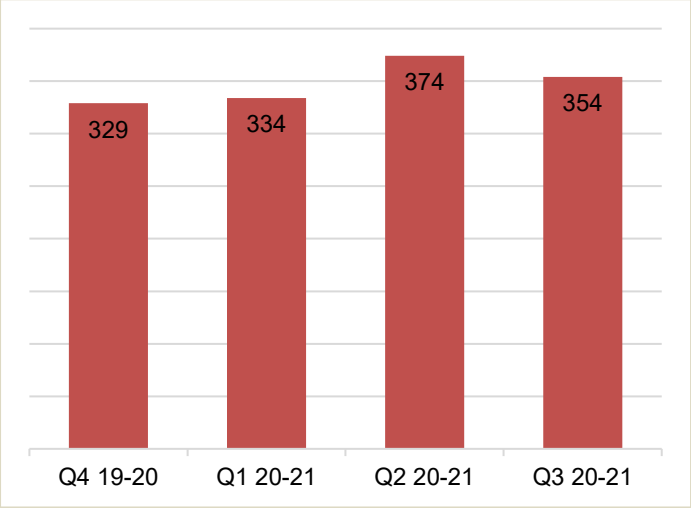
Number of Section 136 24-hour Breaches in Q3



There were 18 136 breaches in Q3, this is a significant reduction from Q2. Analysis indicates that significant improvements have been made in performance compared to pre-August 2019, and more moderate improvements since April 2020.

National Target – 0
Local Target – 0

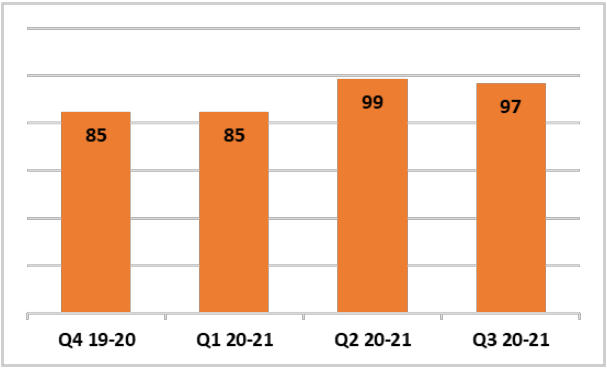
Number of Section 136 Detentions in Q3



National Target – N/A
Local Target – N/A

There were 354 section 136 detentions in Q3 which is a reduction from Q2. Work is continuing to take place with the Police regarding appropriate section 136 detentions. Continued focus on flow and discharges from LSCFT and contract beds to ensure timely placement for patients in 136 suites requiring a bed. Each week breaches of patients in 136 suites are reviewed by a small working group from LSCFT, police and local authorities for the AMHP services to undertake root cause analysis and action plan for improved performance.

Number of Detentions under the Mental Health Act in Q3

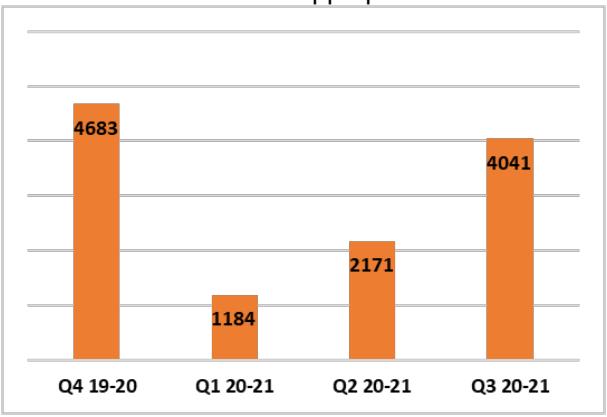


The number of detentions under the mental health act in Q3 were 97 this is a slight reduction from Q2.

National Target – N/A
Local Target – N/A

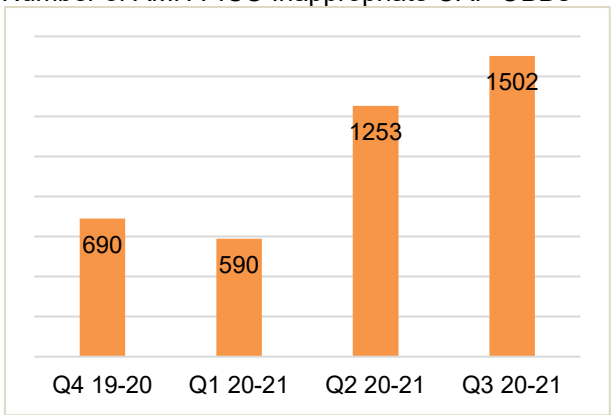
11.3. Out of Area Placements

Number of AMH Acute Inappropriate OAP OBDs



National Target – N/A
Local Target – N/A

Number of AMH PICU Inappropriate OAP OBDs

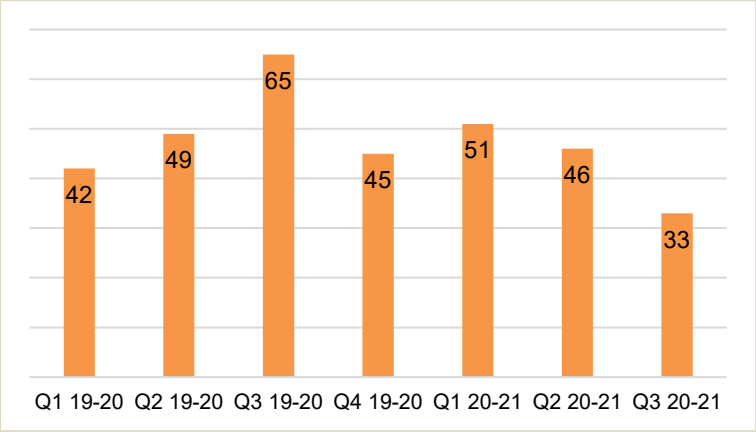


We have remained reliant on Out of Area Placements (OAPs) to meet acute mental health bed demand, through a mix of long-term capacity gap and shorter-term bed closures to facilitate COVID safe wards. Niche Consultancy identified that, in order to meet demand, the Trust requires an additional 27 Older Adult beds and 10 PICU beds. Furthermore, 28 acute functional beds across adult and older adult wards have been closed to enable COVID secure

Wards. This sum of a 65 bed deficit is commensurate with the number of Inappropriate Out of Area Placements in the latter half of 2020/21.

11.4. Suicide Prevention

Annual View of Suspected Suicides by Q3 20/21

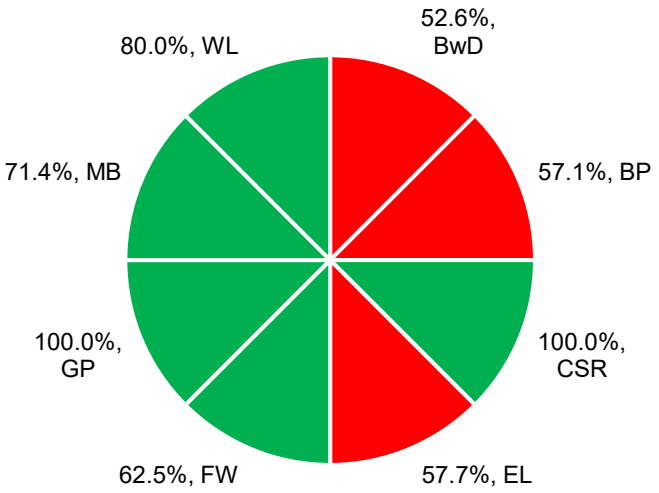


National Target – 10% reduction on previous year
Local Target – TBD

There has been a decrease in the number of suicides in Q3 when compared to Q2. The number of suspected suicides were 10% lower in 2020/21 than in 2019/20. The ICS are continuing to monitor suicides through the bespoke dashboard that has been created. Suicide prevention work is also being reported directly to execs. The team have been awarded a HSJ award for the Real Time Surveillance dashboard.

11.5. Early Intervention to Psychosis

% of people who started treatment within 2 weeks of referral in Q3 - All ages

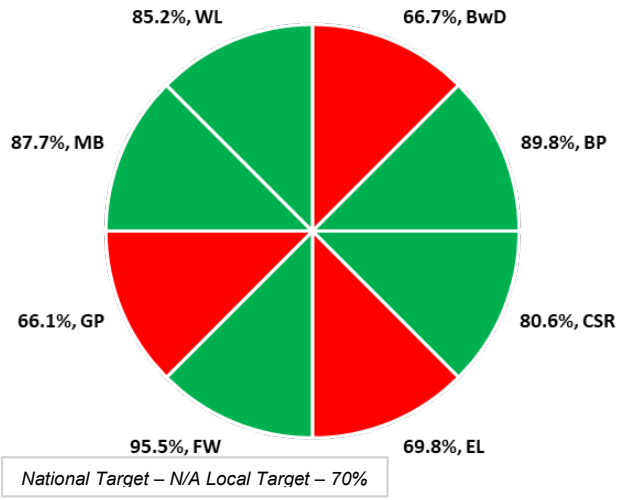


National Target – 60% (20-21)
Local Target – 56% (19-20)

The EIP target was not met in Q3 in 3 CCG areas. There have been some concerns about staffing in the EIP teams however that is being addressed and all CCG areas are working to improve performance against the 2 week referral target. The Individual Placement and Support (IPS) service has been in place in Lancashire since September 2021. The IPS team is fully integrated with the EIP team and is exceeding employment targets, this is a piece of work that should be recognised across the system.

11.6. Older Adult

Memory Assessment Services Seen within 6-weeks Q3

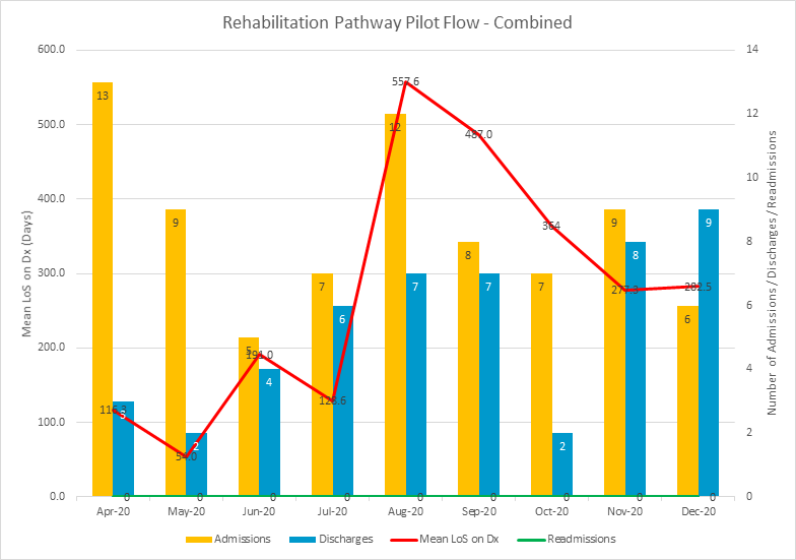


National Target – N/A Local Target – 70%

Service impacted by acute trust suspension of diagnostic testing. Recovery trajectories developed but Network looking to develop detail to a greater degree. Further social restrictions have impacted in Q3. 82.81% of people were seen within the 6-week time frame across Lancashire in February 2021 an increase from 67.32%, achieving the target of 70%. The average wait across Lancashire decreased to 4.1 weeks from 4.6 weeks in January. Staffing continues to be impacted by the COVID-19 pandemic with staff supporting vaccinations. Bank staff are being utilised where possible to support with initial assessments and Occupational Therapy (OT) assessments to reduce the impact on referral to diagnostic times. The team also continue to utilise the Attend Anywhere and telephone assessments. Duty has increased with calls, staff are being more proactive in chasing results, outcomes and actions. OT are completing home assessments where these are still required. Neuropsychology has recommenced and is supporting with virtual Adverse Childhood Experience (ACE) assessments and diagnosis delivery.

11.7. Rehab

Rehabilitation Pathway Pilot Flow - Combined



Admission peaks in April and August correlating with the beginning of the IS pilot and the opening of Skylark. Increasing numbers of discharges as the pilot progresses, despite dip in October 2020 0 readmissions across Q1, Q2 and Q3. Success in discharging long stay patients in August and September 2020.

11.8. IAPT

11.8.1. There have been some data quality issues with IAPT data for Q2 and Q3 which means that IAPT charts have not been produced on the ICS dashboard. The data should be available mid-May 2021. Prevalence continues not to be met across the Lancashire ICPs, due to the service not receiving the required number of referrals. LSCFT have further developed their website to promote the IAPT service and are targeting audiences through social media. The referral criteria for Long Term Conditions has been agreed and implemented which should help to increase prevalence for this cohort of patients.

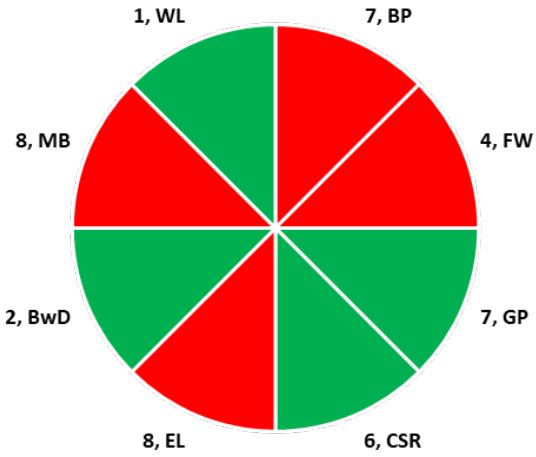
11.8.2. 6-week RTT achieved consistently at 91.97%. 18-week RTT also achieved consistently at 100%. The average Recovery for Service was 57.9%. The highest recovery was seen in Lancaster & Morecambe team at 64% and Ribble Valley at 63.6%. Pendle was the only team to miss recovery at 46.4%. However, there are no significant patterns in low recovery for the Pendle area and they met the Q3 and Year to date recovery targets. Clinical Leads have been asked to support the Pendle team and review discharges to ensure appropriateness and review if additional support offered would support clients into recovery.

11.8.3. The overall waiting list size was 5,452 at the end of February compared to 5,412 end of January. 158 people equating to 2.90% were stepped-up to step 3, having already received therapy at step 2. Now at 89% of seasonal average. There were 0 people were waiting over 26 weeks for their therapy appointment. The outliers continued to be Fylde & Wyre and Lancaster & Morecambe which have longer waits at Step 3, these are continuing to be addressed with waiting list initiatives including CBT Sub-contract with Dr Julian & Birchwood Counselling.

12. Learning Disabilities and Autism Q4

12.1. Non-Secure Inpatient

Number of Patients Against Trajectory - Q4

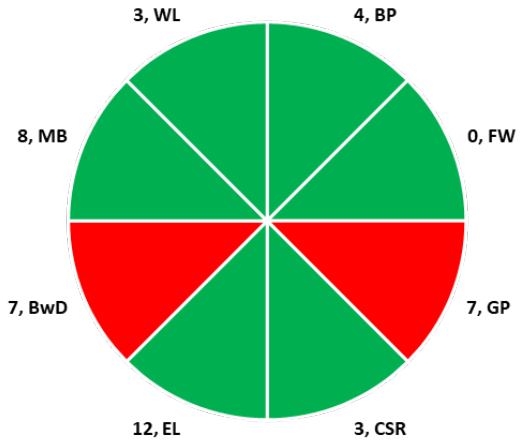


Position at the end of Q4 was 43 against our trajectory of 37 (+6). All CCG in-patients will be reviewed as part of a deep dive by the regional team during April to understand the barriers to discharge.

National Target – Q3 < 39 (not meeting target overall)
Local Target – Q3 20-21 end trajectory of 37

12.2. Secure Inpatient

Number of Patients Against Trajectory - Q4

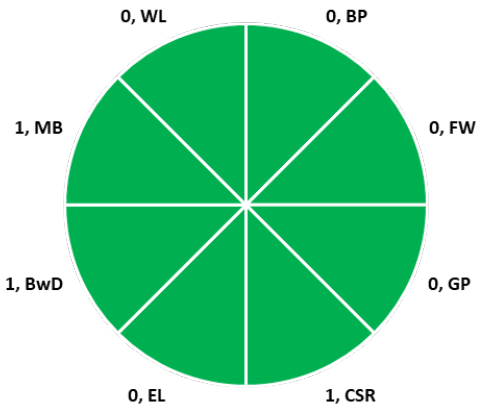


Position at the end of Q4 was 44 which was met.

National Target – N/A
Local Target – Q3 < 47

12.3. Children and Young People Tier 4 Beds

Number of Patients Against Trajectory - Q4



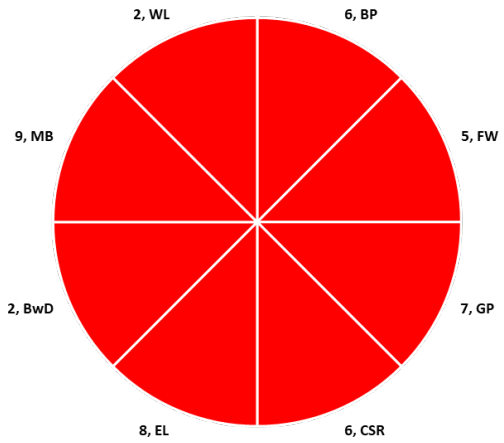
Position at the end of Q4 was 3 against our trajectory of 5 (-2)

National Target – N/A
Local Target – Q4 < 5

12.4. Care (Education) and Treatment Reviews

Trajectory is 75%. 100% compliance for both adults and CYP both for pre-admission and post admission reviews; 91% and 89% for non-secure and secure repeat reviews during Q4.

12.5. Quality Oversight Visits



Quality Oversight Visits continue to take place every 8 weeks. The majority are completed virtually due to COVID and this will be reviewed going forward as things change. CCGs chair the meetings and copies of the reports are then shared back with the ICS team.

National Target – N/A
Local Target – N/A

12.6. Annual Health Checks

Trajectory of 67% for 20-21. Data currently available as at the end of Q2. Work underway with BI to provide a monthly position to each CCG Primary Care Commissioner.

12.7. LeDeR

12.7.1. KPI requirements:

- Notification to be allocated to a reviewer within 3 months.
- Review to be completed and signed off within 6 months of notification.
- KPIs are reported and tracked at the LeDeR Steering Group.

12.7.2. **Review and Refresh of the LeDeR programme:** Hosting arrangements for the LeDeR platform will change on 01/06/2021. The transition to the new platform is still to be finalised. The LeDeR Steering Group is up to date with arrangements and will take steps to mitigate any impact on review completion as a result of the transition.

12.7.3. The National LeDeR programme is considering the outcome of the Ipsos MORI independent research alongside the Oliver McGowan review findings and an options paper has been prepared for the National Programme board around future delivery.

12.7.4. **LeDeR 2021 – Learning from Lives and Deaths – People with a Learning Disability and Autistic People** has now been published. National webinars and a local workshop will take place in April for LAC's to discuss the refreshed guidance and identify next steps.

13. Recommendation

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

Roger Parr
Deputy Chief Officer / CFO from Pennine Lancashire CCGs

Kathryn Lord
Chief Nurse from Pennine Lancashire CCGs

Healthier Lancashire & South Cumbria

Appendix 1: Over 52 week waiters for L&SC CCGs split by Specialty and Provider

SPECIALITY	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	EAST LANCASHIRE HOSPITALS NHS TRUST	SPIRE FYLDE COAST HOSPITAL	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	ALL OTHER	TOTAL	% TOTAL
100 : GENERAL SURGERY	868	376	357	241	116	27	139	**2,124**	18.5%
101 : UROLOGY	240	64	166	101	66	15	82	**734**	6.4%
110 : TRAUMA & ORTHOPAEDICS	370	874	403	360	521	15	131	**2,674**	23.3%
120 : EAR, NOSE & THROAT (ENT)	585	373	145	170	24	58	58	**1,413**	12.3%
130 : OPHTHALMOLOGY	487	153	127	167	226	37	9	**1,206**	10.5%
140 : ORAL SURGERY	-	-	-	1	-	-	-	**1**	0.0%
150 : NEUROSURGERY	-	-	-	-	-	-	-	-	0.0%
160 : PLASTIC SURGERY	473	-	6	-	-	21	4	**504**	4.4%
170 : CARDIOTHORACIC SURGERY	-	-	35	-	-	3	-	**38**	0.3%
300 : GENERAL MEDICINE	478	-	-	-	-	-	-	**478**	4.2%
301 : GASTROENTEROLOGY	34	28	60	10	11	9	74	**226**	2.0%
320 : CARDIOLOGY	25	1	89	3		11	-	**129**	1.1%
330 : DERMATOLOGY	1	93	11	-		-	-	**105**	0.9%
340 : THORACIC MEDICINE	-	9	3	-		-	-	**12**	0.1%
400 : NEUROLOGY	668	-	-	-	-	-	10	**678**	5.9%
410 : RHEUMATOLOGY	-	4	1	-	-	-	-	**5**	0.0%
430 : GERIATRIC MEDICINE	9	-	-	-	-	-	-	**9**	0.1%
502 : GYNAECOLOGY	92	24	63	45	111	172	90	**597**	5.2%
X01 : ALL OTHER TREATMENT FUNCTIONS	223	84	53	5	4	155	39	**563**	4.9%
TOTAL	**4,553**	**2,083**	**1,519**	**1,103**	**1,079**	**523**	**636**	**11,496**	100.0%
% TOTAL	39.6%	18.1%	13.2%	9.6%	9.4%	4.5%	5.5%	100.0%	

Appendix 2: Over 52 week waiters for L&SC Providers split by Specialty

SPECIALTY	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	EAST LANCASHIRE HOSPITALS NHS TRUST	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	TOTAL	% TOTAL
140 : ORAL SURGERY	127	367	1,809	148	2,451	19.6%
110 : TRAUMA & ORTHOPAEDICS	407	365	408	909	2,089	16.7%
100 : GENERAL SURGERY	362	247	933	391	1,933	15.5%
120 : EAR, NOSE & THROAT (ENT)	146	173	610	398	1,327	10.6%
130 : OPHTHALMOLOGY	127	167	497	160	951	7.6%
400 : NEUROLOGY	-	-	686	-	686	5.5%
101 : UROLOGY	171	103	257	68	599	4.8%
160 : PLASTIC SURGERY	6	-	503	-	509	4.1%
300 : GENERAL MEDICINE	-	-	493	-	493	3.9%
X01 : OTHER	54	5	248	104	411	3.3%
150 : NEUROSURGERY	-	-	378	-	378	3.0%
502 : GYNAECOLOGY	63	45	98	26	232	1.9%
301 : GASTROENTEROLOGY	62	10	40	30	142	1.1%
320 : CARDIOLOGY	97	3	28	1	129	1.0%
330 : DERMATOLOGY	11	-	1	96	108	0.9%
170 : CARDIOTHORACIC SURGERY	35	-	-	-	35	0.3%
340 : THORACIC MEDICINE	3	-	-	10	13	0.1%
430 : GERIATRIC MEDICINE	-	-	9	-	9	0.1%
410 : RHEUMATOLOGY	1	-	-	4	5	0.0%
TOTAL	**1,672**	**1,485**	**6,998**	**2,345**	**12,500**	**100.0%**
% TOTAL	13.4%	11.9%	56.0%	18.8%		

Appendix 3: ICS Performance Metrics (separate attachment)

Appendix 4: ICS Safeguarding Deep Dive (separate attachment)

Performance Metrics

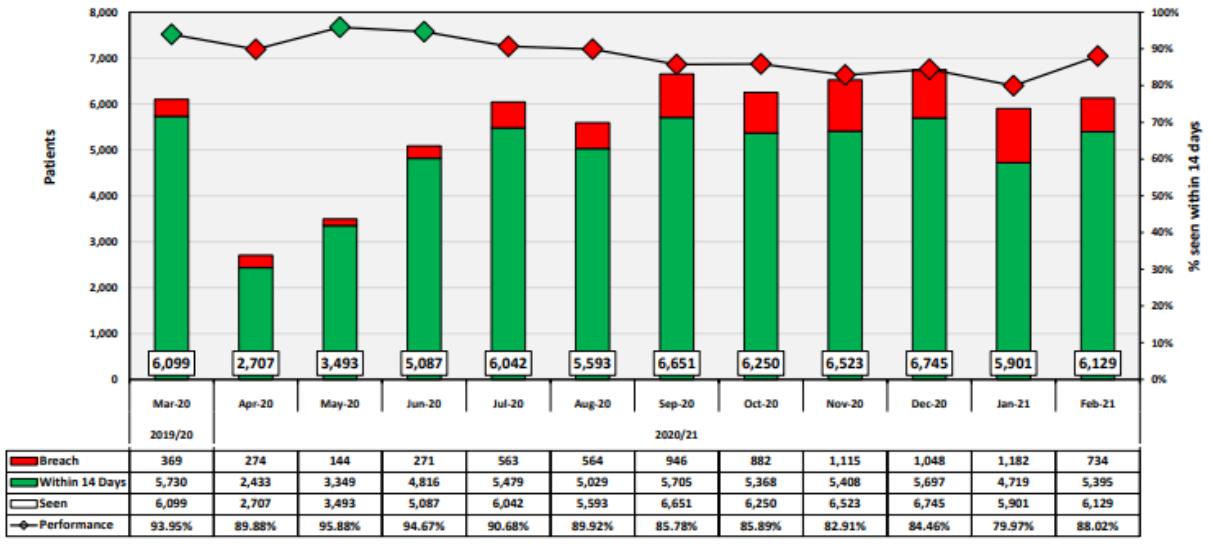
Appendix 3

	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 – Feb 21

2 Week Wait Referrals (93% Standard)

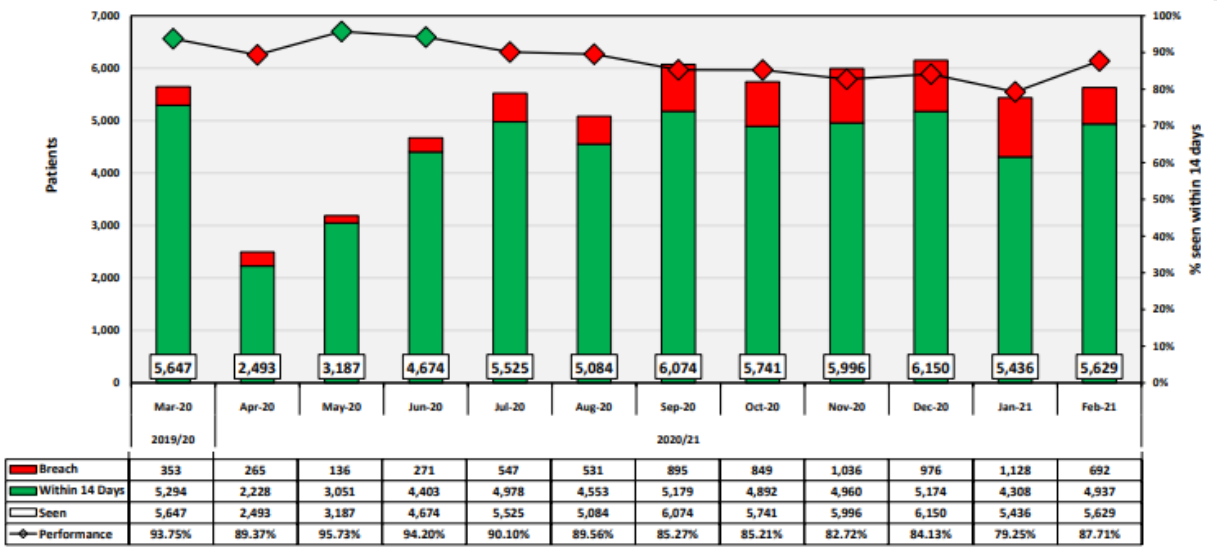
Cancer Alliance CCGs (Mar-20 to Feb-21)



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	369	274	144	271	563	564	946	882	1,115	1,048	1,182	734
Within 14 Days	5,730	2,433	3,349	4,816	5,479	5,029	5,705	5,368	5,408	5,697	4,719	5,395
Seen	6,099	2,707	3,493	5,087	6,042	5,593	6,651	6,250	6,523	6,745	5,901	6,129
Performance	93.95%	89.88%	95.88%	94.67%	90.68%	89.92%	85.78%	85.89%	82.91%	84.46%	79.97%	88.02%

CCG	Feb-21			Mar-20 to Feb-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	472	9	98.09%	4,964	314	93.67%
BCCG	515	15	97.09%	6,280	264	95.80%
CSRCCG	655	93	85.80%	7,358	892	87.88%
ELCCG	1,102	43	96.10%	12,678	823	93.51%
FWCCG	785	39	95.03%	8,817	553	93.73%
GPCCG	865	135	84.39%	9,044	1,102	87.82%
MBCCG	1,272	349	72.56%	12,937	3,677	71.58%
WLCCG	463	51	88.98%	5,142	467	90.92%
CA CCGs	6,129	734	88.02%	67,220	8,092	87.96%

Cancer Alliance Providers (Mar-20 to Feb-21)



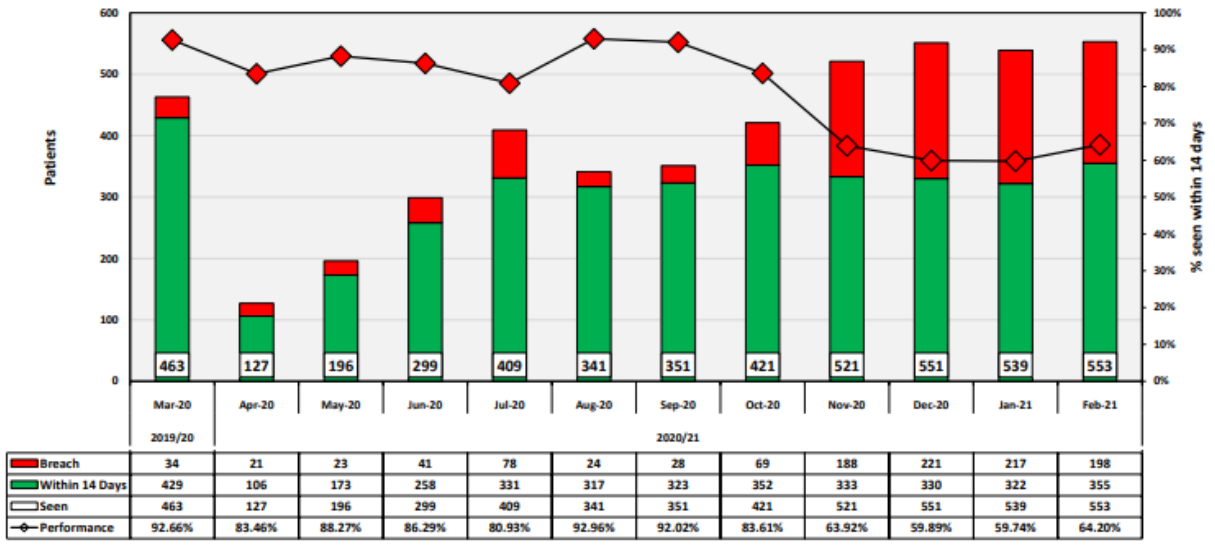
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	353	265	136	271	547	531	895	849	1,036	976	1,128	692
Within 14 Days	5,294	2,228	3,051	4,403	4,978	4,553	5,179	4,892	4,960	5,174	4,308	4,937
Seen	5,647	2,493	3,187	4,674	5,525	5,084	6,074	5,741	5,996	6,150	5,436	5,629
Performance	93.75%	89.37%	95.73%	94.20%	90.10%	89.56%	85.27%	85.21%	82.72%	84.13%	79.25%	87.71%

Provider	Feb-21			Mar-20 to Feb-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	1,132	27	97.61%	13,513	493	96.35%
ELHT	1,491	43	97.12%	16,661	1,035	93.79%
LTH	1,642	243	85.20%	17,657	2,197	87.56%
UHMB	1,364	379	72.21%	13,805	3,954	71.36%
CA Providers	5,629	692	87.71%	61,636	7,679	87.54%

% 2 Weeks Cancer – Urgent Referral (Breast) – Feb 21

2 Week Wait Breast Symptomatic Referrals (93% Standard)

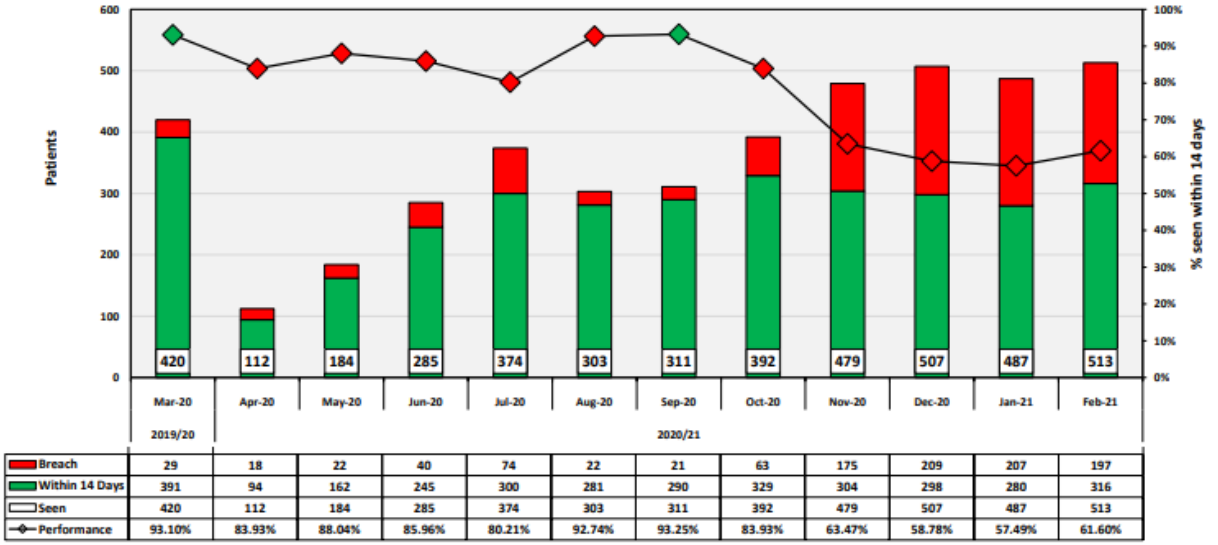
Cancer Alliance CCGs (Mar-20 to Feb-21)



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	34	21	23	41	78	24	28	69	188	221	217	198
Within 14 Days	429	106	173	258	331	317	323	352	333	330	322	355
Seen	463	127	196	299	409	341	351	421	521	551	539	553
Performance	92.66%	83.46%	88.27%	86.29%	80.93%	92.96%	92.02%	83.61%	63.92%	59.89%	59.74%	64.20%

CCG	Feb-21			Mar-20 to Feb-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	49	0	100.00%	590	36	93.90%
BCCG	63	3	95.24%	566	39	93.11%
CSRCCG	80	42	47.50%	557	253	54.58%
ELCCG	100	1	99.00%	1,252	71	94.33%
FWCCG	53	11	79.25%	503	78	84.49%
GPCCG	83	55	33.73%	574	281	51.05%
MBCCG	86	81	5.81%	426	332	22.07%
WLCCG	39	5	87.18%	303	52	82.84%
CA CCGs	553	198	64.20%	4,771	1,142	76.06%

Cancer Alliance Providers (Mar-20 to Feb-21)



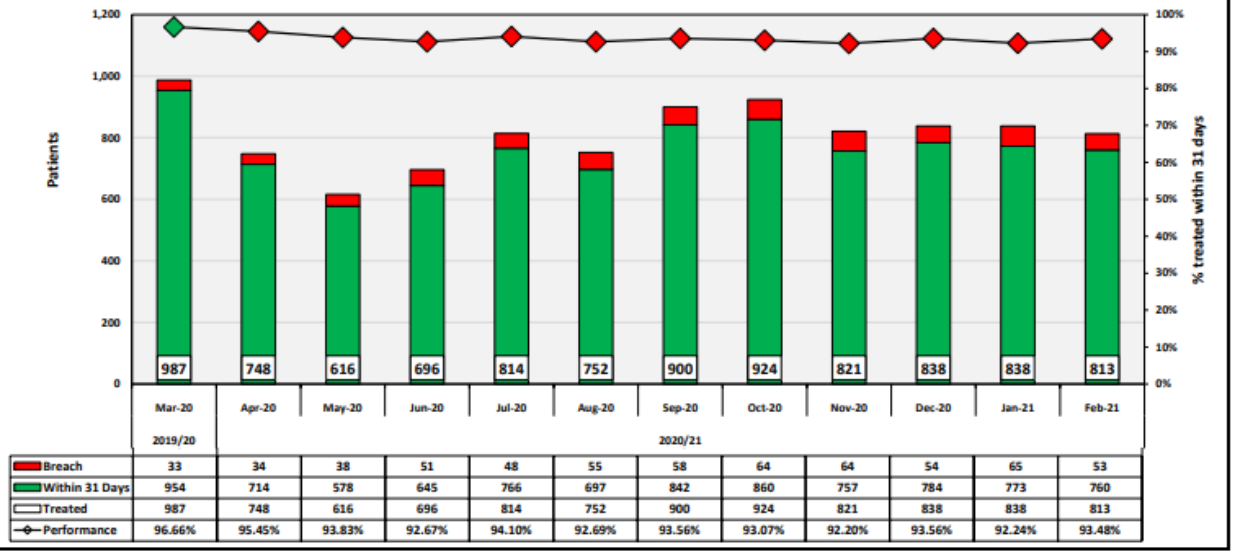
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	29	18	22	40	74	22	21	63	175	209	207	197
Within 14 Days	391	94	162	245	300	281	290	329	304	298	280	316
Seen	420	112	184	285	374	303	311	392	479	507	487	513
Performance	93.10%	83.93%	88.04%	85.96%	80.21%	92.74%	93.25%	83.93%	63.47%	58.78%	57.49%	61.60%

Provider	Feb-21			Mar-20 to Feb-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	105	2	98.10%	1,003	69	93.12%
ELHT	147	1	99.32%	1,748	79	95.48%
LTH	165	102	38.18%	1,160	561	51.64%
UHMB	96	92	4.17%	456	368	19.30%
CA Providers	513	197	61.60%	4,367	1,077	75.34%

% 31 Day Cancer – Definitive Treatment – Feb 21

31 Day First Treatment (96% Standard)

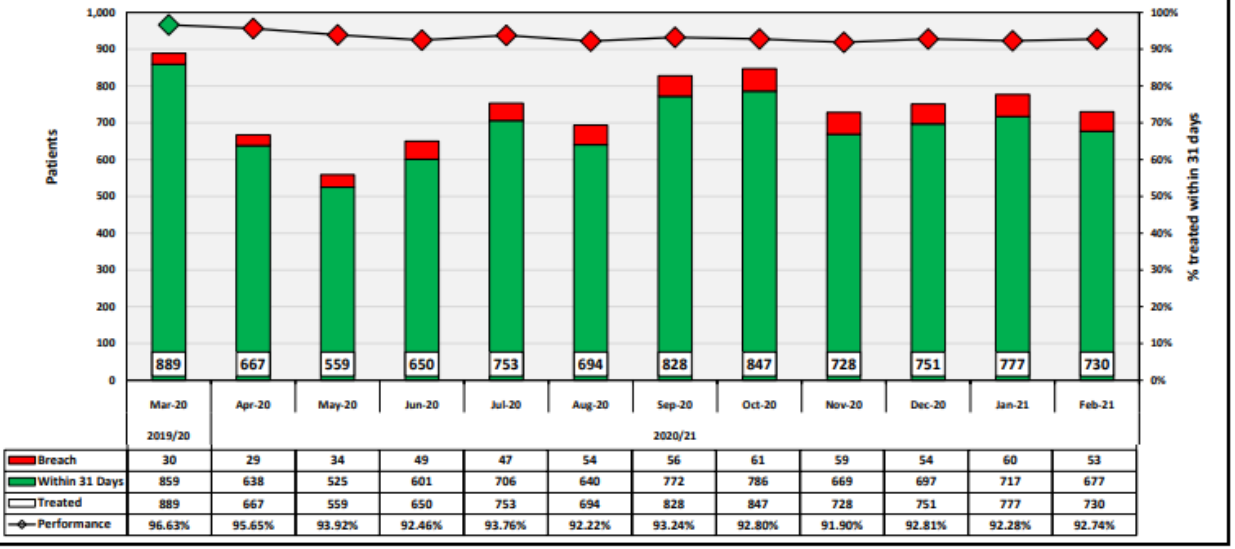
Cancer Alliance CCGs (Mar-20 to Feb-21)



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	33	34	38	51	48	55	58	64	64	54	65	53
Within 31 Days	954	714	578	645	766	697	842	860	757	784	773	760
Treated	987	748	616	696	814	752	900	924	821	838	838	813
Performance	96.66%	95.45%	93.83%	92.67%	94.10%	92.69%	93.56%	93.07%	92.20%	93.56%	92.24%	93.48%

CCG	Feb-21			Mar-20 to Feb-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	51	3	94.12%	705	33	95.32%
BCCG	92	6	93.48%	1,117	63	94.36%
CSRCCG	93	10	89.25%	1,032	86	91.67%
ELCCG	157	8	94.90%	1,860	107	94.25%
FWCCG	109	13	88.07%	1,356	74	94.54%
GPCCG	75	10	86.67%	963	81	91.59%
MBCCG	165	3	98.18%	2,077	149	92.83%
WLCCG	71	0	100.00%	637	24	96.23%
CA CCGs	813	53	93.48%	9,747	617	93.67%

Cancer Alliance Providers (Mar-20 to Feb-21)



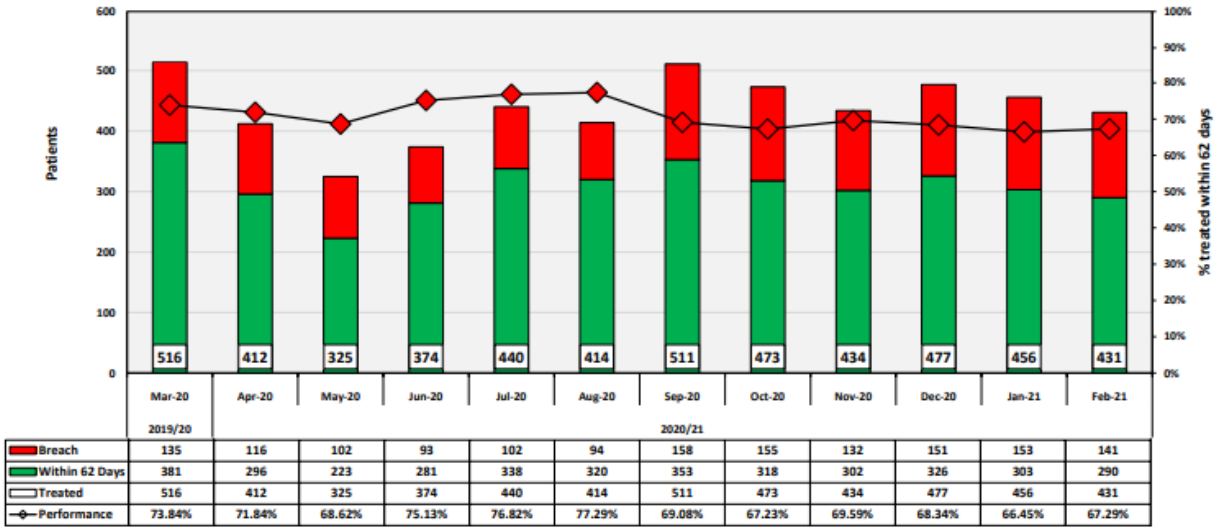
	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	30	29	34	49	47	54	56	61	59	54	60	53
Within 31 Days	859	638	525	601	706	640	772	786	669	697	717	677
Treated	889	667	559	650	753	694	828	847	728	751	777	730
Performance	96.63%	95.65%	93.92%	92.46%	93.76%	92.22%	93.24%	92.80%	91.90%	92.81%	92.28%	92.74%

Provider	Feb-21			Mar-20 to Feb-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	146	5	96.58%	2,067	56	97.29%
ELHT	187	8	95.72%	2,171	104	95.21%
LTH	250	37	85.20%	2,944	326	88.93%
UHMB	147	3	97.96%	1,691	100	94.09%
CA Providers	730	53	92.74%	8,873	586	93.40%

% 62 Day Cancer – Feb 21

62 Day Classic Performance (85% Standard)

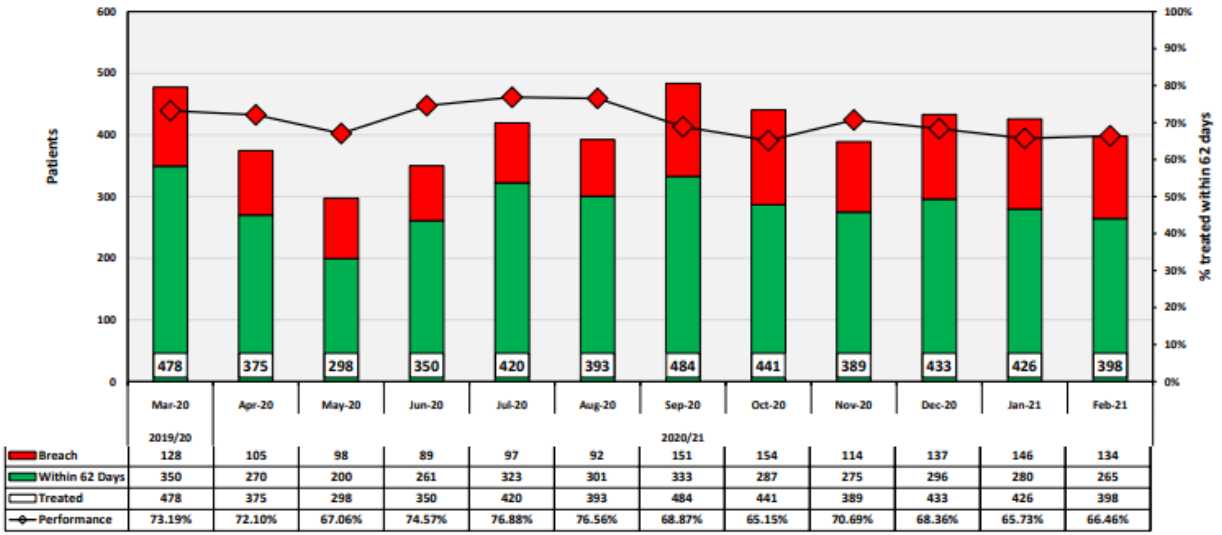
Cancer Alliance CCGs (Mar-20 to Feb-21)



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	135	116	102	93	102	94	158	155	132	151	153	141
Within 62 Days	381	296	223	281	338	320	353	318	302	326	303	290
Treated	516	412	325	374	440	414	511	473	434	477	456	431
Performance	73.84%	71.84%	68.62%	75.13%	76.82%	77.29%	69.08%	67.23%	69.59%	68.34%	66.45%	67.29%

CCG	Feb-21			Mar-20 to Feb-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	27.0	4.0	85.19%	363.0	82.0	77.41%
BCCG	47.0	21.0	55.32%	558.0	152.0	72.76%
CSRCCG	57.0	25.0	56.14%	572.0	179.0	68.71%
ELCCG	76.0	18.0	76.32%	973.0	266.0	72.66%
FWCCG	61.0	22.0	63.93%	776.0	194.0	75.00%
GPCCG	45.0	19.0	57.78%	544.0	189.0	65.26%
MBCCG	85.0	24.0	71.76%	1,137.0	385.0	66.14%
WLCCG	33.0	8.0	75.76%	340.0	85.0	75.00%
CA CCGs	431.0	141.0	67.29%	5,263.0	1,532.0	70.89%

Cancer Alliance Providers (Mar-20 to Feb-21)



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
Breach	128	105	98	89	97	92	151	154	114	137	146	134
Within 62 Days	350	270	200	261	323	301	333	287	275	296	280	265
Treated	478	375	298	350	420	393	484	441	389	433	426	398
Performance	73.19%	72.10%	67.06%	74.57%	76.88%	76.56%	68.87%	65.15%	70.69%	68.36%	65.73%	66.46%

Provider	Feb-21			Mar-20 to Feb-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	88.0	27.5	68.75%	1,181.5	281.5	76.17%
ELHT	97.5	20.5	78.97%	1,202.0	302.0	74.88%
LTH	123.5	58.0	53.04%	1,413.0	511.0	63.84%
UHMB	89.0	27.5	69.10%	1,085.0	348.5	67.88%
CA Providers	398.0	133.5	66.46%	4,881.5	1,443.0	70.44%

% 6 Week Diagnostic Waiters – Feb 21

ICS Level: Lancashire & South Cumbria

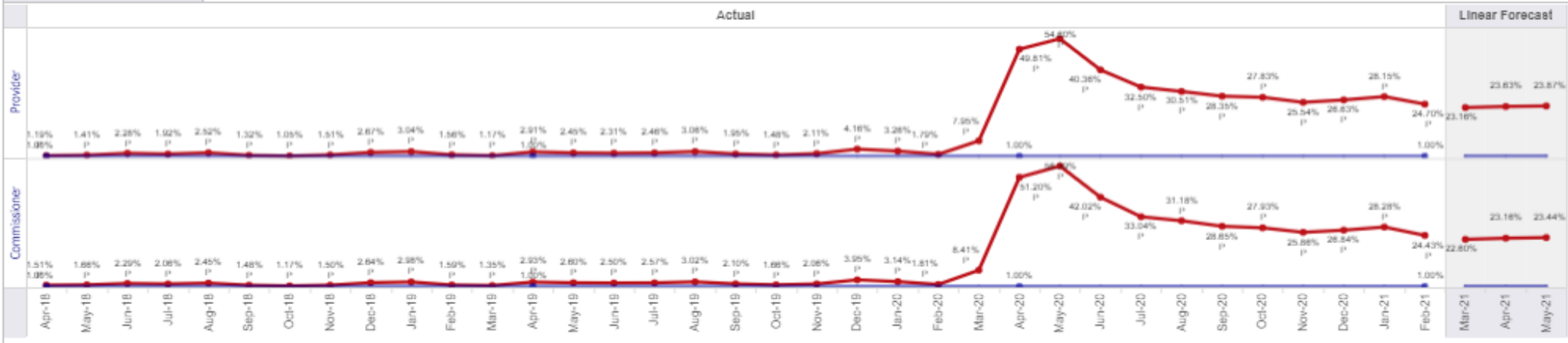
% of patients waiting 6 weeks or more for a diagnostic test

	Provider		YTD
Value	Feb-21	24.70%	32.37%
Target	Feb-21	1.00%	1.00%
Forecast	Mar-21	23.16%	32.37%

	Commissioner		YTD
Value	Feb-21	24.43%	32.61%
Target	Feb-21	1.00%	1.00%
Forecast	Mar-21	22.60%	32.61%

% Waiters 6 Wks Diagnostics

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	24.43% Feb-21	3.71% Feb-21	9.92% Feb-21	43.47% Feb-21	36.94% Feb-21	23.14% Feb-21	30.17% Feb-21	17.82% Feb-21	20.89% Feb-21	15.75% Feb-21
Provider	24.70% Feb-21									

	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	9.92% Feb-21	3.71% Feb-21	36.98% Feb-21	36.91% Feb-21	43.47% Feb-21	31.82% Feb-21	28.55% Feb-21	23.14% Feb-21	21.97% Feb-21	20.38% Feb-21	17.82% Feb-21	15.75% Feb-21

% Incomplete 18 weeks RTT – Feb 21

ICS Level: Lancashire & South Cumbria

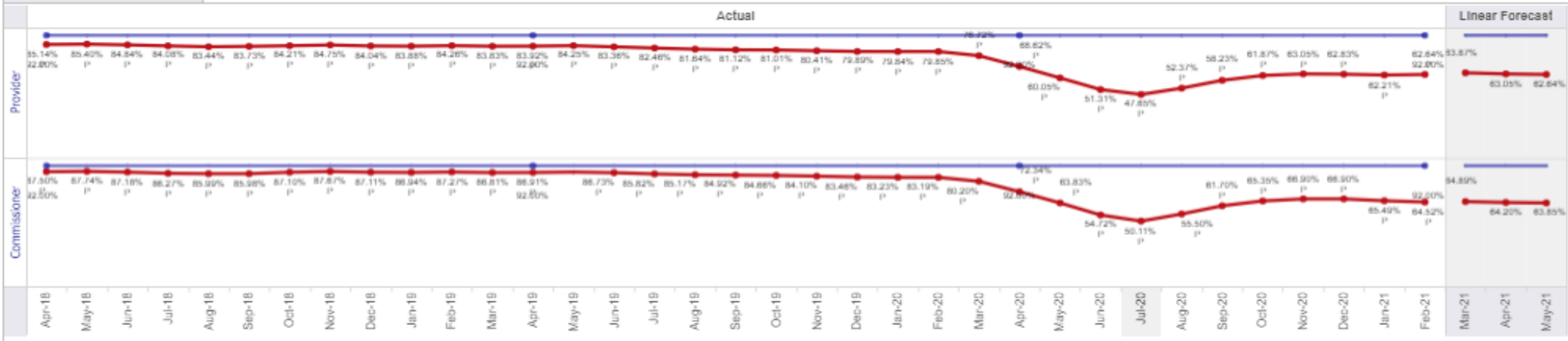
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

	Provider		YTD
Value	Feb-21	62.64%	59.27%
Target	Feb-21	92.00%	92.00%
Forecast	Mar-21	63.87%	59.27%

	Commissioner		YTD
Value	Feb-21	64.52%	62.69%
Target	Feb-21	92.00%	92.00%
Forecast	Mar-21	64.89%	62.69%

% 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	64.52% Feb-21	60.32% Feb-21	59.79% Feb-21	54.29% Feb-21	61.28% Feb-21	66.26% Feb-21	60.44% Feb-21	75.37% Feb-21	72.62% Feb-21	72.34% Feb-21

	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	62.64% Feb-21	59.79% Feb-21	60.32% Feb-21	59.89% Feb-21	62.43% Feb-21	54.29% Feb-21	60.12% Feb-21	60.75% Feb-21	66.26% Feb-21	72.97% Feb-21	72.47% Feb-21	75.37% Feb-21	72.34% Feb-21

Total number of Incompletes RTT – Feb 21

ICS Level: Lancashire & South Cumbria

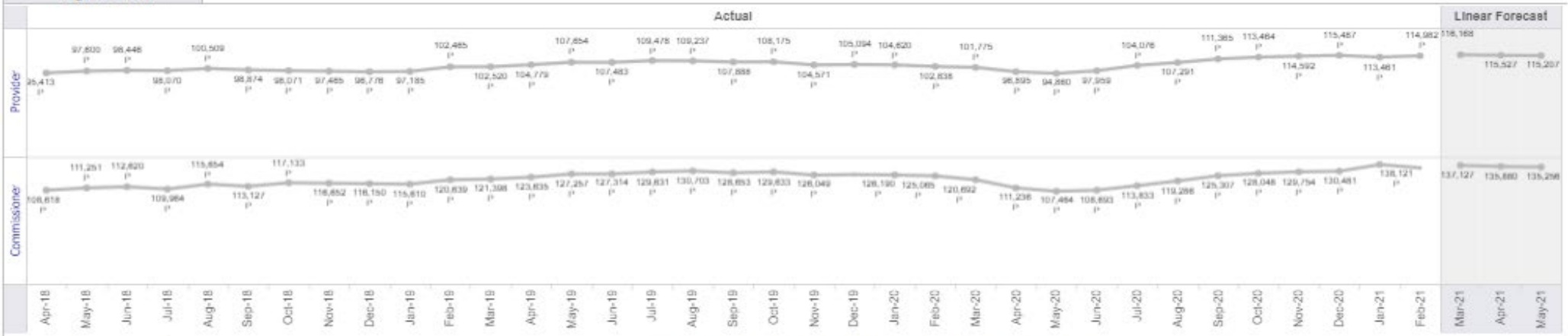
Total Number of Incompletes under and above 18 weeks RTT

	Provider	
Value	Feb-21	114,982
Target	Feb-21	
Forecast	Mar-21	116,168

	Commissioner	
Value	Feb-21	134,251
Target	Feb-21	
Forecast	Mar-21	137,127

Total no. of Incompletes RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Lancashire & South Cumbria

Commissioner: 134,251 Feb-21

Provider: 114,982 Feb-21

Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
24,002 Feb-21	26,943 Feb-21	44,326 Feb-21	34,538 Feb-21	18,444 Feb-21	28,576 Feb-21	28,210 Feb-21	36,324 Feb-21	7,870 Feb-21

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
26,943 Feb-21	24,002 Feb-21	15,653 Feb-21	18,885 Feb-21	44,326 Feb-21	13,848 Feb-21	14,728 Feb-21	18,444 Feb-21	10,984 Feb-21	25,340 Feb-21	28,210 Feb-21	7,870 Feb-21

Over 52 week waiters – Mar 21

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

Midlands and Lancashire Commissioning Support Unit

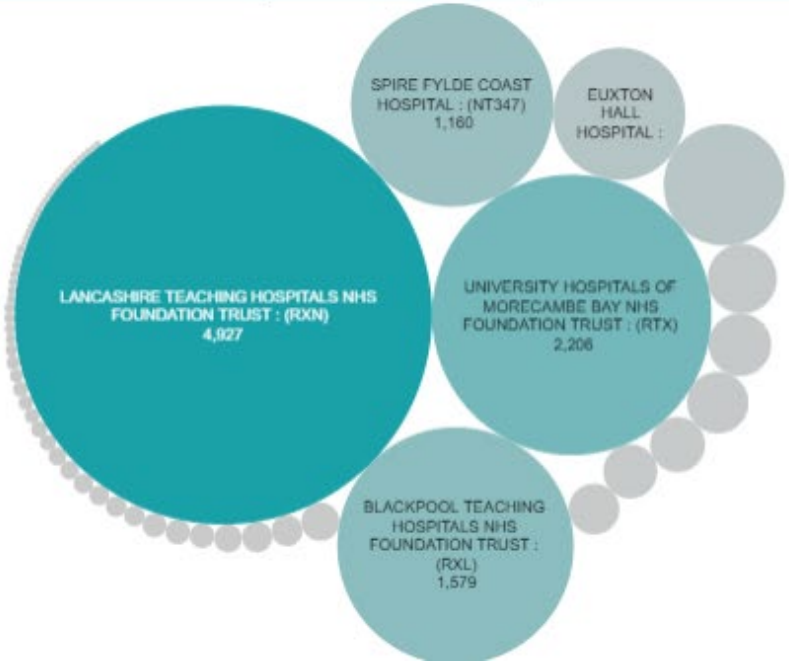
** Areas shaded blue can be used as filters by selecting them.

Referral to Treatment : 2) Incomplete pathways for all patients (unadjusted);
CCG Name : *;
Fiscal Year : 2020-21; Fiscal Month : March 2021
Provider: All; Treatment Function: All

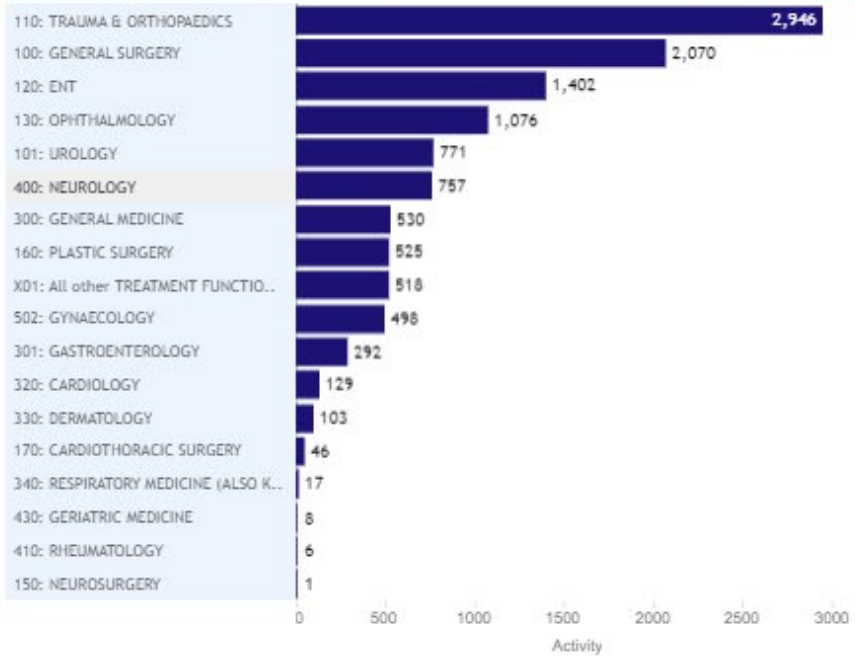
Select Referral To Treatment Pathway: 2) Incomplete pathways for all patients (unadjusted)

Fiscal Year: 2020-21 | Select Month: March 2021 | Select Measure: 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

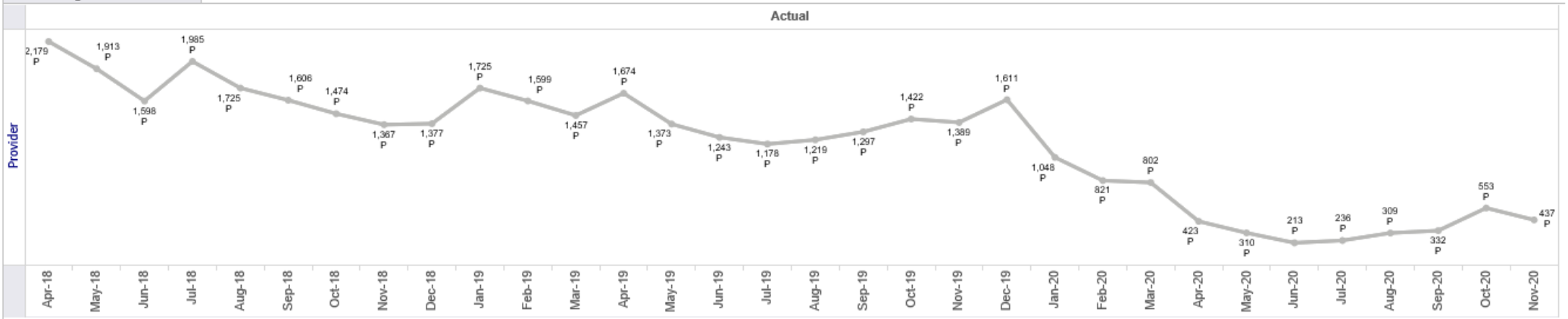
ICS Level: Lancashire & South Cumbria

Amb: 30 Min Handover Delays

	Provider		YTD
Value	Nov-20	437	2,813
Target	Nov-20		
Forecast	Dec-20		

Amb: 30 Min Handover Delays

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

ICS	Bay Health & Care Partners Provider	Central Lancashire Provider	Fylde Coast Provider	Pennine Lancashire Provider
Lancashire & South Cumbria	137 Nov-20	31 Nov-20	129 Nov-20	140 Nov-20

Provider	Bay Health & Care Partners UHMB	Central Lancashire LTH	Fylde Coast BTH	Pennine Lancashire ELHT
437 Nov-20	137 Nov-20	31 Nov-20	129 Nov-20	140 Nov-20

A&E : <4 Hour Waits % All Types – Apr 21

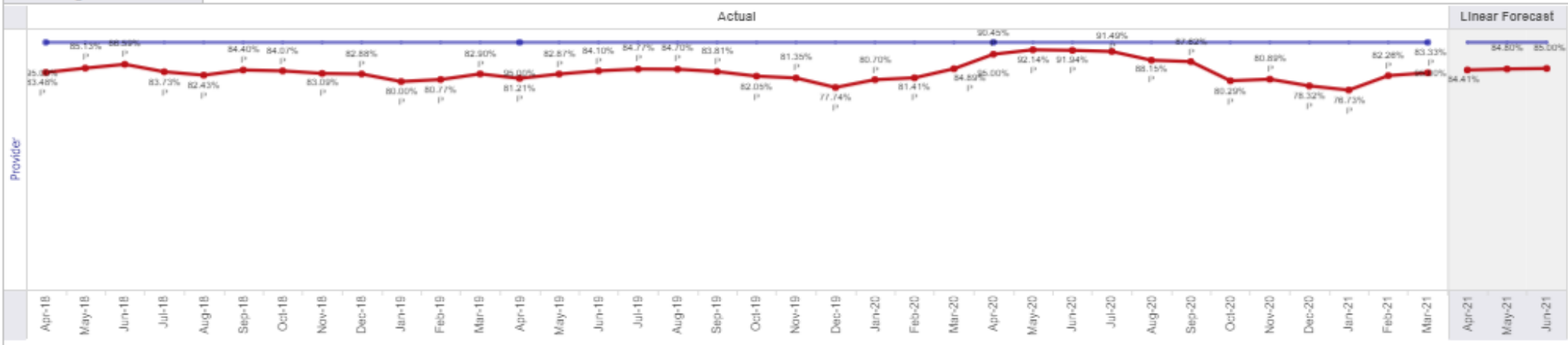
ICS Level: Lancashire & South Cumbria

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

	Provider		YTD
Value	Mar-21	83.33%	85.18%
Target	Mar-21	95.00%	95.00%
Forecast	Apr-21	84.41%	85.18%

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

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations			
	Bay Health & Care Partners Provider	Central Lancashire Provider	Fylde Coast Provider	Pennine Lancashire Provider
Lancashire & South Cumbria	85.03% Mar-21	81.04% Mar-21	82.02% Mar-21	85.52% Mar-21
Provider	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire
83.33% Mar-21	UHMB	LTH	BTH	ELHT
	85.03% Mar-21	81.04% Mar-21	82.02% Mar-21	85.52% Mar-21

Early Intervention Psychosis - % in 2 Weeks – Feb 21

ICS Level: Lancashire & South Cumbria

% First episode of psychosis within two weeks of referral

% EIP Within 2Wks Referral

Organisation

ICS	Integrated Care Partnerships \ Integrated Care Organisations				
Lancashire & South Cumbria	Bay Health & Care Partners Commissioner	Central Lancashire Commissioner	Fylde Coast Commissioner	Pennine Lancashire Commissioner	West Lancashire Commissioner
0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21

Commissioner								
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% Feb-21		0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21	0.00% Feb-21

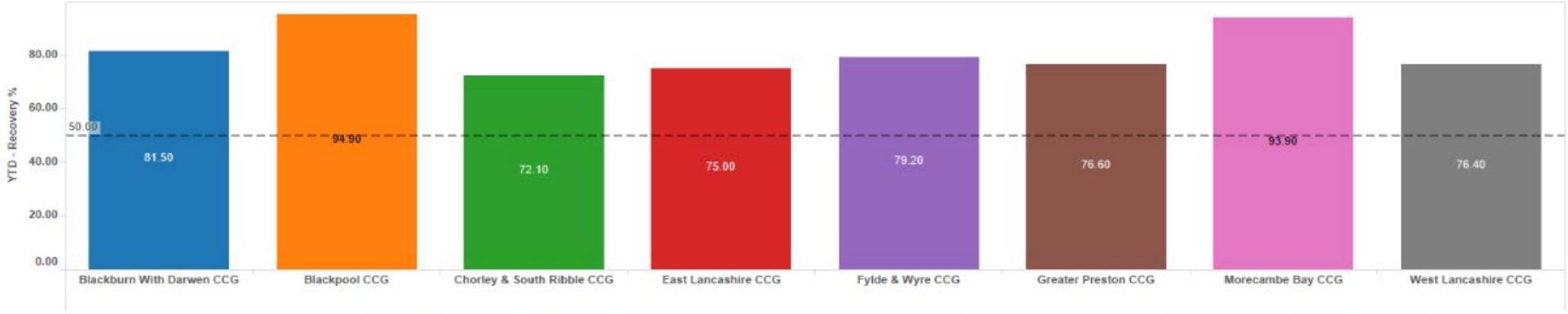
Aristotle xi

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	Recovery %

Selected Area: Lancashire
Financial Year: 2020-21
The graph shows year to date figures for Recovery %. 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	September	October	November	December	January
Blackburn With Darwen CCG	48.00	54.00	56.00	62.00	58.00	172.00	96.00	84.00	53.00	132.00
Blackpool CCG	56.00	50.00	54.00	51.00	54.00	196.00	156.00	114.00	62.00	156.00
Chorley & South Ribble CCG	48.00	44.00	51.00	52.00	48.00	124.00	99.00	86.00	49.00	120.00
East Lancashire CCG	48.00	58.00	50.00	51.00	56.00	136.00	90.00	72.00	45.00	144.00
Fylde & Wyre CCG	48.00	54.00	51.00	62.00	47.00	124.00	114.00	84.00	58.00	150.00
Greater Preston CCG	48.00	49.00	50.00	49.00	52.00	144.00	99.00	92.00	45.00	138.00
Morecambe Bay CCG	49.00	53.00	61.00	59.00	61.00	192.00	138.00	106.00	58.00	162.00
West Lancashire CCG	47.00	61.00	56.00	49.00	63.00	128.00	108.00	74.00	37.00	141.00

Data from NHS Digital Quarterly Extracts

CCG Name	Q1
Blackburn With Darwen CCG	52.000
Blackpool CCG	53.000
Chorley & South Ribble CCG	48.000
East Lancashire CCG	51.000
Fylde & Wyre CCG	51.000
Greater Preston CCG	49.000
Morecambe Bay CCG	54.000
West Lancashire CCG	55.000

Appendix 4

Healthier Lancashire & South Cumbria

Safeguarding – Deep Dive

Margaret Williams
28 April 2021

When reading this slide pack....

There are a number of considerations to note:-

- Deep dive undertaken to provide system leaders with a level of insight and assurance of what is known, what continues and what is expected to impact delivery of Safeguarding functions in Covid restoration period.
- Partners have adapted and diligently kept ‘check’ points in place and worked in new ways to maintain statutory delivery throughout Covid.
- Populations have responded differently to each of the phases of Covid pandemic including the stages of lockdown/response levels. Therefore for safeguarding much remains unknown

Content ....

- What is Safeguarding
- ICS Health Partnership Safeguarding Priorities
- General Themes
- Hot spots
- Good practice
- Mitigation
- Governance and Escalation wrap around

What do we mean by Safeguarding....

Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect.

It is an integral part of providing high-quality health care.

The NHS is dedicated in ensuring that the principles and duties of safeguarding children, young people, and adults at risk are holistically, consistently and conscientiously applied with the wellbeing of all, at the heart of what we do.

We are dedicated to ensuring that the principles and duties of safeguarding children and adults are applied every time a citizen accesses the NHS making every contact count.

https://www.england.nhs.uk/safeguarding/

In law……

NHS Constitution, Children Act 1989, 2004, Children and Families Act 2014, Children and Social Care Act 2017, Working Together to Safeguard Children 2018, Intercollegiate, Care Act 2014, Domestic Abuse Bill, Mental Capacity Act 2005 and more ……

ICS Health Partnership Safeguarding Priorities ……..

Priorities & Work Plan

- Statutory
- Looked After Children
- Violence Reduction Unit
- Domestic Abuse
- Mandatory Training
- System learning to improve
- Service Change
- Covid Impact on Safeguarding, restoration & proactive response planning
- Workforce Health & Wellbeing, succession planning & Development

Context in which we have & continue to work…

- Health in and out of level 4/5 command and control between March 2020 to March 2021
- Multiple emergency directives in law i.e. Visiting directives, pause of CHC
- Ensuring statutory requirements upheld – MCA,(mental capacity act) DNACPR (Do not actively attempt cardiac arrest),LAC (Looked After Children), quality monitoring, safeguarding reviews (Child Safeguarding Practice Reviews, Safeguarding Adult Reviews, Domestic Homicide Reviews)
- Operationally flexing and responding i.e. regulated care, MCA best practice, EoL pathway, decisions for those who lack capacity, vulnerable populations.
- Complexity of case management, strategy meetings, optimise safe care and experience (all age)
- Response bespoke to Placed based population demographics, often response varies
- Preparing for key changes in statute i.e. Domestic Abuse Bill, Liberty Protection Safeguards

General Themes .(1)...

- Reduced visibility – not brought in, or late presentation to health services due to fear of Covid, increase in referrals into Child Safeguarding Practice Reviews where neglect is a theme
- Bereavement impact – variable service touch points or access, 3rd sector reduced service offer
- Profile of incidents changed in some instances i.e. suicide linked to domestic abuse, safer sleep increased vulnerability
- Increased complexity when care package or placements breaking down. Access to services impacting most vulnerable i.e. Looked After Children stuck on acute wards
- Extensive challenge to the regulated care providers, particularly those supporting adults with high risk behaviours, complex dementia and those with high nursing needs.
- Down side to new ways of working - reduced face to face contact with children and adults from health services means potential abuse and neglect not identified, or opportunity to disclose lessened.

General Themes…(2)……

- Adverse experiences - families in crisis, break down in care, heightened risk of mental health in the home, reduced social network, immediate and longer term physical health impact of isolation on shielded, vulnerable groups
- Variability of impacts across each ICP area, bespoke to populations, data quantification required i.e. % increases in reported Child Sexual Exploitation, Child Criminal exploitation
- Experience impact, trauma, short, longer term unknown
- Inequality impact unknown- living in poverty, experience for sleeping rough, living with a learning disability
- Adverse experiences – physical & mental health impact unknown, individuals living with LTCs, receiving therapy and or treatment i.e. chemotherapy

HOT SPOTS Summary....

Statutory	Children & YP	Adults	Partnerships
Safer sleeping –increased risk in lock down (All levels)	Breadth, themes and number of serious reviews (System)	Increase in Domestic Abuse 9% via Lancs Community Safety Partnership (All levels)	News ways of working – risk stratification i.e. infant face to face vs virtual (System)
Unregulated Placements for Looked After Children (LAC), out of areas placing (System)	LTH- 54% increase from Feb to March of Young people with MH presentation at ED (Place)	Regulated Care closures (Place)	Home Schooled Education and increased risk to Criminal/ Sexual Exploitation (National)
LAC reduced access to dental care (System)	Inequalities- BwD review of child poverty (Place)	Delay in planned service change i.e. Multi-agency Risk Assessment conference (MARAC)	Tier 4 access and outreach services. Diagnosable MH presentation or attachment disorder (system)
Dip in compliance in Mandatory Training including PREVENT (Place)	Violence Reduction unit- place based profiles of need (Place, System) Radicalisation on line increased referrals	LSCFT report increase in individuals with mental health presentations 1st time in under 30s (data quantification requested)	Regulated Care – CQC state increase in whistle blowing (National & System)

What we know & what's been done……..

Statutory

- Mandatory Training
  - Providers and CCGs reporting below standard
  - Recover plans in place
  - Refresh of how training delivered to be more intuitive to on line

- Looked After Children
  - Unregulated placements who are providing residential provision for children with complex needs and/or Looked After Children often placed in from other Local Authorities. Not known to local LA or CCG Team. Risk of exploitation, package breakdown and present to ED. From Oct 21, law will state under 16 year olds can not be placed in unregulated settings. Statutory partners to agree an assurance framework and escalation process, national fully aware.
  - Dental access, LAC routine checks not seen as risk and therefore poor or no access via lockdown, lost touch point and care intervention. Recommission of pathway currently being piloted

- Safer Sleep
  - Sudden Infant death rate similar to pre Covid though presentation changed. Less likely respiratory and infectious deaths (shielding) more risk of safer sleep deaths. Environmental stresses contributing including change in routine.
  - Huge campaign driven across system partners, region and nationally, much more will be visibly seen in relation to this in coming weeks/months.

What we know & what's been done……..

Children and Young People

Child Safeguarding Practice Reviews

- We currently have 22 Children's case reviews on going. Historical themes of abusive head trauma and disclosed pregnancy remain, new presentations include neglect (medical) and safer sleep
- ICS have set up a learning review network and a trauma informed group. Via MIAA we have secured a safety specialist to discuss and meet initially with system leads then wider group. This is to challenge they way we approach learning (all age learning)

Mental Health Presentations

- Requests for Tier 4 services and a combination of different assessed needs to access this, capacity of out reach services and availability of alternate high quality community placements has resulted in significant challenges.
- Increased presentation to ED reported in some areas, potentially linked to anxiety and return to education settings
- Pennine ICP report an approximate 60% increase in to East Lancs Child and Adolescent Service (ELCAS)

Violence Reduction Unit & Domestic Violence

- Needs assessment to each of the 12 District areas had been completed, this is supporting submission of bid into the Home Office to support additional activity. i.e Emergency Department Navigators and Trauma Informed practice across all agencies.

What we know & what's been done……..

Adults

Regulated Care

7 home closures total of 183 beds due to quality issues, financial, fire safety and owner retirement

- 3 homes - 56 beds Pennine
- 2 homes- 38 beds in MB
- 2 homes- 89 beds in Fylde

Significant support in to homes around ensuring safe good quality care, DNACPR, implementation of MCA and least restrictive practice as well as support for wider vaccinations for individuals lacking capacity.

Mental Health Presentations

- LSCFT have reported increase in presentations of eating disorders (Need to quantify)
- MH identified as a theme across all LSAB's and a partnership priority for Pan-Lancs
- Concerns around increased presentation of Self-neglect (anecdotally a theme, have asked for data from MASH)
- Have requested SIRG (serious incident review group) theme and link to safeguarding over last 12months

Service Delivery

- Multiple pilots and service delivery models have been delayed due to pandemic, such as MARAC, however system is now moving at pace to implement these
- LPS (Liberty Protection Safeguards) has remained a focus and work has continued in supporting the system to prepare and agree infrastructure for new ways of working
- The pending DA Bill my influence way we work and work is underway to prepare for this.

What we know & what's been done……..

Partnerships

- National picture verses System & Place
  - Many publications starting to be cascaded, show themes and potential synergies, but this is not always the case for our populations. Each Place slightly differing picture
  - Continuing to work closely with regional and national teams
  - Continuing to align narrative and quantify data sets to inform direction and decision making

- New Ways of working
  - Further evaluation needed i.e. LAC evaluate virtual assessment well in terms of uptake (less DNA), infant under 1 requiring consistency and risk stratification. Lessening opportunity to disclose and note signs of neglect

- Intelligence, ensuring focus in right areas
  - Over burden of reinstating multiple sub groups (need to check context, interface and deliverable)
  - Lack of partnership data has led to more reactive approach, need to start moving upstream.
  - Opportunity to redesign approach of sub groups to fit within ICS system and ensure consistency and reduce unwarranted variation.

What we know & what's been done……..

Partnerships

Channel

- Channel is the multi-agency arena where we manage individuals who have been radicalised but have not committed any offences (referred to as the pre-criminal space), Lancashire has seen a 153% increase in referrals last year compared to the previous year.
- 14% of these referrals were made by the NHS. This has also seen a move to more representation of young adults and an increase in people who have self-radicalising online whilst in lockdown. A deep dive in to this data is currently being undertaken to look for other thematic elements and links to mental health, autism, neglect etc.
- Designate professionals link across with Cumbria to ensure a ICS view and response

Home Schooled Education

- National publication linking home schooling associates and increased risk to exploitation specifically criminal. One local audit undertaken of 10 cases indicating a similar theme. Additional work with partners required. Local audit has led to a review of service offers to ensure equity of access

Learning themes

- In terms of individuals accessing, presenting with MH- Disengagement from services, Alcohol/substance misuse & dual diagnosis working, Non concordance with medication, Communication between services, Lack of appropriate risk assessments
- In terms of overall adult/children reviews, Domestic violence, Neglect, Substance misuse, Adverse Childhood experiences, Mental health
- The ICS learning group have agreed principles for delivery and engagement. We will aspire to move from a process driven system of learning to ‘system reform and change approach to learning. This group is in its infancy
- Local organisation learning remain in place

Good Practice..(1)..

- LAC team-Innovative adaptations to mitigate dental access issues i.e. provided dental packs for a children, including toothpaste, toothbrushes, age appropriate literature on teeth development, recommended brushing guidance, ages and stages of oral health.
- Pennine identified an increase in compliance around routine enquiry of domestic abuse and subsequent increase in disclosures, linked to women being seen alone due to Covid restrictions. Historically routine enquiry was unable to be done at certain times due to partners being present. Going forward the pathway has been updated to ensure that the first 15 minutes of their booking appointment and for the first 15 minutes at the 28 week must be on their own.

Good Practice...(2).

- An ICS survey monkey was carried out with looked after children, their carers and social care professionals regarding their experiences of virtual initial and review LAC health assessments. Feedback from this has resulted in virtual health assessments being part of the health assessment offer going forward to support engagement and access to health provision for our most vulnerable children. (child more likely to engage)
- Integrated working incorporating multi-professional working approaches whilst reducing multiple contacts
- Utilising audit to check local best practice following publication of national LeDeR report . UHMB Covid positive patient with learning disability noted to receive excellent care, no evidence of discriminatory practice.
- ICS commended for Violence Reduction Unit Governance Blueprint, shared nationally
- Blackpool Teaching Hospitals, HSJ award for Domestic abuse and sexual violence services
- CCGs Designate network, HSJ, patient safety award for Safeguarding initiative (partnership working)
- ICS feature VRU partnership working at Global event
- Successful bids to support set up of learning network and workforce HnW and resilience programme

Mitigation & escalation ....

- CCG statutory function remains
- Health Partnership Governance Structure via MOU (Safeguarding Health Executive)
- Multi agency partnership networks, Boards and collaborative (Region, System, place, Police, Local authority, probation, 3rd sector and more)
- Heads of Safeguarding and Designate Professionals Network
- Safeguarding System Business leads (all Providers, Public Health and CCG's)
- Statutory Organisations
- Teams, individuals
- Region assure who are involved at key meetings
- Priority areas of focus in place and active single/multiagency groups
- Strategic Risks profile and mitigation in place

Next Steps

- Deliver priorities and plans
- Quantify, national picture locally, quantify local picture across the system
- Map both data and narrative to support decision making, action to mitigate
- Continue to flex & respond- we are not yet through Covid, much is not known
- Continue to work with partners and support the evolving Safeguarding Provider Network
- Maintain rigour of due diligence during reform
- Escalation and reporting processes in place

Strategic Commissioning Committee (SCC)

Title of Paper	New Hospitals Programme Quarter 4 Board Report		
Date of Meeting	13 May 2021	Agenda Item	7

Lead Author	Rebecca Malin, Programme Director				
Contributors	N/A				
Purpose of the Report	Please tick as appropriate				
	For Information	X			
	For Discussion				
	For Decision				
Executive Summary	The purpose of this report is to provide an update on the New Hospitals Programme for the quarter 4 period, January – March 2021. The report includes progress on the developing governance, the revised critical milestones, progress against plan and the engagement activities taken place. This quarterly report is presented to the following Boards; • University Hospitals of Morecambe Bay FT • Lancashire Teaching Hospitals FT • East Lancashire Hospitals Trust • Blackpool Teaching Hospitals FT • Lancashire & South Cumbria FT • Integrated Care System (ICS) And the Strategic Commissioning Committee (SCC).				
Recommendations	It is recommended the SCC; 1. Note the progress undertaken in Q4. 2. Note the submission of key products to NHS England Checkpoint Assurance 1.				
Is this a level 1 or Level 2 decision?	Level 1	X	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:	Rebecca Malin				

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee (SCC)

NEW HOSPITALS PROGRAMME Q4 BOARD REPORT

1. Introduction

1.1 This report is the 2020/21 Quarter 4 update from the New Hospitals Programme (NHP).

2 Background

2.1 Board Colleagues will be aware that University Hospitals of Morecambe Bay NHS FT (UHMB) and Lancashire Teaching Hospitals NHS FT (LTHT) 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.

2.2 In line with this being an ICS programme and taking a whole view of the ICS geography, services and patient flows, East Lancashire Hospitals Trust (ELHT), Blackpool Teaching Hospitals NHS FT (BTHFT) and Lancashire and South Cumbria NHS FT (LSCFT) joined the programme throughout Q2-Q3.

2.3 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.

2.4 As a reminder, commissioners are statutorily responsible for the development and presentation of the Pre Consultation Business Case (PCBC) and providers/Trusts responsible for the development and submission of the capital business cases. The first of which is the Strategic Outline Case (SOC).

2.5 Members are reminded the Lancashire and South Cumbria (L&SC) New Hospitals Programme is one of 40 schemes in the national programme led by NHS England-Improvement (NHSEI) and the Department of Health and Social Care (DHSC). The Government has committed that all 40 new projects will be built by 2030 with the L&SC scheme scheduled for a build starting 2025.

3 Programme governance

3.1 Throughout Quarter 4, the governance structure has embedded with the Programme Management Group (PMG) ensuring a robust control function within the programme on behalf of the Strategic Oversight Group (SOG). A further two oversight groups have commenced the Finance and Infrastructure Oversight Group (FIOG) and the Estates Oversight Group (EOG), these are accompanied by the existing Clinical Oversight Group (COG) and the Communications and Engagement Group (CEOG). The Digital and Workforce groups remain. To avoid duplication and maximise the use of our resources, these will be aligned to existing ICS workstreams.

3.2 To support the oversight groups, operational working groups have been established to ensure the development of key products for the PCBC. The groups mirror the oversight groups and include an additional Commissioner Working Group and Business Case Production Group. During this period, the programme has benefited from commissioning leadership with Gary Raphael as the Commissioning Executive Lead.

3.3 With the oversight of the programme governance largely mobilised the operational working groups have been a significant undertaking in Quarter 4. These ensure the co-development of key products for the PCBC and SOC between the stakeholders, programme team and external advisors.

3.4 All key governance arrangements are now in place and as part of effective programme assurance, an external review of the mobilisation phase is scheduled for the next period.

4 National New Hospital Programme – NHSEI, DHSC

4.1 A round-table meeting took place on the 11 March 2021 attended by representatives of NHSEI (regional and national) and DHSC. All New Hospital schemes from across the country have taken part in such discussions which have been incredibly helpful and informative. As the national team embeds, further support and guidance is anticipated. The first output will be the phasing of all schemes anticipated at the end of April.

4.2 The round table meeting concluded there is flexibility on the timeline for submission of the Strategic Outline Case (SOC), originally due April 2022. As a result, the NHP has

taken time to review the timeline in particular allowing for greater time in this pre consultation phase. A revised target timeline is included in Appendix A. The timeline should be treated as draft pending discussion with the national team.

5 Progress against plan (for the period January – March 2021)

5.1 **Board development** – A first joint Boards session (UHMB and LTHT) was held this quarter with a focus on legal and policy duties, case for change and the proposed approach to communications and engagement. This was a highly engaged session and as part of our collaborative arrangements, planning for a series of joint Boards is underway. The Joint Committee of CCGs received a similar session in March 2021 with a specific focus on the process and associated assurance during this pre consultation period.

5.2 **Programme plan and critical path** - in light of the NHSE/I and DHSC round-table meeting the programme plan has been revised (Appendix A**)**. Throughout Q4, the programme remained on track against the critical path milestones. A weekly Operational Meeting has monitored internal progress against plan and maintained mitigations. The revised programme plan, critical path and risk register are now embedded within the programme and formally reviewed at the monthly Programme Management Group (PMG).

5.3 **Key programme products** – the programme has prepared the following draft products - case for change, critical success factors, framework model of care, emerging thinking regarding options and communications and engagement plan. Some of which will be presented to NHS England Checkpoint Assurance 1 in May 2021. The case for change has been developed with stakeholders through two workshops in Q4, attended by a wide range of stakeholders including patient representatives. Significant contributions have also been made through the oversight and working groups. The critical success factors have been derived from the objectives and challenges identified through those workshops and enhanced through the NHP governance structure. The Clinical Oversight Group has reviewed the framework model of care developed by NHP clinicians with stakeholders.

5.4 Members will appreciate this phase is iterative, allowing the programme team to test and challenge thinking and assumptions. Q1-Q2 2021/22 will see the programme further develop the emerging thinking around options with the long list of options workshops.

5.5 Interdependencies – members will recognise that with any complex programme such as this there are many interdependencies. This period has focused on bringing synergy between the NHP and the Provider Collaborative. In addition, work to develop clinical service models for the NHP will be closely aligned to the work of the ICS clinical strategy.

5.6 **Programme team** –this quarter has seen several core team members commence in post, including project managers, medical, nursing and operational leads, commissioning leads and a new Senior Responsible Officer, Jerry Hawker, ICS Executive Director. Clinical leadership in the programme includes a range of clinicians from across professions and organisations bringing a breadth of experience and perspective. The programme is internally led, externally supported bringing the skills that we do not currently have in the NHS. To ensure a legacy within the internal resource the programme team works in partnership with external advisors to bolster the skills of the internal team.

5.7 **Stakeholder management -** the Board will recognise there will be a breadth of stakeholders in such a programme. During Q4, there has been the launch of proactive internal and external communications including stakeholder updates with MPs and local authorities and communications and engagement webinars have been undertaken. A report was submitted and presented to the Lancashire Health Overview and Scrutiny Committees (HOSC) on 23 March 2021, the committee agreed to a joint HOSC, in the meantime, further work continues with the Blackpool, Cumbria and Blackburn with Darwen committees. Also this quarter, the NHP joined the Lancashire Local Enterprise Partnership (LEP) Health Sector Board and the programme is looking forward to working with Board partners over the coming period.

6 Public, patient and workforce communications and engagement

6.1 The NHP communications and engagement team met with regional and national colleagues from NHSEI and DHSC this period to present and review communication and

engagement plans. The NHP plan was well received and supported. The NHP will remain closely linked to the DHSC campaigns team and NHSEI communications team throughout the programme.

6.2 The NHP formally launched this quarter and engagement work is now building with a range of activities planned for the coming months. Of note is the launch of The Big Chat (engagement platform), which facilitates online conversations of which there has been significant uptake so far. This is one crucial element of listening to our 40,000+ employees and Trust members.

6.3 During Q4, there have been preparations taking place for the Colleague Summit on 11 May 2021, with Dr. Bertalan Mesko, PhD from the Medical Futurist being a keynote speaker. The summit will be repeated – date to be confirmed.

7 Next period – Q1 2021/22

7.1 The next period will see the progression of key products that make up the PCBC. In particular, the draft case for change will be presented to the Strategic Commissioning Committee (SCC (previously the Joint Committee of CCGs)) in May 2021 ahead of NHSE checkpoint assurance 1 which largely focuses on the strategic context for the NHP. Also throughout Q1 each clinical area will further develop their service model which provides input to the long list of options.

7.2 As the statutory body responsible for the PCBC, the SCC will formally approve the submission of products to the NHSE ahead of checkpoint assurance 1.

8 Conclusion

8.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 4 2020/21.

9 Recommendations

9.1 The SCC is requested to:

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee (SCC)

- Note the progress undertaken in Q4.
- Note the submission of key products to NHS England Checkpoint Assurance 1.

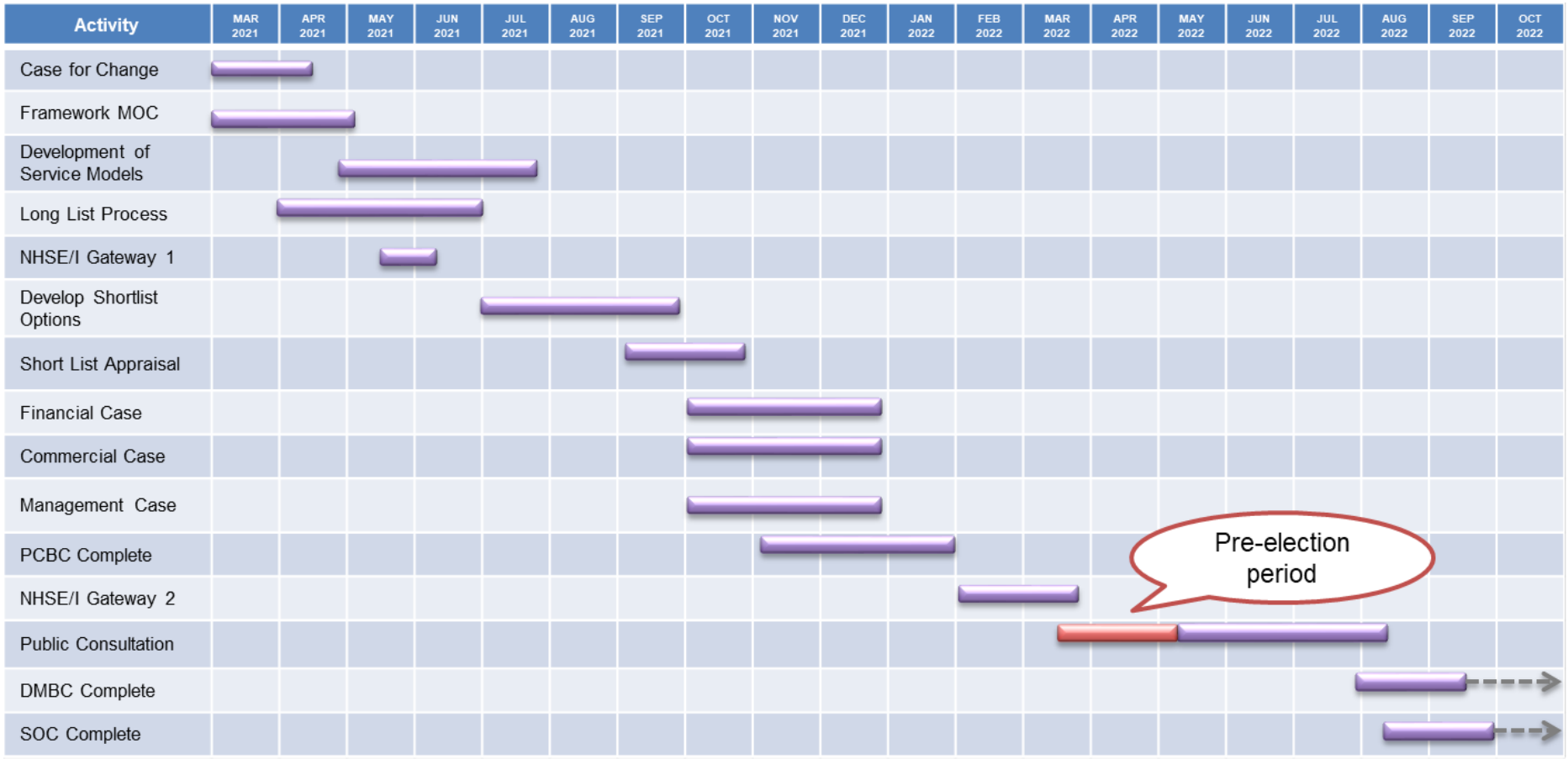
Rebecca Malin, Programme Director

April/May 2021

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee (SCC)

Appendix A – Target New Hospitals Programme Timeline



Strategic Commissioning Committee (SCC)

Title of Paper	Proposal for the development of the Acute Specialised Services workplan for Lancashire and South Cumbria Integrated Care System		
Date of Meeting	13th May 2021	Agenda Item	8

Lead Author	Nicola Adamson – Specialised Commissioning				
Contributors					
Purpose of the Report	Please tick as appropriate				
	For Information				
	For Discussion	✓			
	For Decision				
Executive Summary	This paper begins to set out a suggested programme of work in relation to Acute Specialised Services in Lancashire and South Cumbria (LSC) over the next 12 months. The paper is written in the context of the 2021 NHS White Paper *'The Future of Health and Care'* which articulates a vision around system based working for the NHS and integration; the Clinical Strategy, the New Hospitals Programme which will see the replacement of a significant proportion of Lancashire's Hospital estate; and the challenges of recovery from the Covid-19 pandemic.				
Recommendations	The SCC is asked to discuss the paper and agree the next steps.				
Next Steps	1. More detailed analysis of opportunities for increased local choice 2. Prioritisation and refinement of the transformational work plan 3. Establish working group to look at the future model of networks in LSC 4. Bring a further paper post legislation on future of commissioning.				
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:	Andrew Bennett, Executive Director of Commissioning				

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee (SCC)

Proposal for the development of an Acute Specialised Services workplan for Lancashire and South Cumbria Integrated Care System

1. Executive Summary

1.1 This is the first of a series of papers and is presented to enable an initial discussion on the programme of work required for acute specialised services.

1.2 There are 148 specialised services (205 service lines) which are commissioned by NHS England and NHS Improvement (NHSEI). This includes services such as chemotherapy and neonatology, provided in most hospitals, to rare conditions where patients must travel to only one or two hospitals in the country for their treatment and care.

1.3 Work is ongoing to prepare for a future system architecture subject to legislative change. NHS England's national specialised commissioning team has set out 5 pillars of work looking at how we can move towards the planning and delivery of services as close to place as possible. Timescales for this are unclear, with the possibility of a phased transition of specialised services to ICS level over 2022/23 and possibly into 2023/24.

1.4 As part of the above work, to explore how services could be planned across a system to provide more seamless care for patients without the boundaries of current commissioning arrangements, pathfinder projects are being developed. Lancashire and South Cumbria (LSC) is asked to look in the first instance at neuro-rehabilitation services in 2021/22.

1.5 £467,793,163 is spent on specialised acute services for the population of LSC of which £159,674,705 of the activity is provided outside LSC.

1.6 There are opportunities to expand choice for some services to provide access more locally for residents in LSC, including within cardiac, neurosciences, renal and haematology. This should be further explored with the Provider Collaborative Board to ascertain capacity and capability. The New Hospitals Programme may provide opportunities that would not otherwise be available.

1.7 There are significant national reviews planned in Women's and Children's services in which there will need to be consideration across LSC as to how and where we provide paediatric intermediate Critical Care, neonatal services and enhanced paediatric oncology shared care units (POSCU). Intermediate paediatric critical care and enhanced POSCUs are not currently commissioned in LSC. The neonatal critical care units do not currently meet minimum activity numbers as set out in national standards.

1.8 There is a need to look at the long-term provision of Adult Critical Care in LSC which falls significantly below national levels of intensive care beds per 100,000 population.

1.9 There is an urgent need to prevent and manage health inequalities and issues in accessing specialised services that have been highlighted during the Covid-19

pandemic, requiring collaborative approaches both within LSC and across the wider North West clinical networks.

2. Introduction

2.0 This paper introduces an early sense of the programme of work required for acute specialised services in Lancashire and South Cumbria (LSC), led by the Integrated Care System (ICS) and in doing so aims to cover the following:

2.1 Integration of Commissioning; subject to legislation, LSC will need to be clear on the process, capacity and capabilities required to take on a greater role in the direct specialised commissioning functions and the commissioning budget for defined and agreed services effectively for the LSC population. This provides opportunities to streamline patient pathways by removing barriers to integrated planning and delivery.

2.2 To begin to identify which services could also be provided in LSC in the future (that currently are provided from Manchester or Liverpool) and what factors need to be considered to do this safely and effectively.

2.3 To suggest that the configuration of specialised services in LSC needs consideration, maximising the opportunities of the extensive capital programme to create a sustainable platform for the delivery of tertiary hospital care underpinned by robust critical care provision. Working on the principle of single service models for LSC, services may need to be provided from one site to meet national standards for minimum numbers or co-location with other services, or, it may be possible to provide some services across more than one site and achieve good quality and outcomes.

2.4 To set out where there is a need for increased focus, potentially significant change and improvements in LSC specialised services.

2.5 To explain the need to ensure that the work set out in this paper is aligned to and part of the ICS Clinical Strategy and the Provider Collaborative Board; 3 of the 7 transformation priorities agreed by the PCB have pathways that include specialised services. As we restore activity lost during the Covid-19 pandemic, we need to ensure equity of access to specialised services across the North West and resilience in those services provided for the rarer conditions and often clinically high priority patients, whilst also ensuring that interdependencies of specialised services with urgent care and elective recovery are considered.

3. Integration of Commissioning

3.1 Subject to a draft bill, potentially in May 2021 - and Royal Assent subsequently - ICS are anticipated to be statutory bodies from April 2022. From April 2022, there will be greater flexibilities in the ICS on how and where specialised services are planned and delivered.

3.2 In line with the planning guidance, we are working to the principle that direct commissioning functions (including specialised commissioning) will be transferred or delegated to the ICS.

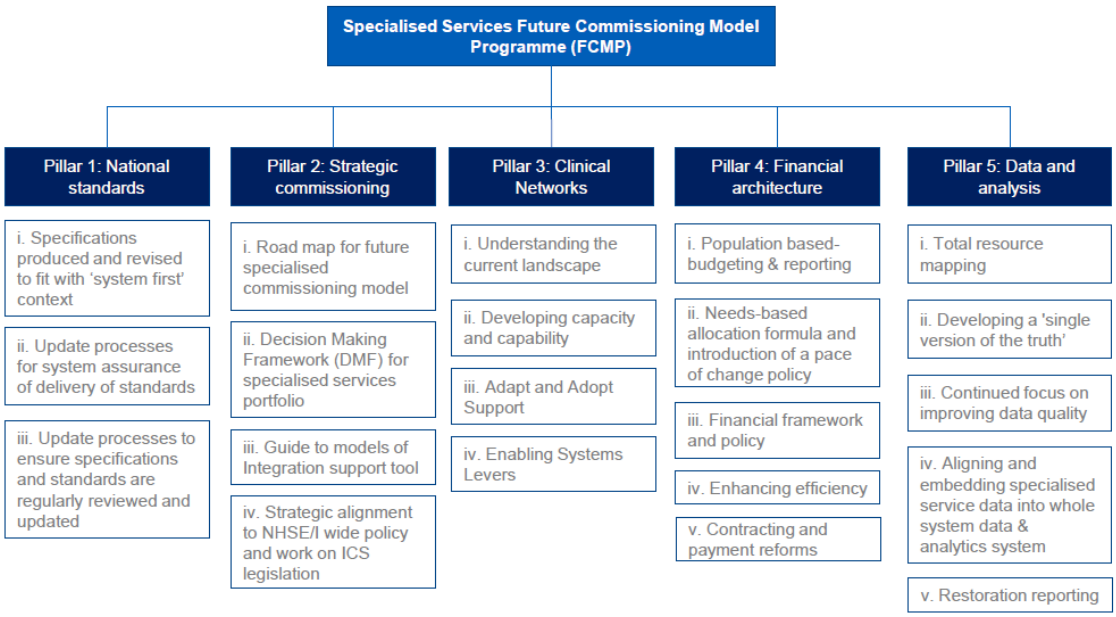
3.4 It is currently proposed that a Decision-Making Framework will be developed nationally to support decisions on what level specialised services could be planned and commissioned at; of the 205 Specialised Service lines that are currently commissioned by NHSEI

- Approximately 70 specialised services need to be commissioned nationally; these may be provided in only 1 or 2 hospitals in England (Tier4)
- Approximately 75 can be commissioned regionally i.e. across the North West (NW); this may be services provided in only one or two hospitals in the NW and often patients from Lancashire and South Cumbria will travel to a center in Manchester or Liverpool (Tier 2/3)
- The remaining service lines (40-60) could be potentially commissioned in the future by the LSC ICS for its local population, although the exact number is yet to be determined (Tier 1)

3.5 It is likely there will be a robust transition assurance process ensuring the safe handover of functions and responsibilities for certain services to ICSs that is phased over a period (which it is currently thought may extend beyond 2022/23) taking into consideration:

- Readiness of the service to be handed over
- Readiness of the ICSs to take on responsibilities

3.6 In October 2020, the national team in NHSEI Specialised Commissioning set out the framework for the transition to integrated commissioning, in anticipation of the direction set out in the White Paper in February 2021 *'Integration and Innovation: working together to improve health and social care for all'*. This work is organised into 5 pillars as shown below:



3.7 Specialised commissioning policy and service specifications will continue to be led at a national level ensuring patients have equal access to services across the country.

3.8 However, Specialised Commissioning currently remains outside of systems despite representing a significant proportion of the cost base and services for the local ICS population.

3.9 As the NHS moves to system by default and increased population health management, ICSs need to have appropriate financial information for specialised services in order to inform meaningful commissioning decisions for all patients in their population. The current model of provider-based contracting does not support this need.

3.10 So, to support the strategic direction, funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'. During 2021/22, regional allocations are being aligned to ICS footprints based on historic actual costs (although we are not changing allocations in 2021/22 to reflect population-based flows outside of mental health services). A cautious and phased approach is proposed which puts in place the necessary building blocks for meaningful integration yet minimises financial instability in year 1 and at a time when systems will still be responding / recovering from the COVID-19 pandemic.

3.11 Specialised mental health services are leading the way in this area, with the delegation of the commissioning budget for the population and operational commissioning responsibility to ten first wave NHS-led provider collaboratives on 1st October 2020.

3.12 The 2021 NHS White Paper on – 'The Future of Health and care' sets out a direction in which NHS England will have the ability to:

- Joint commission its direct commissioning functions with more than one ICS Board allowing services to be arranged for their combined populations.

- Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).

and enable NHS England to:

- Delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or:
- Jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards.

3.13 In 2020/2021, as part of the former Joint Committee of Clinical Commissioning Groups (JCCCG), the Director of Specialised Commissioning could - under delegated responsibilities from NHSEI - take decisions on the commissioning of Specialised Services whilst in parallel to the JCCCG and whilst partaking in the same discussions. The governance and decision making however remains clearly with Specialised Commissioning as part of the regional NHSEI team.

3.14 It is not possible to change these arrangements under current legislation, however much more can be done to ensure that there is involvement of the ICS in the decision making of Specialised Commissioning both in relation to determining priorities and workplans, and in taking commissioning decisions on services affecting the LSC population.

3.15 This paper is an initial start of this new intention and relationship.

At the same time, we need to develop the capacity and capability within the ICS to be ready to take on the commissioning of specialised services for its local population should the anticipated bill be passed. This will require a sophisticated matrix of working with the current regional team to ensure that the pharmacy, case management, finance, contract, quality and service specialist team expertise is accessible and that these skills and resources are not lost during transition. Often these teams consist of small teams often of only 2 or 3 people, in some cases working across Mental Health and Health & Justice in addition to acute services and could not be easily split into three separate ICS teams.

4 Clinical Networks

4.1 Another critical pillar for early consideration is that of clinical networks and the need to determine which Operational Delivery Networks (those commissioned for specialised services) should be managed at an ICS level, in line with the proposed reporting structures for the Provider Collaborative Board, with clinical managed networks as key enablers for the work of the PCB.

4.2 Further, looking wider at networks and particularly Strategic Clinical Networks, thought needs to be given to the opportunities to reduce silos and consider a whole patient pathway. We want to develop network arrangements so that they can take on a wider range of responsibilities and, increasingly, become accountable for a range of functions on behalf of commissioners. This is not a network review dismantling existing arrangements but rather a paradigm shift where network working takes on central importance as we move to integrated systems, as demonstrated by the collaborative approaches seen in systems and networks during Covid-19.

4.3 Clinical networks, aligned to the Provider Collaborative Board, will be fundamental in advising us on the transformation and repatriation work set out in the following sections.

5. Strategic Considerations for the ICS Clinical Strategy / New Hospitals Programme

5.1 Lancashire and South Cumbria already provides a range of specialised services.

5.2 The New Hospitals Programme creates a once in a lifetime opportunity for providers and clinicians to work collaboratively and design the optimal model for patients across Lancashire and South Cumbria.

5.3 Most of the activity for West Lancashire residents and for some areas of East Lancashire, e.g. Rossendale, takes place outside of LSC. With size and big numbers come expertise and good outcomes (many specialised procedures are safer when done in high volume centres) and the ability to offer very specialised services that are needed for a relatively smaller cohort of patients. There are therefore advantages to ensuring that we provide a high quality choice of service locally for specialised services already commissioned in LSC.

5.4 Where services are not currently commissioned in LSC, consideration needs to be given firstly to the ability to meet the national service standards and then also to the capacity, sustainability and financial viability of the service, especially for rarer conditions where there may be small numbers of patients but still requiring costly infrastructure. Similarly, consideration will need to be given to the financial and clinical impact on existing providers where activity is moved to LSC but overheads within the current providers remain and volumes of activity may no longer meet minimum standards.

5.5 Specialised services currently provided in LSC include the following. This is not a list of every service provided; a full list is provided in Appendix A.

5.6 Cardiac

All adult cardiology and cardiac surgery are provided in LSC at the centre in Blackpool, except for transplants, Congenital Heart Disease and Cardiac Valvular and Septal repair indications including Patent Foramen Ovale (PFO) closures. There are significant flows

for ICDs and Electrophysiology services to Greater Manchester due to historic outreach arrangements into parts of LSC, where instead patients could access services more locally. A review of the provision of PFOs is planned nationally which may enable a service at Blackpool to be established.

5.7 Vascular

There are plans to move to a single system wide service in LSC collocated with major trauma and neurosurgery but this is subject to consideration of the necessary estates infrastructure in the short to medium term (prior to the New Hospitals Programme). It is worth noting that patients from Wigan currently are treated within Lancashire and South Cumbria.

5.8 Neurosciences

All adult neurology and neurosurgery services are provided in LSC with the centre at Lancashire Teaching Hospitals, except for the following for which patients need to travel to The Walton Centre (Liverpool) or Salford (Greater Manchester):

- Deep Brain Stimulation for Parkinson's Disease, Dystonia and Essential Tremor.
- Fully developed Stereotactic Radiosurgery for brain tumours.
- Full surgical service for epilepsy.
- Adult onset scoliosis surgery.
- Some Myasthenia Gravis services where there may be some further sub specialization that needs to be understood with clinicians i.e whether this could be provided more locally.

Some of the activity flowing to Manchester and Liverpool is for treatment that could be provided in LSC. In many cases the patient resides nearer to the neurosciences centre in LSC than either Salford or Walton. Historic waiting list issues for neurosurgery and neurology (pre-Covid) may be a factor.

A sizeable proportion of neurology in patients treated beyond LSC is for multiple sclerosis. Most of the treatment will be for day case drug infusion. There is nothing in the national service specifications to suggest that these MS infusion drugs cannot be undertaken in LSC.

Treatment for "other inflammatory polyneuropathies" is another major area of flow out of Lancashire & South Cumbria that needs to be explored with clinicians.

Inpatient neurosurgery that takes place outside of Lancashire and South Cumbria is characterised by small numbers of spells for services not commissioned locally.

5.9 Haematology

LSC provides services for blood disorders including Thalassemia and a haematology service at Blackpool which provides an autologous Blood Harvest and Autologous Stem Cell Transplant Service (but not Allogeneic transplants). In addition, adult Leukaemia

patients and complex conditions such as Hereditary factor VIII/IX deficiency are treated in Manchester. All Allogenic transplants are undertaken outside LSC but this has not been reviewed for a number of years and it would be timely to consider if accreditation standards could now be met in order to provide a local service that would increase patient choice. An initial discussion with the Provider Collaborative Board should take place.

5.10 Respiratory

Cystic Fibrosis (adults) is provided from Blackpool as part of a networked service with Manchester and in addition, Complex Ventilation and Severe Asthma services are all provided in LSC at Lancashire Teaching Hospitals. In addition, a networked Interstitial Lung Disease network was established across LSC in August 2020.

5.11 Renal

Dialysis including home dialysis and management of both chronic and acute kidney injury take place in LSC hosted by the centre at Lancashire Teaching Hospitals but with dialysis units across the area. Kidney Transplantation takes place in Manchester.

5.12 Cancer

Specialised commissioned services provided in LSC include diagnostics such as PET-CT, all chemotherapy and radiotherapy, most surgery and specialised treatments such as Stereotactic Ablative Body Radiotherapy (SABR) for most indications. For Proton Beam Therapy, Brachytherapy and some rarer cancer surgery L&SC patients travel to Liverpool or Manchester depending on the condition. Stereotactic Radiosurgery for metastatic brain tumours is a service that could potentially be provided in the future in LSC with the right workforce and infrastructure. There are CCGs where there is a disproportionate value of chemotherapy activity that flows towards Manchester (that is not explained by geography) and it is possible that this is an opportunity to repatriate some activity.

Attain are currently supporting the L&SC Cancer Alliance to undertake a non-surgical oncology review across LSC. The scope of this work includes chemotherapy and radiotherapy outpatients, acute inpatient oncology, aseptic pharmacy as well as mapping and planning for radiotherapy. Within the initial draft scope is the review of key workforce shortages and specialisation for rarer diseases. The report is due in July 2021.

A small number of services have become unsustainable in recent months as a LSC service, this is due to small patient numbers and single-handed consultants, including skull-based oncology and more recently sarcoma. These services are being supported by the North West operational delivery networks but for a small number of patients their travel will be increased in order to access specialised care in Manchester.

5.13 Adult Critical Care

Adult critical care services are provided across LSC and the value of the adult critical care operational delivery networks has never been more clearly seen than in adult critical care during the Covid-19 pandemic. Adult Critical Care and Trauma is the only specialised service for which the Operational Delivery Network is currently hosted within

Lancashire and South Cumbria (as one of three in the North West). As set out in section 4 of this paper there is a need to consider the current and future capacity in Adult Critical Care and how best to organise services. Any repatriation of services into LSC needs to consider the added demand on Adult Critical Care.

5.14 Location of Services

There is a strong case made nationally for large specialised single specialty hospitals (e.g. The Walton Centre, Liverpool Heart and Chest, The Christie) who have benefitted from not having to fight for recognition/resources from other specialties and are acknowledged as attractive places to train and work, with a dedicated focus on the areas of interest and research.

Single speciality cardiac hospitals (examples being Papworth, Brompton and Harefield) have clearly seen some of these benefits but it is worth noting that they also plan to address issues of co-location for example with Papworth location with Addenbrooks and Brompton looking to co-locate with St Thomas.

There are strong arguments for co-location of services due to the co-morbid presentation of patients. For example, the essential specialties for cardiac centres are cardiology, respiratory medicine, radiology, pathology, haematology and transfusion. Strokes occur in 1% of cardiac cases, diabetes in 25%, renal failure/dialysis in 1-2%, vascular surgery is required in 5-10% of TAVI cases (but relatively uncommon for any regular cardiac operations), general surgery for acute post op abdomens <1%, gastroenterology (for GI bleeds) maybe 1-2% and general ITU/ long-term rehab can be up to 5% (*source specialised commissioning public health team*).

As part of a large teaching hospital or specialised campus, stroke consultants can easily see patients in the cardiac centre within an hour of referral – and treat for thrombolysis or percutaneous intervention. The diabetic team sends their specialist nurse to see every single diabetic patient admitted and review all the medications/management. The vascular and general surgery teams are instantly available (i.e. a consultant within 30 minutes). Long term intensive care is managed by intensivists. There is a special team dealing with rehabilitation for patients requiring a long inpatient stay.

In Lancashire and South Cumbria, the expertise for services such as stroke, cardiac and vascular are currently not all specialised on the same site or campus.

Whilst it is not essential for all these services to be integrated on one site, they need to be easily and rapidly accessed, when required.

6. Significant Transformation Projects

6.1 Significant transformation projects are anticipated in the following:
a) Women's and Children's
b) Neurorehabilitation
c) Adult critical care

6.2 Within acute services the most significant service reviews that have been set out nationally for specialised services lie within Women's and Children's services. A North West Women's and Children's Board is being established (the draft reporting arrangements are set out in Appendix B) on which there will be representatives from each ICS. The purpose will be to co-ordinate the transformation programme and ensure local leadership whilst managing the complex co-dependencies with the regional tertiary children's centres in Manchester and Liverpool.

6.3 The work includes the following:

- Implementation of the national neonatal review and standards, which will need to consider how to achieve national standards in units across LSC.
- Introduction of robustly governed intermediate paediatric critical care (previously known as HDU level 2) into appropriately sized paediatric services outside of the tertiary children's hospitals.
- Development of enhanced Paediatric Shared Care Oncology units.
- Establishment of Children and Young People (CYP) and Teenager and Young Adult (TYA) cancer networks across the NW.
- Review of paediatric radiotherapy, recognising the changes needed due to the introduction of Proton Beam Therapy.

64 As part of the transfer of direct commissioning functions, the North West has proposed that there is a focus on the integration of commissioning across neurorehabilitation. Work has already been undertaken in LSC to transfer commissioning responsibilities for appropriate inpatient care from NHSEI to CCGs, with Chorley and South Ribble CCG as the lead CCG. However, we have different models of care and possible inequalities in access and service across the North West with potentially significant opportunities for improvement in LSC that need to be further explored. The merging of NHSEI and CCG functions at ICS level will provide an opportunity to look at whole pathway change in a collaborative and radically different way.

6.5 Adult Critical Care (ACC) faces several operational and strategic challenges which can be summarised into 3 areas of focus:

- Supporting the recovery of elective activity and return of staff to theatres post covid-19, whilst continuing to look after a small cohort of covid-19 patients, considering the workforce required to achieve this and how best to organise services across LSC.

- Preparing for the next wave of covid-19; at the peak of the pandemic the use of 'surge' beds across the system meant that approximately 75 additional critical care beds were in use in LSC representing an increase of about 90% from baseline.

- Long term transformation to address some of the challenges facing LSC ACC services including the baseline shortage of beds (5.4/100,000 population compared to 7.3/100,000 population nationally with aspiration of providers for 10/100,000) and the expansive geography that results in significant times for transfers. As part

of this work it will be important to ensure capacity is aligned to need at place and service level.

7. Restoration and Recovery

7.1 For all the services mentioned in section 2 and listed in Appendix 1, recovery of activity is a significant challenge and priority for the system in the coming months. During the pandemic we have been operating a Cell structure to co-ordinate system-wide working. Moving forward, the Hospital Cell function will transition into a formal Provider Collaboration Board and structure which will be key to both the initial Restoration Phase and the long-term sustainability of service delivery.

7.2 As we restore elective activity in line with the 2021/22 planning guidance, we need to ensure that patients accessing specialised services can do so in a way that is equitable across the North West and that doesn't disadvantage any local population. It will be necessary to consider how the recovery and restoration of specialised services is taken forward within these LSC PCB responsibilities, whilst being mindful of the need to also ensure collaboration across the North West tertiary services to ensure equality of access for patients and mutual aid in the event of a further covid-19 surge.

7.3 Of the 7 transformation / clinical network priorities that the PCB has set out for 2020/21, 3 include specialised services as a key component in the patient pathway:

- Vascular;
- Stroke (mechanical thrombectomy);
- Haematology;

and the others also all have pathways into specialised services (mental health, diagnostics, ophthalmology and dermatology).

7.4 Developing the governance of the PCB to assist and support the ICS as it transitions to the commissioning of specialised services for its local population is therefore important.

7.5 Moreover, as we have seen with provider collaboratives in mental health, there is a role for further development of collaborative commissioning and network functions. Consideration needs to be given to the specialised operational delivery networks (ODNs) and strategic clinical networks (SCNs) that could be aligned to the PCB to support this work.

8 Suggested Next Steps

8.1 More detailed analysis of opportunities for increased local choice to be undertaken including Equality Impact Assessments, working closely with the Provider Collaborative Board and the commissioning workstream of the New Hospitals programme.

8.2 Prioritisation and refinement of the transformational work plan for specialised services, working through the Provider Collaborative Board

8.3 Establish an ICS led working group to look at the future model of networks in LSC

8.4 Subject to legislation, to ensure that there is a clear road map that enables the transfer of specialised services commissioning functions to the ICS where appropriate for the population size.

Nicola Adamson

Head of Acute Strategy and Transformation, Specialised Commissioning North West NHSEI

4th May 2021

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee (SCC)

Appendix A

The following are based on historically suggested Tiers as set out in the North of England Specialised Services Strategy in 2018. Which services sit in which Tier is currently under discussion nationally.

Tier 1 services should be able to be provided within the footprint of an ICS the size of LSC.

Key:

BTHTR
LTHTR
M Bay
E Lancs
More than 1 of above

1. Head and Trauma Programme of Care

Tier 1 ICS	Tier 2 NW	Tier 3 supra-regional	Tier 4 National
Specialised Rehab	Critical Care ODN (Adult)	Hyperbaric Oxygen Therapy	Hand Transplantation
Spc Neurosciences	Communication Aids	Middle Ear Implant Aids	Artificial Eyes (Implants)
Spc Ophthalmology (Adult)	Environmental Controls	Spinal Cord Injuries	Rare Neuromuscular Neuromyelitis
Spc Ophthalmology (Child)	Prosthetics		Optica Ocular Oncology
Complex Spinal Surgery	Stereotactic Radiosurgery		Ophthalmic Pathology
Implantable Hearing Aids	Specialised Burns		OOKP
Bone anchored hearing aids (BAHA)	Cleft Lip & Palate		Stickler Syndrome
Neurosurgery (Adult)	Specialised Pain		ECMO (Respiratory) (Adult)
Spc Orthopaedics	Cochlear Implants		
Major Trauma	Neurointerventional Services for Acute Ischaemic & Haemorrhagic Stroke		
	Specialised opthalmology		
	Mechanical Thrombectomy		

2. Internal Medicine Programme of Care

Healthier Lancashire & South Cumbria

Strategic Commissioning Committee (SCC)

Tier 1 ICS	Tier 2 NW	Tier 3 supra-regional	Tier 4 National
Cardiac Surgery	Cystic Fibrosis (Adult) (with MFT)	Pulmonary Hypertension	Liver Transplant (Adult)
Cardiac ICD/Cardiac resynchronisation therapy (CRT)	Cystic Fibrosis (Children)		Small Bowel Transplant (A)
Cardiac MRI	Interstitial Lung Disease		Sclerosing Peritonitis Surg
Cardiac EP and Ablation	Complex Ventilation		Auto Intestinal Reconstruct
Cardiac PPCI	Severe Asthma		Pseudomyxoma Peritonei
Vascular Surgery	Spc Rheumatology (A)		Pulmonary Thromboendart.
Complex IBD	Spc Dermatology (A)		Epidermolysis Bullosa
Faecal Incontinence	Skin Cancer (Adult)		Xeroderma Pigmentosum
Colorectal TEMS Surgery	Renal Transplantation		Behcets Syndrome
Acute Kidney Injury	Distal Sacrectomy (A)		Complex Ehlers Danlos
Assessment for Dialysis	Congenital Heart Disease		Ataxia Telangiectasia (A)
Renal Dialysis (Hospital)	Hepatobil & Pancreas (A)		Chronic Pulm Aspergillosis
Renal Dialysis (Home)	Pancreatic Cancer (A)		Congenital Hyperinsulinism
Renal Dialysis (Peritoneal)	Anal Cancer (Adult)		Insulin Resistant Diabetes
	Intestinal Failure (A)		Islet Cell Transplantation
	Spc Endocrinology (A)		Pancreas Transplantation
			Alstrom Syndrome
			Bardet-Biedl Syndrome
			Wolfram Syndrome
			Ventricular Assist Devices
			Heart & Lung Transplant

3. Cancer Programme of Care

Tier 1 ICS	Tier 2 NW	Tier 3 supra-regional	Tier 4 National
OG Cancer (Adult)	SABR		Breast Radiotherapy Injury
Kidney Bladder Prostate Cancer	Radiotherapy		Proton Beam Therapy
Chemotherapy (Adult)	Brachytherapy		Primary Bone Cancers
PET-CT	Malignant Mesothelioma		Complex NF Type 1
Head & Neck Cancer (Ad)	Soft Tissue Sarcoma (Adult)		NF Type 2
	CNS Cancers (Adult)		Ex-vivo Partial Nephrectom
	Penile Cancer (Adult)		
	Testicular Cancer (Adult)		
	Chemotherapy (TYA)		
	TYA Cancer		

5. Blood and Infection Programme of Care

Tier 1 ICS	Tier 2 NW	Tier 3 supra-regional	Tier 4 National
HIV (Adult)	HSCT (Adult)		SCIDS
Haemoglobinopathies Spc (small service at E Lancs under visiting consultant from MFT)	HSCT (Children)		High Secure Infectious Dis.
Immunology	Haemophilia HIV (Children)		Atyp Haeomlytic Uremic S Parox
Spc Allergy	Spc Infectious Diseases (A)		Nocturnal Haemogl
	Tropical Medicine		HTLV I & II
	Bone & Joint Infection		
	Hep C Adults		

6. Women's and Children's Programme of Care

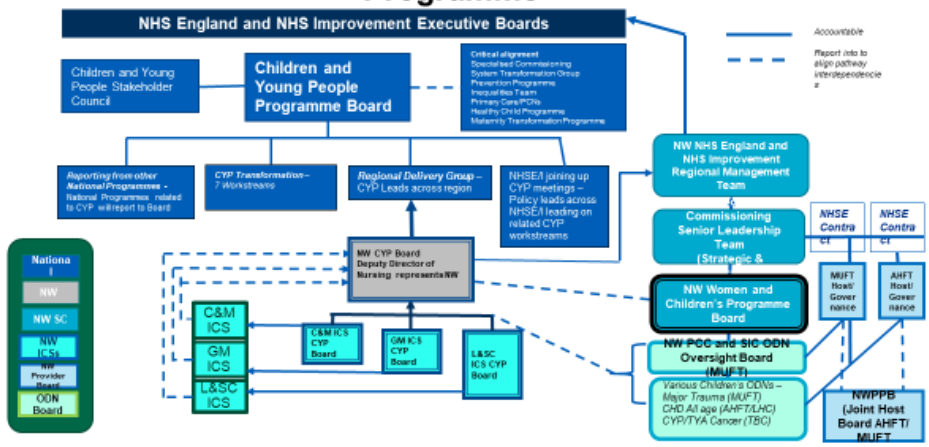
Tier 1 ICS	Tier 2 NW	Tier 3 supra-regional	Tier 4 National
Neonatal Critical Care	Paed Surgery	Paediatric Cardiol & Surg	Medical Genetics
Gynae: Endometriosis	Neonatal Surgery	Metabolic Disorders (Adult)	Beckwith Wiedemann
Gynae: Urogenital/Anorectal	Paed Neurosurgery	Metabolic Disorders (Child)	Bladder Exstrophy
Gynae: Incontinence/Prolap	Paed Neurology	Metabolic Disorders (Labs)	Complex Tracheal Surgery
Gynae: Cancer	Paed Immunol & Infection		Craniofacial Surgery
	Paed Haematology		Liver Transplant (Child)
	Perinatal Pathology		Small Bowel Transplant (C)
	Paed Palliative Care		Spc Liver Disease (C)
	Paed Oncology (POSCU level 1)		Retinoblastoma
	Paed Intensive Care		Paed Pulmonary Hypertens
	Paed High Dependency		Alkaptonuria
	Paed Long Term Ventilation		Barth Syndrome
	PIC Retrieval		LSDs
	NIC Retrieval		Epilepsy Surgery (Child)
	Paed Neurodisability		Ataxia Telangiectasia (C)
	Paed Neurorehabilitation		Vein of Galen Malformation
	Gynae: Congenital Abnorm		Choriocarcinoma
	Gynae: Urinary Fistulae		Osteogenesis Imperfecta
	Fetal Medicine		CAPS
	Paediatric Renal		Amyloidosis
	Paed Gastro Hep & Nutritt		Primary Ciliary Diskenesia (C)
	Paed Chronic Pain		Rare Mitochondrial Disords
	Paediatric Major trauma		McArdles Disease
	Paed Rheumatology		Severe Acute Porphyria
	Paed Endocrinol & Diabetes		
	Paed Respiratory		
	Paed Allergy		Paediatric Gender Identity

Strategic Commissioning Committee (SCC)

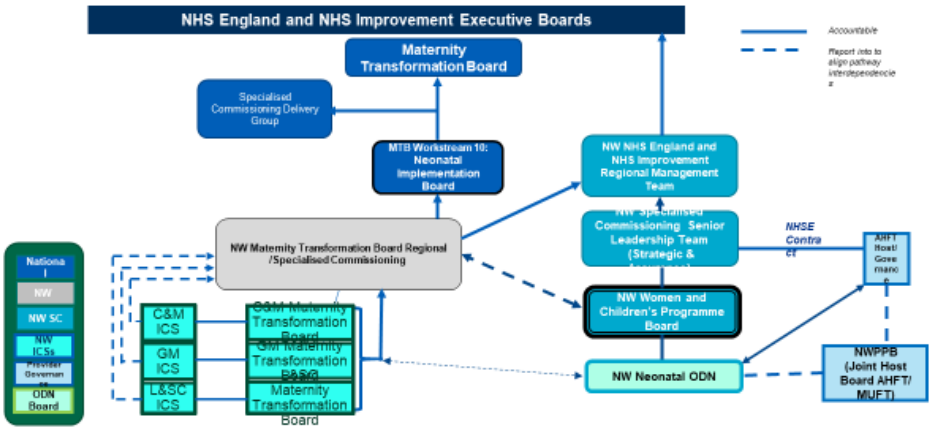
Appendix B

Draft reporting arrangements for Women's and Children's specialised services transformation

National Children & Young Persons (CYP) Transformation Programme



National Maternity Transformation Programme



Strategic Commissioning Committee (SCC)

Strategic Commissioning Committee (SCC)

Title of Paper	**Special Educational Needs and Disabilities – End of Year Update and Assurance**		
Date of Meeting	13 May 2021	Agenda Item	9

Lead Author	Zoe Richards on behalf of Debbie Corcoran and Kevin Toole	
Contributors	Hilary Fordham	
Purpose of the Report	Please tick as appropriate	
	For Information	√
	For Discussion	
	For Decision	
Executive Summary	Each Local Authority area is delivering improvements for SEND that involve health as equal partners. This paper provides an update on the position for each LA footprint, along with the priorities for action. There are six priority areas that cross the ICS which contain specific actions that must be delivered on to ensure each SEND Partnership is meeting its statutory obligations in relation to SEND. Additionally, the paper provides assurance related to the scrutiny of the Lancashire Accelerated Progress Plan	
Recommendations	SCC is asked to: • Note the position for each local authority area in relation to SEND inspections • Note the progress with the improvement areas. • Note and continue to support the priorities for delivery under the Accelerated Progress Plan for Lancashire. • Note the risks associated with the SEND priorities	
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	Inability to address the remaining areas of significant concern	
Report Authorised by:		

Strategic Commissioning Committee (SCC)

Special Educational Needs and Disabilities – 2020/21 End of Year Update and Assurance
30th April 2021

Purpose

To update the Strategic Commissioning Committee (SCC) on the progress being made with regard to Special Educational Needs and/or Disabilities (SEND) across the ICS area, and with particular reference to the assurance related to delivery of the Lancashire Accelerated Progress Plan.

SCC is asked to:

- Note the position for each local authority area in relation to SEND inspections
- Note the progress with the improvement areas
- Note and continue to support the priorities for delivery of Lancashire's Accelerated Progress Plan
- Note the risks associated with the SEND priorities

Background

This paper provides an update of the overarching SEND Programmes for the ICS, alongside assurance that the Lancashire SEND Accelerated Progress Plan (APP) is being delivered. At its 3rd September 2020 meeting the Joint Committee of CCGs (JCCCGs) agreed two non-executive members to join the sub-committee of the Health and Wellbeing Board in Lancashire that would undertake the monitoring of the Accelerated Progress Plan (APP), from the Fylde Coast and Central Lancashire – and the nominated representatives from the respective CCGs (Kevin Toole and Debbie Corcoran) provide that assurance to the SCC in respect of the Lancashire APP.

The SEND inspection position across the ICS is as follows:

- Blackburn with Darwen had a joint Ofsted and CQC inspection in June 2019. This was a successful inspection with required improvements covered in the letter received in August 2019. The Improvement Plan activity is ongoing, with a second inspection expected in late 2022 to early 2023.
- Blackpool is yet to be inspected. Prior to the latest lockdown the expectation was that an inspection would be conducted in early 2021. This has not happened. An inspection is therefore imminent.
- Cumbria had its inspection in March 2019 which identified 9 areas of significant concern. Considerable work has been delivered in line with the Written Statement of Action, and an inspection revisit is anticipated later in 2021.
- Lancashire's initial inspection took place in November 2017 which identified 12 areas of significant concern. The inspection revisit took place in March 2020, which was reported in August 2020, delayed due to the COVID response. The revisit identified 7 of the 12 areas as having made sufficient progress, however 5 areas sufficient progress had not been made, or other issues arisen eg increase waiting times for Autism Spectrum Disorder services and remained of concern. These are now covered in an Accelerated Progress Plan which was reported to Collaborative Commissioning Board in August 2020. Delivery of the Plan is currently being monitored by DfE and NHSE/I with the expectation that sufficient progress will be made by 30th September 2021.

CCB, and subsequently the JCCCG, has received regular updates since Lancashire's initial inspection, and this report provides the next update.

Current Position

Many of the areas for ongoing development apply across the ICS and are being delivered as a collaboration between the CCGs and with each of the SEND Partnerships. They are highlighted in greater detail in the table on page 4, however in brief the priorities are:

- Continuous improvement in line with the SEND Code of Practice that identifies the statutory duties for local authorities, CCGs, schools and the third sector.
- Joint commissioning arrangements
- Equity in provision
- Improvement of data to inform decision-making
- ASD Waiting Times
- Transitions in healthcare
- Ongoing improvements in Local Offer websites, particularly in relation to health input

Additionally, there are priorities for each area SEND Partnership Board as follows:

- Blackburn with Darwen has priority areas related to transitions in social care alongside health care, improving opportunities post-19 particularly for those young people with complex needs, and further improve the support available to children and young people with Social, Emotional and Mental Health needs.
- Blackpool has yet to be inspected, and as a result, alongside the priorities mentioned above, the area is concentrating on its readiness for inspection. In this context, Blackpool undertook a Local Government Association Peer Review for SEND at the end of March 2021, and the feedback from that will inform the urgent priorities for action. It is clear from the review that there is significant work to be delivered in relation to integration and partnership working, and with regards to managing commissioning gaps.
- Lancashire and Cumbria have an additional priority to improve the local leaders' knowledge and understanding of the area in relation to SEND needs and the role of our workforce in the wider SEND agenda, beyond those staff delivering a SEND related service. A draft Workforce Development Strategy is currently being reviewed in both areas. Additionally, a presentation 'SEND is Everyone's Business' has been presented to each CCG over recent weeks, and providers have now requested the same presentation.
- Cumbria must deliver on its Written Statement of Action and illustrate sufficient progress has been in the 9 areas of significant concern by the time the inspectors undertake a revisit later in 2021. A number of challenges and risks have been identified by the jointly funded SEND Strategic Lead, and these are contained in the progress report which is contained in Appendix A.

Lancashire SEND Accelerate Progress Plan

Lancashire must deliver on its Accelerated Progress Plan (APP) by 30th September 2021 in order to complete targeted monitoring of improvements.

The current position with the APP at the mid-way point is that 54% of the actions have been delivered, 23% of ongoing actions are on target, and 23% are behind due to either COVID related issues or intractable issues, however plans are in place for the next 6 months to support ongoing delivery. Those that are behind in delivery, described in full in the next section of the report, relate to robust healthcare data (Action 1), the management of the waiting list initiative for ASD (Action 3), the engagement of adult services in transitions in healthcare (Action 4), and the implementation of the directory of services on the Local Offer (Action 5). Monthly Highlight Reports are used to provide updates through Lancashire's governance route. The

presentation embedded below was delivered to the Department for Education and to NHSE and gives the position as at 22nd March 2021. The monitoring update was received positively by both DfE and NHSE.

Key Priorities

The following table provides a brief update on delivery of the key priorities across the ICS.

Priorities Update	Current Position
Continuous Improvement	
Lancashire SEND Plan 2021-25	The Lancashire SEND Partnership is currently undertaking an extensive review of improvement activity, monitoring and delivery needs to inform the development of the Lancashire SEND Plan for 2021-2025 – this is with a view to commencing delivery on the new co-produced plan from 1st September 2021. The SEND Plan 2021-25 will then demonstrate to the monitors of the Accelerated Progress Plan that the area knows the ongoing continuous activity that will happen up to 2025, when it is anticipated the next inspection will take place.
Leaders	
Leaders' Understanding of the Local Area (Lancashire & Cumbria)	Around 350 CCG, CSU, ICS and provider staff have received the briefing 'SEND is Everyone's Business' at virtual team meetings, and this continues to be rolled out to ICS groups such as the safeguarding leads group, and the mental health group. Providers are now asking for the briefing to be delivered to their senior leadership teams and various groups. This briefing demonstrates the cross-over between children's and adult services alongside the current priority areas for improvement.
Equity of Service Provision as part of Joint Commissioning Arrangements	
Commission services in consumables, starting with continence products	Bladder and Bowel Framework, covering continence products, has been co-produced and was presented to CCB as a separate paper for approval. The next stage is to manage commissioning gaps to deliver the Framework, and to identify what other gaps exist in relation to consumables that must be addressed.
Inequitable special school nursing provision	A review has been undertaken and a separate paper was presented to CCB
Access to public health nursing in special schools	A review of the service has been carried out, and all headteachers have now been informed of their named special school nurse. Further work is being undertaken to ensure any additional issues are managed in a timely manner. Headteachers have also been provided with a flowchart that describes their route to escalation for any matters that they perceive are not being appropriately addressed.
Gaps in specialist children's nursing services	A mapping exercise has identified the scope of work required to create consistency across specialist nursing services, and a review is currently underway to identify priorities for addressing the inequalities identified by the inspectors. From this a project plan is being developed with outcomes expected within approximately 12 months.
Data	
Improve the data set for SEND through a Data Quality Improvement Project	Data Quality Improvement Project established with engagement from provider Business Intelligence colleagues, issues identified, and data set being developed, however it will take some time to achieve a robust, cleansed data set

Priorities Update	Current Position
	The main issues with health data are due to the lack of national data collection in relation to SEND, and the lack of flagging of SEND on patient records. The first step in changing this at a local level is for providers to flag ASD which has commenced from March 2021. The improved data set will be added to SEND Data Dashboards which will be part of improving leaders' understanding of the local area, and in turn enables providers and commissioners to monitor performance, measure on-going improvements with the SEND agenda, and make appropriate decisions in relation to service provision.
ASD Waiting Times	
Implement the Autism Pathway rapid recovery plan to manage increasing waiting lists across the ICS, and identify whole-system improvements that prevent a return to the same position	Waiting List Initiative Funding has been received, and the recovery plan is in place, though issues were identified with commissioning a third party to deliver some of the assessments. As a result work is ongoing to identify the most appropriate way to deliver additional assessments, which means that the funding allocated to the use of a private provider has not been utilised in 2020/21. This will now be delivered by end of Quarter 2 in 2021/22 in order to deliver the reduction in the waiting times. Data demonstrating delivery on the waiting list initiative illustrates ongoing issues with capacity, due in part to the high number of referrals that do not result in a diagnosis. A new Autism waiting list description has been developed and agreed, and is currently being implemented. This will take some time to filter through to the data as adjustments have been required. Additionally, it is anticipated that, even though the descriptions were developed through co-production with parent carers, families will take some time to adjust to the new descriptions. The definitions align with other waiting list descriptions. Improvement Plan activity for Autism needs to commence from April 2021 working as a whole-system to prevent a return to the same position. As part of this work it is crucial that the threshold for referral is managed. Lancashire and South Cumbria currently has a low ratio of referral to diagnosis telling us that too many children or young people are referred when it's not the appropriate solution to the identified need. As a result, a deep dive is currently underway across the whole system including local authorities, health and schools, and with the Lancashire SEND Partnership Board.
Transitions in Healthcare	
Implement the plan for Transitions for 0-25 in Healthcare, monitored by CCGs to ensure providers engage both children's and adult services in the work required	There are pockets of good practice being delivered in providers in terms of transitions in healthcare (also referenced as Preparing for Adulthood). However these pockets are service-specific, and not widespread within each provider, indicating that we have yet to reach the point where there is a culture of supporting young people from the age of 14 in their transition from children's services to adult services. There are 4 issues that have come to light with this: • Adult services do not routinely engage in the transition process, with many rejecting the need to be involved until a young person is 17yrs and 9mths old. Until services are commissioned and delivered across the age range of SEND for 0-25 year olds, it is expected this will continue to be an issue. (CCB has instructed the senior manager for SEND to attend the Cells to inform

Priorities Update	Current Position
	providers of their statutory duties for children and young people from aged 14 in relation to the transition process into adult services.) • Many practitioners report they do not feel confident to support transition conversations because they lack training in this area. • Data is not currently captured in relation to transition, added to which, because SEND is not flagged on patient records any data that is collected would not be SEND specific. • Survey completion by families tends to be from those who are not satisfied with their experience of transition. Providers are now implementing a survey approach that they will ask those young people who are involved in a transition conversation to complete. The transitions Task and Finish Group has been established with strong engagement across providers within Children's Services. There is currently no engagement from adult services – COVID is referenced as the reason for this. Each provider has confirmed the model for transitions that is being adopted, and has agreed to adopt the suggested pathways for 4 different forms of transition. The next step is to make sure transition conversations take place and 14+ yr olds are given a transition plan to work on with regards to their aspirations related to health. Multi-Disciplinary Team panels need to be set up with local authorities for those young people with the most complex health needs.
Local Offer	
Further development of the Local Offer to improve its use	Lancashire and South Cumbria was successful with a bid for £20,000 to strengthen the health input to the Local Offer. Work commences April 2021, with Healthwatch co-producing the approach with parent carers across the ICS

Recommendations

SCC is asked to:

- Note the position for each local authority area in relation to SEND inspections
- Note the progress with the improvement areas, and the assurance regarding that progress
- Note and continue to support the priorities for delivery for the ICS
- Note the assurance provided that the required activity for the Lancashire Accelerated Progress Plan is being delivered

Debbie Corcoran
Non-Executive Director for CSR & GP CCGs
April 2021

Kevin Toole
Non-Executive Director for Fylde Coast CCGs

APPENDIX A: Cumbria Update

Progress report on Cumbria SEND Written Statement of Action

Report by Executive Director of People

1. Introduction

1.1 This report provides a review of the progress made in implementing the local area Written Statement of Action (WSoA) for SEND in response to the findings of the Ofsted/CQC inspection which took place in March 2019.

1.2 The report also summarises the feedback from the recent formal monitoring visit by the DfE/NHSE in November 2020.

1.3 Finally, it provides a strategic overview from the recently appointed partnership Strategic Lead for SEND of the programme strengths, challenges and opportunities for CMT to contribute.

2. Background

2.1 Cumbria local area SEND services were inspected by Ofsted and the Care Quality Commission (CQC) in March 2019 to judge how effectively the special educational needs and disability (SEND) reforms had been implemented, as set out in the Children and Families Act 2014. The inspection raised significant concern about the effectiveness of the local area and determined that there were nine areas of significant weakness.

2.2 The partners in Cumbria were required to produce a Written Statement of Action, setting out the immediate priorities; the progress on implementing these actions has been, and will continue to be, closely monitored by the Department for Education (DfE) and NHS England (NHSE).

2.3 The Cumbria SEND Partnership Improvement Board is responsible for ensuring the delivery of the written statement of action and for reporting on progress to the Health and Wellbeing Board. The Board is led by an independent chair who is an experienced DCS and Improvement Lead for the DfE.

2.4 The action plan takes a thematic approach to respond to the findings set out in the letter issued by Ofsted/CQC following the inspection and is supported by six corresponding thematic partnership working groups. These groups meet regularly to progress the work of the partnership and monitor progress. Progress is reported every six weeks to the SEND Partnership Improvement Board.

3. Progress Report

3.1 Implementing the Written Statement of Action

3.1.1. Since the approval of the WSoA, work to progress the action aimed at securing improvement has been taking place across the partnership.

3.1.2 This has included key pieces of work to:

Improve our understanding about population need and service performance

Develop Joint Strategic Needs Assessment for SEND
Undertake focused work on Emotional Health and Wellbeing and Violent and Challenging Behaviour
Produce a Performance Management Quality Assurance Framework
Secure a system wide comprehensive dataset

Plan and commission services jointly to meet the needs of those with SEND
Co-produce an area Commissioning Intentions document
Improve the performance monitoring of commissioned services
Recommission 5-19 Public Health Nursing service and Careers Information Advice and Guidance service
Develop a service specification for Speech Language and Communication Therapy
Add a further 80 places for Alternative Provision across the county

Improve access to and delivery of services/provision
Improve access to CAMHS services and reduce waiting times in line with national guidance
Facilitate access to psychological support for those with complex and life-limiting conditions
Provide county-wide online counselling, support and advice services for young people
Develop a Social, Emotional and Mental Health (SEMH) Pathway
Produce a Preparation for Adulthood Route Planner

Engage and communicate with parents, carers and young people
Produce a Co-Production Charter, Pledge and Toolkit supported by training
Include parents as part of the improvement process
Improve communication using a regular newsletter, short films and a new Facebook page
Support the development of a new Parent Carer Forum

Improve system guidance, processes and support
Produce a SEND Handbook and admission guidance
Implement an audit process to improve the quality of Education Health and Care Plans
Monitor those with SEND on part time timetables
Embed support for those with SEND within the Early Help process
Host a Virtual Preparation for Adulthood Fair with over 200 attendees
Add NHS numbers to the local authority dataset for those with SEND
Deliver governor training events and establish an annual program of SENCO Networks

3.1.3 This work has improved understanding of local need and enabled senior leaders to hear directly from families about their experiences of the services provided. It has secured greater engagement with families as part of the improvement process and ensured that increasingly this influences the delivery, development and commissioning of services. Supporting guidance has been developed and training delivered to support operational practice, alongside improving the pathways and access to services which continues to be a priority.

3.1.4 Work has also started to:

Develop a visual data dashboard	Co-produce a service Occupational Therapy service
Produce simple JSNA tools	Co-produce Short Breaks Provision
Analyse the outcomes from case studies	Simplify access to Personal Budgets
Pilot an 'Always On' feedback mechanism	Improve and re-launch Local Offer website
Improve SEND support within schools, including training SEND reviewers	Redesign the Continuing Health Care process

4. DfE/NHSE Monitoring Arrangements

4.1 As part of the formal monitoring arrangements a review of progress by the DfE/NHSE takes place every six months. Prior to the review a written progress report is submitted by the local area. The most recent review took place on 16 November 2020, with the formal post review letter received on 21 December 2020.

4.2 The written report described in more detail the progress, as outlined in section 3.1.2 above, also highlighting those actions delayed, largely due to the impact of the pandemic on staff resources and changes in practice required to move activity online.

4.3 The post-review letter from the DfE/NHSE concluded that, as in all local areas, the pandemic has presented challenges for the pace of work or required a change of approach. Where this has occurred, the local area was encouraged to illustrate the operational or implementation changes made as a result, in addition to indicating a delay.

4.4 A review undertaken by the SEND Strategic Lead in November 2020 of the nine areas of concern against the statements made in the inspection letter was well received and felt to be helpful in enabling the local area to more clearly link the action being taken with the points made by inspectors.

4.5 The local area was also advised to ensure that timescales for action, approval and implementation are clearly set out, so that 'sufficient' progress continues to be demonstrated. The overall assessment by the DfE/NHSE concurs with our own view.

4.6 The next review meeting with the DfE/NHSE is scheduled for 25 March 2021, earlier than the usual six-month period at the request of the local area. At this meeting greater emphasis will be expected on the impact of the improvement work on children, young people and their families and the consistency of service performance and access to provision across the local area. There is likely to be an expectation that governance arrangements ensure continued line of sight to senior leaders, including council leaders and elected Members and that the additional investment made to drive and support change remains sufficient.

5. Strategic overview of the programme strengths, challenges and opportunities

5.1 It is clear from the outline of work and activity listed in 3.1.2 above which has taken place since the initial inspection, alongside more recent work, that a great deal has been achieved to ensure the necessary foundations are in place to support and sustain improvement for the longer term. These include cross partnership relationships; co-production of services with parent carers; shared governance, systems and guidance; increasing understanding of need and performance. There is also some specific service improvement with evidence of impact, for example to support emotional health and wellbeing, where access times have been improved and services have been adapted to meet the current restrictions.

5.2 Equally there are a number of challenges that the approaching Ofsted and CQC re-visit to the Cumbria local area poses. The aim of the revisit is to assess the progress made in addressing **each of the nine areas of significant weakness** detailed in the WSoA. Ahead of a re-visit inspection the review of the local area's progress to implement the WSoA, as referenced in 3.2.4 above, provided feedback to senior leaders on apparent gaps and potential risks in delivering the improvement required as set out in the post inspection letter.

5.3 These challenges include the:

- Constant and continuing impact on staff resource of as a result of the pandemic
- Impact on children and families with SEND, both nationally and locally due to the pandemic
- Number of delayed actions, without clearly specified plans to provide the necessary confidence that action is being taken and milestones to assess progress are in place
- Gaps in action to address some points made in the post Ofsted/CQC inspection letter e.g., leisure and employment opportunities, independent living arrangements for those with SEND, SEND support in schools
- Engagement of parents as equal partners in leading the improvement programme
- Oversight and coherence to improve area nine - the inequities in access to and performance of services across the county
- Ability to demonstrate the impact of action to date, some of which e.g., commissioning new services will take time to result in measurable change.

5.4 Some of these challenges are more difficult to manage, others are guiding priorities for action in 2021 and work has already commenced to draw up implementation plans for delayed actions; actively re-engage schools in the improvement programme; progress the development of a Cumbria Parent Carer Forum and consider the use of proxy measures supported by feedback from services and parents to demonstrate impact.

5.5 This action is supported by the development of a draft self-evaluation for SEND to help consistently narrate the action taken and the progress made, whilst highlight aspects that are limited by lack of action and/or evidence. The first draft was considered by the SEND Partnership Improvement Board at their meeting on 1 February 2021.

5.6 The Ofsted/CQC revisit is expected to take place within 18 months of the WSoA being approved; the approval was received on 18 October 2019 and therefore expected to take place by 18 April 2021. Arrangements to prepare for the revisit inspection will be led by the SEND Strategic Lead on behalf of all partners; this will require additional work by all those currently contributing to the improvement programme.

5.7 Over the next three months and more realistically the next six prior to inspection there are a number of opportunities for CMT to provide a focused contribution, including to ensure the risks identified are minimised. These include the following as examples for consideration:

- Championing children and young people with SEND as a key priority for the council
- Securing understanding and commitment across all council services
- Leveraging influence beyond the council with partners e.g., District Council re leisure services and opportunities
- Supporting essential pieces of work, such as updating JSNA, improving the Local Offer website and creating accessible performance tools
- Considering the council and partners as providers of training/employment for those with SEND, building on the approach for children looked after
- Focused discussion on other key aspects of the improvement programme.

6. Recommendations

6.1 To note the progress made to date and receive a further update following the next DFE/NHSE review on 25 March 2021.

6.2 Expect this report to set out the impact of the mitigating action being taken in relation to those issues currently presenting a risk to the local area and specifically the Council.

6.3 Consider and agree the contribution that CMT can make to the improvement programme over the next 3 – 6 months.

Report Author

Sian Rees, SEND Partnership Strategic Lead

2 February 2021

Strategic Commissioning Committee (SCC)

Cover sheet

Title of Paper	New: Terms of Reference for the Collaborative Commissioning Advisory Group		
Date of Meeting	13 May 2021	Agenda Item	10

Lead Author	Dennis Gizzi			
Contributors	Heather Bryan			
Purpose of the Report	Please tick as appropriate			
	For Information			
	For Discussion			
	For Decision	X		
Executive Summary	This paper presents to the Committee the new Terms of Reference for the Collaborative Commissioning Advisory Group (CCAG – formerly the Collaborative Commissioning Board) aligned to the governance structure for the wider System Reform programme and the Strategic Commissioning Committee (SCC). The Terms of Reference have been developed in conjunction with members of the current group and were share with the CCG Transition Board on 4th May 2021. The Board were in support of the document being presented to the SCC and acknowledged that further amendments were pending following discussions with Local Authority Commissioners on 6th May 2021. The meeting with Local Authority Commissioners served to capture their views within the document prior to final sign off at the SCC. Notably, it has been agreed that the group formerly referred to as the Collaborative Commissioning Board, be renamed, to better reflect its role and purpose. The group will now be referred to as the Collaborative Commissioning Advisory Group (CCAG).			
Recommendations	The Committee are asked to: • Approve the new Terms of Reference for the CCAG			
Next Steps				
Is this a level 1 or Level 2 decision?	Level 1	X	Level 2	

Strategic Commissioning Committee (SCC)

Cover sheet

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:	Denis Gizzi		

Level 1: *Where decision making authority is within the delegated authority of the Strategic Commissioning Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Strategic Commissioning 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.*

COLLABORATIVE COMMISSIONING ADVISORY GROUP
TERMS OF REFERENCE

Document Control			
Title	Lancashire and South Cumbria COLLABORATIVE COMMISSIONING ADVISORY GROUP – Terms of Reference		
Responsible Person	Independent Chair		
Date of Approval			
Approved By	Strategic Commissioning Committee		
Author	Denis Gizzi		
Date Created	November 2014 – original version		
Date Last Amended	6th May 2021		
Version	V0.9		
Review Date	31st March 2022		
Publish on Public Website		**Yes**	**No** ☑
The version of the policy posted on the intranet must be a PDF copy of the approved version			
Constitutional Document		**Yes**	**No** ☑
Requires an Equality Impact Assessment		**Yes**	**No** ☑

Amendment History		
Version	**Date**	**Changes**
V 0.6	12/04/21	Current TOR Reviewed
V 0.7	19/04/21	Revised and committed to new L&SC ICS template
V 0.8	28/04/21	Revised to incorporate feedback from current CCB members
V 0.9	06/05/21	Revised to incorporate feedback from Local Authority Commissioners and members of the CCC TB Agreed change of name for the group

1. Purpose and Objectives	
1.1	The Strategic Commissioning Committee (SCC) is established to enable existing CCGs to harmonise collective business into a single formal arrangement. Therefore, the Collaborative Commissioning Advisory Group (CCAG) will be obligated to take direction on priorities from the SCC and, make recommendations back to the SCC on areas of care systems that require a single co-ordinated approach from CCGs. The Group will support and deliver collaborative programmes of change, transformation, oversee service risk and create solutions for collective programmes in support of the Lancashire and South Cumbria Integrated Care System.

1.2	Aim: To build effective, single systems of programme reform on behalf of the whole system. These will be structured using proven methods and will drive greater Time to Value (T2V) benefits
1.3	Objectives: • Co-ordinate the development an overarching strategic approach to collaborative system and care process reform across Lancashire and South Cumbria and delivery of agreed collaborative programmes, ensuring compatibility and calibration between health and local authority strategy and objectives • Ensure the public, partners and stakeholders are engaged in the development and delivery of the strategic and technical approach proposed • Engage Health and Wellbeing Boards in the development of the strategic approach, in addition to the proposed (reformed) model of care • Contribute to the development of system (ICS) and partner strategies, for example ICPs, PCNs and Local Authority at Place • Identify and prioritise those service areas that will benefit from single system reform, using validated methods & data driven thinking • Establish the single system operating arrangements, specifically which commissioning / system management functions are included (e.g. finance support) • Promote integrated delivery solutions and ensure compatibility with wider system reform programme and the design and delivery of care services (i.e it is an integrated care solution, working with provider partners) • Promote innovation, research, and evidence-based practice.
1.4	Benefits: To realise Clinical Improvements: • Consistent, evidence-based pathway development alongside the embedding of regulated standards • Effective and consistent performance management, clinical governance, and risk management • Service integration aligned to the Lancashire & South Cumbria ICS • Enabling the 8 CCGs to take effective collaborative action
1.5	Benefits: To improve efficiency: • Optimising collaborative working/commercial arrangements with providers as partners Reducing transaction costs to the lowest pragmatic levels • Harvesting scarce expertise and capacity via adoption of integrated working with appropriate incentives • Raising the economic standing of targeted Programme Budget to upper quartile benchmarked rate (improved clinical outcome & lower cost)
1.6	Benefits: To increase resilience and risk management: • Improve the management of financial risks • Greater efficiency and effectiveness of regulatory and legal change • Greater workforce productivity and technical efficiency • Improved risk management and intelligence systems • Regulated and sustainable business continuity arrangements

2. Scope	
2.1	The scope of the Collaborative Commissioning Advisory Group will be centred on a re-set of priorities, as determined by SCC in line with this year's (21/22): • operating plan requirements • seeing to conclusion those strategic areas that are currently part way through transformation, where a collective approach from CCGs is required (e.g. stroke, LD etc) • the 12-month programmes determined by CCAG members surveillance of the care system to mitigate risks (reporting into SCC).

3. Membership	
3.1	Members will be drawn from across the Lancashire & South Cumbria system covering representation from CCGs, NHSEI, and the ICS. Colleagues from Local Authorities will also join the group for discussion of relevant issues as appropriate
3.2	Membership will comprise of the following roles: Chair (CCG Clinical Lead or Lay Member) Vice Chair to be appointed from within membership of the group CCG Executive Directors with a minimum of one Director per ICP ICS Executive Lead - Commissioning ICS Executive Lead - Finance NHSE/I - Locality Director NHS England NHSE/I - Deputy Director (Specialised Commissioning) Exec Finance Lead (from CCGs) Lead CSU Executive
3.3	CCAB members will: • At all times act in good faith towards each other. • Collaborate and co-operate to deliver the agreed work programme. • Act in a timely manner & observe T2V requirements as set out in the Programme Mandates • Communicate openly about concerns and seek to work collaboratively to realise opportunities and outcomes relating to delivery of the agreed work programme. • Be accountable for the delivery of the agreed work programme and deployment of associated resources and adhere to agreed task and KPIs • Share information and experience to learn from each other • Adhere to statutory duties, laws and standards • Adopt a positive outlook and proactive manner, and focus on value to the recipient of the service in question • Manage internal and external stakeholders effectively • Seek to identify and manage any potential unintended consequences of collaborative decisions on individual members

4. Governance and Reporting	
4.1	The Collaborative Commissioning Advisory Group reports to SCC via established reporting processes.

4.2	Notes of the CCAG will be formally shared with the SCC
4.3	Representatives from CCAG are expected to communicate the work of CCAG into their host organisation throughout 2021/22, however the formal reporting will be into the SCC.
4.4	**Appendix 2** shows the governance architecture for the SCC and its associated Subgroups

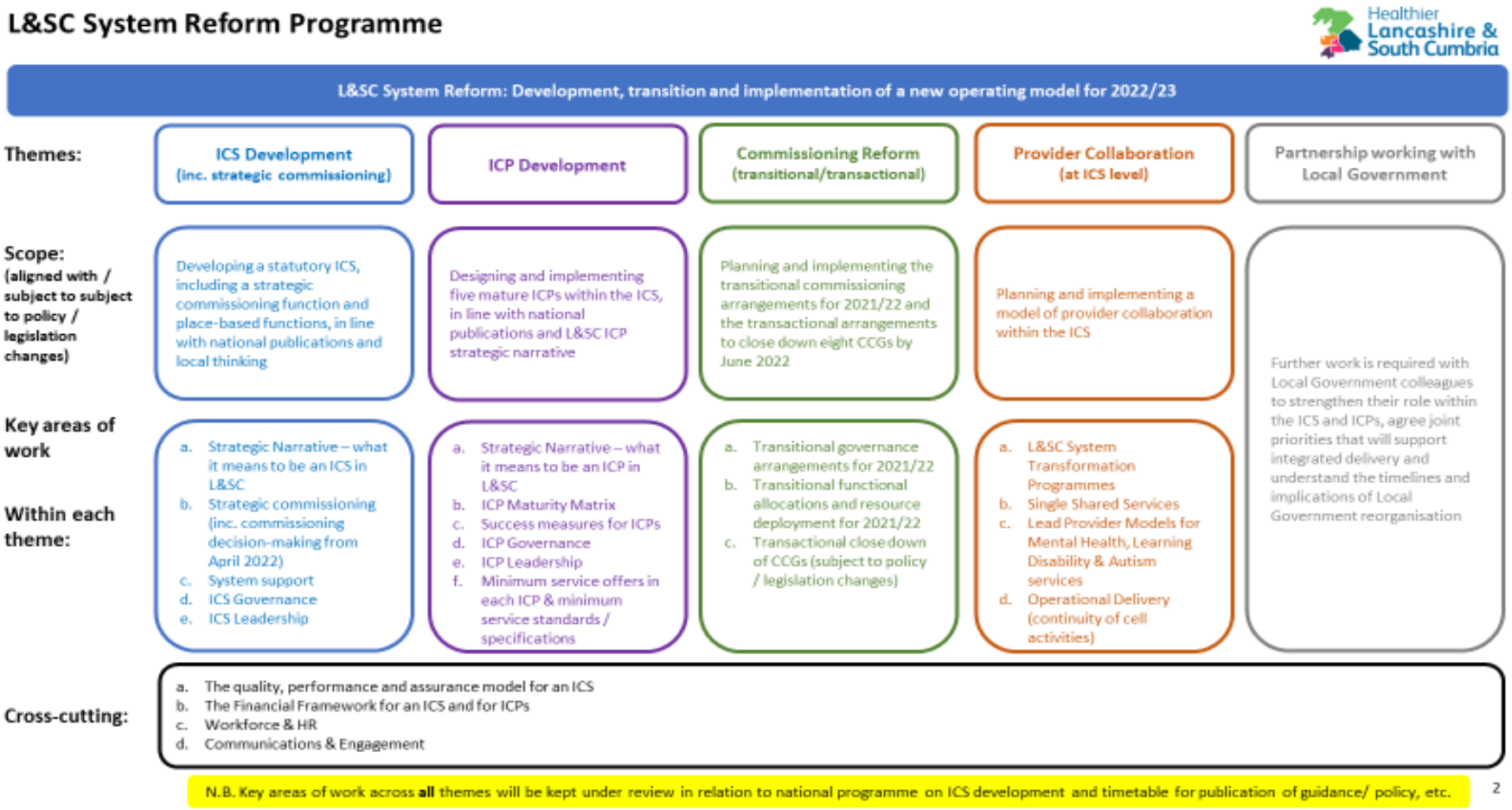
5. Access and Attendance	
5.1	The meetings are not held in public
5.2	Other CCG, CSU, NHSEI Directors and Local Authority colleagues may be invited to attend meetings to speak on specific matters

6. Programme and Supporting Papers	
6.1	The agenda and all relevant papers will be circulated at least five working days prior to the meeting.
6.2	Items that are late but urgent and important for circulation outside of the above can be done so with approval from the Chair.
6.3	Actions and decisions will be recorded and followed up at each meeting
6.4	Programme Plans will be maintained, and regular reports provided to the CCAG to ensure that the group can oversee the delivery of objectives and milestones, risks and issues.
6.5	The ICS Development Oversight group will have oversight of the overall System Reform critical path including risks and issues.
6.6	The CCAG will conduct a quarterly review of programmes to ensure that work is aligned to SCC delegated directives and plans, delivering on the highest priorities and focused on the areas of greatest opportunity for value-based reform, taking into account complexity and maximum value.

7. Meeting Arrangements	
7.1	Meetings will be held monthly, and be aligned with SCC reporting timetable
7.2	The Collaborative Commissioning Advisory Group will be quorate when a representative from each ICP is present. Deputies are permissible with prior approval by the Chair.
7.3	Where collective decisions are required, these will be agreed based on a majority decision

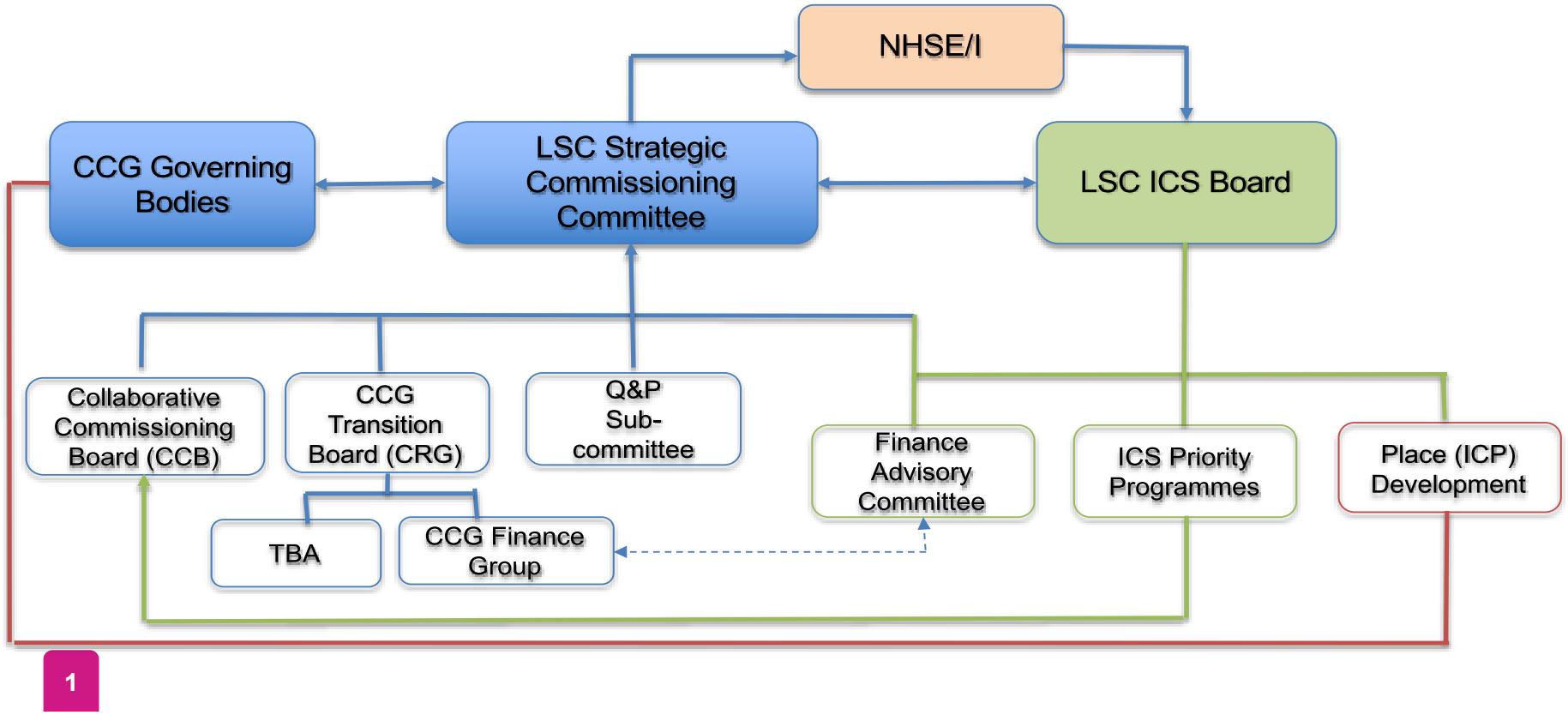
8. Review	
8.1	The Terms of Reference and Membership of the Collaborative Commissioning Advisory Group will be reviewed during Quarter 4 of 2021 by the SCC, in order that subsequent arrangements post White Paper implementation are compatible with published operating model.
8.2	Thereafter, the Terms of Reference will be formally reviewed by the CCAG at least annually and may be amended by mutual agreement between the Group members at any time to reflect changes in circumstances as they arise

APPENDIX 1 – L&SC SYSTEM REFORM PROGRAMME



 Document Status: *This is a controlled document. Whilst this document may be printed the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.*

APPENDIX 2 – L&SC ICS SCC GOVERNANCE ARRANGEMENTS



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APPENDIX 3 – MEMBERSHIP

Role on Board	Member	Organisation	Designation
Chair (CCG Clinical Lead or Lay Member)			
Vice Chair			
CCG Executive Directors – 1 per ICP			
ICS Executive Lead - Commissioning			
ICS Executive Lead - Finance			
NHSE/I - Locality Director NHS England			
NHSE/I - Deputy Director (Specialised Commissioning)			
Exec Finance Lead (from CCGs)			
Lead CSU Executive			

Item 11

STRATEGIC COMMISSIONING COMMITTEE

Title of Paper	Development of Lancashire and South Cumbria clinical commissioning policies: A decision paper for the Strategic Commissioning Committee (SCC)		
Date of Meeting	13th May 2021	Agenda Item	x

Lead Author	Amtar Ali – Senior Programme Consultant, NHS Midlands and Lancashire Commissioning Support Unit	
Contributors	Julie Hotchkiss FFPH – Consultant in Public Health, NHS Midlands and Lancashire Commissioning Support Unit	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	√
Executive Summary	The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed the development of policies for: • [gammaCore™] Non-invasive vagal nerve stimulation for the management of cluster headaches and migraines (new policy) • Spinal Injections and Radiofrequency Denervation in low back pain (revision) • Waiver of a condition with the Cosmetics surgery Policy for blepharoplasty and brow lift surgery The wiaver and these policies have been prepared for adoption across Lancashire and South Cumbria. This paper details the development process undertaken and seeks ratification of the policies.	
Recommendations	That the SCC: - note the content of the policies - approve the policies	
Next Steps	Following approval arrangements will be made to implement the policies within relevant commissioned services.	

Equality Impact & Risk Assessment Completed	**Yes**	No	Not Applicable
Patient and Public Engagement Completed	**Partially**	No	Not Applicable
Financial Implications	**Yes**	No	Not Applicable
Considerable resource will be released once the Spinal Injections policy is fully implemented. The gammaCore device has brought an upfront cost to CCGs from April 2021, but will bring			

about reduced use of expensive drugs in the target group, i.e. it is a cost-effective intervention if its use is restricted as in the proposed Policy.		
Risk Identified	Yes	**No**
If Yes : Risk		
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, Healthier Lancashire and South Cumbria	

STRATEGIC COMMISSIONING COMMITTEE

The development of Lancashire and South Cumbria clinical commissioning policies:

A decision paper for the Strategic Commissioning Committee (SCC)

1. Introduction

1.1 The purpose of this paper is to apprise the SCC of work undertaken by the Commissioning Policy Development and Implementation Working Group (CPDIG) in 2020, and to progress recently completed policies.

1.2 All Policy development work was paused at the end of March 2020.

1.3 At that time one new policy was ready to go to JCCCG for ratification (gammaCore) and one policy revision was ready to go to formal clinical consultation (Spinal Injections); these two are both brought to today's meeting for consideration and ratification.

1.4 In July 2020 the issue of extension of age thresholds in the Assisted Conception Policy needed to be dealt with urgently; an extraordinary CPDIG meeting was held, amendments made and the draft revised Policy extending the upper age threshold by one year to the end of March 2021. This was ratified at the September JCCCG meeting.

1.5 In February 2021 the CPDIG started meeting again, under the new Chair, Brent Horrell, and policy development work has started again.

1.6 An urgent update of the Continuous Glucose Monitoring (CGM) Policy came to the March 2021 JCCCG meeting so the new policy would be in place on 1 April 2021. This amendment extended the criteria to allow pregnant women with Type 1 diabetes to have access to a CGM device during their pregnancy and also adults with Learning Disabilities with Type 1 diabetes (not time limited) and is being funded for this year by NHSE. This is scheduled for review in September 2021.

2. New Policy Development - gammaCore™

2.1 Non-invasive Vagus Nerve Stimulation (VNS) with the device called gammaCore™ is the first innovation to be subject to NHS England's MedTech Funding Mandates, transitioning from the ITP (Innovation and Technology Payment) programme. It has been promoted by the Academic Health Science Networks and funded by NHSE to promote its wider adoption in the NHS over the last two years. From April 2021 commissioning responsibility came to CCGs and a number of patients were "inherited".

2.2 This product is being very actively marketed internationally for a very wide range of indications for which there is a paucity of evidence, therefore commissioners need to be aware that this first entry into the NHS, is in a very narrowly defined group, but there may pressure for its wider adoption in other areas. The decision was taken in 2019 to prepare a policy for the device, and an evidence review was completed which found that it was only shown to be effective in the treatment of cluster headaches. For reference, over the Lancashire and South Cumbria and Cheshire and Merseyside footprint, there have been 17

IFR requests for this device since 2017, one for Chronic Fatigue Syndrome and the remainder for headaches, 4 defined as migraine, 3 as *hemicrania continua* and the other 9 not further defined.

2.3 In the North West gammaCore™ has been used exclusively by the tertiary headache service at the Walton Centre. Members of the Policy Development Team went and undertook direct clinical engagement with this sole provider. The Headache Service was satisfied with the draft policy, which was based on NICE guidance that the Walton Centre had been involved in drafting.

2.4 The policy criteria are that the CCG will only commission the use of non-invasive vagus nerve stimulation (nVNS) to treat cluster headache in patients with refractory episodic or chronic cluster headache when all of the following criteria are satisfied:

- The treatment is initiated by a clinician specialising in the treatment of refractory headaches AND
- The patient has undergone an initial 3-month period of treatment at no cost to the commissioner AND
- The initial 3-month period of treatment resulted in a significant reduction in symptoms as recorded in a headache diary.

2.4 The Academic Health Science Networks/NHSE provided data on current users in December 2020 in preparation for commissioning shifting to CCGs in April 2021.

Current patients in receipt of gammaCore devices, cost and population rate, for Lancashire and South Cumbria, December 2020

CCG	gammaCore devices	Annual cost	Total Population	Crude rate
NHS Blackburn with Darwen CCG	5	£12,500	148,772	3.36
NHS Blackpool CCG	2	£5,000	139,870	1.43
NHS Chorley and South Ribble CCG	8	£20,000	175,681	4.55
NHS East Lancashire CCG	5	£12,500	377,111	1.33
NHS Fylde and Wyre CCG	4	£10,000	190,711	2.10
NHS Greater Preston CCG	1	£2,500	201,984	0.50
NHS Morecambe Bay CCG	11	£27,500	328,671	3.35
NHS West Lancashire CCG	8	£20,000	113,881	7.02
Healthier Lancashire and South Cumbria	**44**	£110,000	**1,676,681**	**2.62**

2.5 Those CCGs who send most patients to the tertiary service will have more users, in Lancashire and South Cumbria this is West Lancashire CCG, with 8 users (a rate of

7/100,000). The average rate for the ICS is 2.6/100,000. For comparison, the average in Merseyside is nearly 10/100,000.

2.6 Using gammaCore™ for cluster headaches is cost-effective because it reduces the use of the very expensive drugs (subcutaneous triptan injections) and home oxygen. NICE created a tool to show how much money CCGs will save over the next 5 years as the technology is adopted by those suffering from cluster headaches.

2.7 It is not anticipated to generate any public interest; it is a new technology, it is little known, and those patients who have been using it for cluster headaches will continue to receive it for as long as it is effective. CPDIG considered that a public consultation was unnecessary at this time as it would require a disproportionate use of resource to conduct the consultation and would be extremely unlikely to affect the final policy.

2.8 An Equality Impact and Risk Assessment (EIRA) was undertaken and no risks were identified and no changes made to the Policy.

2.9 The draft policy can be found in Appendix 1.

3. Revision of existing policy Spinal injections and radiofrequency denervation Policy for Low Back Pain

3.1 The existing policy for Spinal Injection and Radiofrequency Denervation for low back pain, which was ratified on 01 November 2018 needed to be reviewed because:

- the criteria were not fully aligned with 2016 NICE guidance, in that it still allowed some therapeutic injections to be given, rather than not commissioned for patients with low back pain
- the interval before repeat radiofrequency denervation, provided certain criteria were met, was 6 monthly, repeat radiofrequency denervation is now not commissioned
- activity on spinal injections continues to be very high in Lancashire and South Cumbria

3.2 The draft Policy was amended in line with NICE NG 59, the national Low Back Pain and Radicular Pain Pathway and Evidence-Based Interventions List 1. In March 2020, the then draft was sent for pre-formal consultation clinical feedback through a Musculo-skeletal service redesign workshop over 3 days held by the Pennine CCGs. There were two major changes compared to the existing policy:

- all therapeutic injections for low back pain (non-specific and specific) were to be discontinued. One injection was to be permitted for patients with low back pain and radicular pain (sciatica) providing certain criteria were met. Also diagnostic medial branch blocks were still permitted (in defined circumstances)

- only one Radiofrequency Denervation was allowed. This contrasted to the existing policy which allowed repeats, as frequently as 6 monthly if criteria were met.

3.3 The response was voluminous, over 50 comments were received and considered – many were challenging the recommendations which were in the NICE guidance, some were commenting on the standard wording used in all clinical policies, a few were clinical opinions where one specialist was arguing for one approach and another the opposite. A few issues raised required further consideration, which included further reference to the literature and discussion with clinical colleagues. Amendments were made and the draft was held in suspension until February 2021 when it went it went to the re-established CPDIG.

3.3 Activity on spinal injections has been very high in Lancashire and South Cumbria, particularly in some providers, and was one of the service areas identified as an outlier for the Pennie CCGs by RightCare. In an analysis of the impact of the COVID-19 service suspension comparing before and after, in the most recent pre-COVID-19 quarter, January to March 2020, there were 899 spinal injections for low back pain in Lancashire and South Cumbria, at a cost of £623,749.

3.4 The draft policy was considered against Evidence-Based Interventions List 2, published November 2020, which includes Radiofrequency Denervation for low back pain which was exactly the same as NICE NG59, questioning the effectiveness and cost-effectiveness of repeat denervation for chronic low back pain in the long term. CPDIG had debated the issue previously and agreed to not fund repeats.

3.5 The formal clinical consultation through the Trauma and Orthopaedic Network, finished on the 3 May 2021, and based on this a further change was made, namely to remove the distinction between non-specific and specific low back pain categories, as they were treated the same, and this distinction is not found in NICE nor the National Pathway and simply describe it as low back pain.

3.6 Although a Public Consultation was planned, it coincided with the Pre-Election Period so has not been undertaken. CPDIG debated whether to undertake a public engagement, and decided that as it was a revision of an existing policy and was being brought into line with NICE and Evidence-Based Interventions List 2, that it was appropriate for this usual stage in policy development to be foregone. An EIRA was completed on the existing policy.

3.7 The draft policy can be found in Appendix 2.

4. Waiver to a requirement in the Cosmetics Policy in relation to Blepharoplasty and Brow Lift Surgery

4.1 In September 2020 one of the Oculoplastic Surgeons requested that the requirement for a formal visual field measurement which was usually undertaken in hospital be

waived in order to reduce patient movement and therefore infection risk. His clinics were being held virtually, but the patients still had to come to the hospital for their visual field measurement.

4.2 CPDIG agreed to amend the criteria in the Cosmetics Policy as shown:

The CCG will commission blepharoplasty in the following circumstance:

a. The patient has excess of loose skin around the eyes which (~~with robust clinical evidence~~ with the best measurement which can be obtained without subjecting the patient to risk of infection.) is impairing vision within 30 degrees of the line of sight.

Face or Brow lifts will not be performed to correct the natural process of aging. The CCG will commission face or brow lifts in the following circumstances:

f.) The patient has brow ptosis which (~~with robust clinical evidence~~ with the best measurement which can be obtained without subjecting the patient to risk of infection) is impairing vision within 30 degrees of the line of sight.

4.3 This will be scheduled for review in January 2022.

4.4 SCC is asked to ratify the 2 amendments to the Cosmetics Policy above.

5. Recommendations

6.1 The SCC is asked to consider and ratify the above policies.

Brent Horrell

Chair of the CPDIG

4 May 2021

REPORT TO: COMMISSIONING POLICY DEVELOPMENT AND IMPLEMENTATION WORKING GROUP (CPDIG)

TO BE HELD ON: 18/February/ 2021

Agenda Item Number:	07/21
Report Title:	Non-invasive Vagus Nerve Stimulation (VNS) - (gammaCore) Policy
Author:	Julie Hotchkiss
Presented by:	Julie Hotchkiss
Purpose of the Report:	~~Discussion/~~Decision/~~Information/Update~~
Executive Summary:	The paper contains a briefing on gammaCore™, what the device is and how it is used. It gives numbers of patients using the device who will be inherited from NHS England when the funding passes over to CCGs in April - a total of 44 patients, costing £110,000 for Lancashire and South Cumbria. The Policy covers cluster headache (commissioned with criteria) migraine (not routinely commissioned). It is suggested that the public consultation stage be foregone and this policy be sent for Equality Impact Assessment, and subject to any required modification, sent to be ratified as soon as possible.

Innovation, Need and Equity: Please summarise.	The gammaCore device is the first of NHS England's new MedTech mandates. From April 2021 CCGs will pick up the cost of the existing patients using the device, and will have to fund future patients prescribed the device for use in cluster headaches,		
Financial Implications:	Are there any financial implications of the decisions requested in this paper?	Yes	No
If Yes please summarise	The costs of funding the existing patients using this device must be assumed by CCGs whether there is a policy or not. The policy restricts its use to only the condition shown to be effective (cluster headaches). The device is cost-effective compared to usual treatment with expensive drugs and oxygen.		
Service Impact Issues:	Are there any service impact issues identified in this paper?	~~Yes~~	No
Equality and Inclusion Issues:	Are there any equality and inclusion issues identified in this paper?	Yes	No
If Yes please summarise.	The Equality Impact Assessment will be completed after any required consultation.		

Cross Border Issues:	Are there any cross border issues identified in this paper?	~~Yes~~	No
Legal Issues:	Are there any legal issues identified in this paper?	~~Yes~~	No

Media/ Public Interest:	Is this likely to result in significant media/public interest?	~~Yes~~	No

Non-invasive vagus nerve stimulation (gammaCore™)

gammaCore™ is the first innovation to be subject to NHS England's MedTech Funding Mandates, transitioning from the ITP (Innovation and Technology Payment) programme. It has been promoted by the Academic Health Science Networks and funded by NHSE to promote its wider adoption in the NHS over the last two years. From April 2021 commissioning responsibility will fall to CCGs and a number of patients will be "inherited".

gammaCore™ is a hand-held device which allows the patient to stimulate their vagus nerve using a non-invasive method. This "disrupts the pain signals" caused by cluster headaches, and other chronic headaches. The patient holds the device against their neck either during an attack, or as prophylaxis to prevent a headache developing. There is a video showing its use on the manufacturer's website https://www.gammacore.co.uk/.

There are two relevant NICE publications, IPG 552 Transcutaneous stimulation of the cervical branch of the vagus nerve for cluster headache and migraine and the recently published (December 2019) MedTech Guidance 46 gammaCore for cluster headache, which establish its effectiveness for cluster headaches, but not for migraine. It is cost-effective because it reduces the use of the very expensive drugs (triptan injections) and home oxygen. NICE has created a tool to show how much money CCGs will save over the next 5 years as the technology is adopted by those suffering from cluster headaches.

This product is being very actively marketed internationally for a very wide range of indications for which there is scant or non-existent evidence, therefore commissioners need to be aware that this first entry into the NHS, in a very narrowly defined group, but there may pressure for its wider adoption in other areas.

The device is provided free by the manufacturer and the patient tries it for a 93-day period. If unsuccessful it doesn't cost the commissioner anything. If successful, the commissioner then pays £625 for each 93 day top up (total cost of £2,500 per year). Future patients who have success with the device may generate savings to the future medicines bill, thus making it cost-effective. But savings will have already been accrued in the drug budgets of the host CCGs for the current cohort of patients, so for 2021 there will be a net additional cost coming to CCGs.

In the North West gammaCore™ has been used exclusively by the tertiary headache service at the Walton Centre. Therefore is to be expected that those CCGs who send most patients to the tertiary service will have more users, in Lancashire and South Cumbria this is West Lancashire CCG, with 8 users (a rate of 7/100,000). The average rate for the ICS is 2.6/100,000. For comparison, the average in Merseyside is nearly 10/100,000.

Current patients in receipt of gammaCore devices, cost and population rate, for Lancashire and South Cumbria, December 2020

CCG	gammaCore devices	Annual cost	Total Population	Crude rate
NHS Blackburn with Darwen CCG	5	£12,500	148,772	3.36
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Healthier Lancashire and South Cumbria	**44**	£110,000	**1,676,681**	**2.62**

Over the Lancashire and South Cumbria and Cheshire and Merseyside footprint, there have been 17 IFR requests for this device since 2017, one for Chronic Fatigue Syndrome and the remainder for headaches, 4 defined as migraine, 3 as *hemicrania continua* and the other 9 not further defined.

Whether we have a policy or not, CCGs will have to pay for its use in cluster headache. There is a strong evidence base for cluster headache, but not for any other conditions. The Policy Development Team undertook an Evidence Review in 2019, undertook clinical engagement and drafted a Policy which was reviewed by CPDIG and approved to go out for public consultation early in 2020.

When policy development can recommence the Policy is ready to go out to public consultation, should that stage be deemed necessary. It is not anticipated to generate any public interest; it is a new technology, it is little known, and those patients who have been using it for cluster headaches will continue to receive it for as long as necessary. CPDIG should consider whether a public consultation is necessary at this time when there is little resource available to conduct the consultation and any consultation undertaken is extremely unlikely to affect the final policy.

The final stage would be to complete an Equality Impact Assessment and if there were no amendments made to sent to CPDIG for final approval and on to JCCCG for ratification.

Recommendations

- That CPDIG takes the decision to waive the public consultation on this policy.
- That CPDIG agrees to the Policy being sent for Equality Impact Assessment.
- That should no amendments be required, that the Policy be sent for ratification by JCCCG at the next available meeting.
- If amendments are suggested that these be reviewed by members via email for approval.

Attachment embedded

Draft Policy for the use of non-invasive vagus nerve stimulation (nVNS), including gammaCore® transcutaneous electrical vagal nerve stimulation, in the management of headaches v0.3

Please note that when embedded in this document the spacing has changed. As a separate file it is more condensed.

Document control: Policy for the use of non-invasive vagus nerve stimulation (nVNS), including gammaCore® transcutaneous electrical vagal nerve stimulation, in the management of headaches.		
	Version Number:	**Changes Made:**
Version of: January 2020	V0.1	First draft policy done.
Version of: February 2020	V0.2	- Scope of the policy restricted to migraine only, following indication that commissioning responsibility for cluster headache will remain with NHSE. - Scope clarified to patients over the age of 18 years, in line with supplier marketing/evidence base.
Version of: November 2020	V0.3	Scope changed back to include cluster headaches as commissioning responsibility transfers to CCGs on 1 April 2021

Notes

Lancashire and South Cumbria CCGs

Policies for the Commissioning of Healthcare

Policy for the use of non-invasive vagus nerve stimulation (nVNS), including gammaCore® transcutaneous electrical vagal nerve stimulation in the management of headaches.

	Introduction
	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
1	**Policy**
1.1	The CCG will only commission the use of non-invasive vagus nerve stimulation (nVNS) to treat cluster headache in patients with refractory episodic or chronic cluster headache[1,2] when all of the following criteria are satisfied:
1.1.1	• The treatment is initiated by a clinician specialising in the treatment of refractory headaches AND
1.1.2	• The patient has undergone an initial 3-month period of treatment at no cost to the commissioner AND
1.1.3	• The initial 3-month period of treatment resulted in a significant reduction in symptoms as recorded in a headache diary.
1.2	The CCG will not routinely commission the use of nVNS in the management of patients with migraine[1,3] as it considers the use of nVNS in this indication does not accord with the Principles of Effectiveness and Cost-Effectiveness.
2	**Scope and definitions**
2.1	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).

2.2	nVNS are used for a wide range of indications. For the purpose of this policy nVNS refers to a non-implantable hand-held stimulator whose objective is to prevent or treat headaches.
2.3	The scope of this policy includes requests for nVNS for patients over the age of 18 years.
2.4	The CCG recognises that a patient may have certain features, such as • having a headache condition; • wishing to have a service provided for their headache condition; • being advised that they are clinically suitable for nVNS, and • be distressed by their headache condition, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.6	For the purpose of this policy the CCG defines refractory as persisting despite trying a number or combination of pharmacological therapies at sufficient doses for sufficient time and when the patient is measurably disabled by the condition.
2.7	This policy reflects NICE guidance gammaCore for cluster headache. MedTech Guidance (MTG) 46. https://www.nice.org.uk/guidance/mtg46
3	**Appropriate Healthcare**
3.1	The purpose of using nVNS stimulation is normally to either prevent headache attacks in patients with chronic/episodic headaches or to disrupt pain signals during an attack, reducing the symptoms experienced.
3.2	The CCG regards the achievement of this purpose as according with the Principle of Appropriateness. Therefore, this policy does not rely on the Principle of Appropriateness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question when considering an application to provide funding.

4	**Effective Healthcare**
4.1	The policy criteria relating to the use of nVNS for the management of migraine relies on the Principle of Effectiveness as the CCG considers there is insufficient evidence to demonstrate it is effective in preventing migraine occurrence or reducing the symptoms of attacks.
5	**Cost Effectiveness**
5.1	The policy criteria relating to the use of nVNS for the management of migraine relies on the Principles of Cost-Effectiveness. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the purpose of the treatment is likely to be achieved in this patient without undue adverse effects when considering an application to provide funding.
6	**Ethics**
6.1	The CCG does not call into question the ethics of nVNS for the management of headaches and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient when considering an application to provide funding.
7	**Affordability**
7.1	The CCG does not call into question the affordability of nVNS for the management of headaches and therefore this policy does not rely on the Principle of Affordability. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient when considering an application to provide funding.
8	**Exceptions**

8.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
8.2	In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
9	**Force**
9.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
9.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
10	**References**
	[1]NICE Interventional procedures guidance (IPG) 552 Transcutaneous stimulation of the cervical branch of the vagus nerve for cluster headache and migraine. Published March 2016. https://www.nice.org.uk/guidance/ipg552 [2] NICE MedTech Guidance (MTG) 46 gammaCore for cluster headache. Published December 2019https://www.nice.org.uk/guidance/mtg46 [3] Diener HC, Goadsby PJ, Ashina M *et al.* Non-invasive vagus nerve stimulation (nVNS) for the preventive treatment of episodic migraine: The multicentre, double-blind, randomised, sham-controlled PREMIUM trial. Cephalalgia Sep 2019; p. 333102419876920 https://journals.sagepub.com/doi/pdf/10.1177/0333102419876920

Date of adoption

Date for review

Spinal Injections and Radiofrequency Denervation for Low Back Pain Policy		
	Version Number:	**Changes Made:**
Version of: 08 April 2020	V0.1	Original rewritten policy
14 April 2020	V0.2	Corrections from Paula Whittaker, MLCSU
01 July 2020	V0.3	Corrections from Kirsty Eyre and Gemma Hedge, EL CCG
08 July 2020	V0.4	OPCS codes amended Julie Hotchkiss- NB – will need checking/amending when everything else finalised.
09 February 2021	V0.5	Amended to ensure compatibility with Evidence Based Interventions List 2 on Radiofrequency Denervation published November 2020 by Julie Hotchkiss
23 February 2021	V0.6	Following discussion at CPDIG 18/02/21 added the wording “as part of package of multi-disciplinary care with a current service provider”
3 May 2021	V0.7	Following clinical consultation, merged non-specific and specific low back pain sections, so it is now all “low back pain”.

Lancashire and South Cumbria Clinical Commissioning Groups (CCGs)

Policies for the Commissioning of Healthcare

Spinal Injections and Radiofrequency Denervation for Low Back Pain Policy

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right, but will be applied with reference to other policies in that suite.
1.2	This policy is based on the CCGs' Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Policy**
2.1	Invasive, non-surgical interventions and treatments for low back pain and sciatica must be considered in line with NICE NG59[1], the National Low Back and Radicular Pain Pathway[2], and Evidence Based Interventions, 2019 wave[3] and 2021 wave[4]. Clinical review or triage should establish whether the pain is non-specific or specific low back pain or back pain with radicular pain (sciatica).
2.2	**Spinal Injections for low back pain** The CCG considers that, in line with NICE Guidance NG59, spinal injections for managing low back pain do not accord with the Principle of Effectiveness, therefore the CCG will not routinely commission this intervention.
2.3	**Spinal Injections - Low back pain with Radicular pain (sciatica)**
2.3.1	An early clinical review should be undertaken in line with the National Back and Radicular Pain Pathway to ensure emergency symptoms such as impending cord compression or cauda equina are treated rapidly.
2.3.2	The use of non-pharmacological (physiotherapy, psychological therapies, exercise) and pharmacological interventions, including self-management, should be **optimised prior to injection therapy.** The injection should only be given as part of package of multi-disciplinary care with a current service provider. **Eligibility criteria:**
2.3.3	The CCG will commission **one therapeutic** epidural steroid injection of the lumbar spine for the management of radicular pain when the following criteria are satisfied:
2.3.3.1	- The patient has **acute and severe sciatica and**
2.3.3.2	

2.3.4	- The injection is part of a comprehensive multi-disciplinary package of care The CCG will commission medial branch blocks for **diagnostic** purposes, as a prerequisite for radiofrequency denervation.
2.5 **2.5.1** **2.5.1.1** **2.5.2.2** **2.5.2.3** **2.5.2.4**	**Radiofrequency denervation** The CCG will commission **one** radiofrequency denervation procedure for a person with chronic low back pain with radicular pain in the following circumstances: - non-surgical treatment has not worked for them **and** - the main source of pain is thought to come from structures supplied by the medial branch nerve, as confirmed by a positive response to a diagnostic medial branch block within the last 6 months **and** - they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) **and** - the treatment is part of package of multi-disciplinary care with a current service provider
3	**Scope and definitions**
3.1	The scope of this policy includes the use of spinal injections, including facet joint injections and epidural injections of steroid and anaesthetic and radiofrequency denervation for the management of low back pain in patients over the age of 16 years.
3.2	The scope of this policy does not include the specific management of back pain related to related to the following conditions: - Infection - Trauma (e.g. fractured spine which may need vertebroplasty or kyphoplasty as approved by NICE) - Inflammatory disease such as spondyloarthritis - The evaluation of people with sciatica with progressive neurological deficit or cauda equina - Scoliosis - Spinal injury - Metastatic spinal cord compression - Suspected cancer - Sacroiliac joint pain If serious underlying pathology is suspected refer to the relevant NICE guidance.
3.3	The CCG recognises that a patient may have certain features, such as - having back pain, - wishing to have a service provided for back pain,

	- being advised that they are clinically suitable for spinal injections, and - being distressed by their back pain, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
3.4	There are two groups of pathologies that commonly affect the lumbar spine and cause back pain for which injections have been considered. These groups respond differently to injection therapy. Before treatment, patients need adequate assessment by a multi-disciplinary team and management approach to make a diagnosis or diagnoses. Injections may be part of the diagnosis process (diagnostic blocks). For the purpose of this policy the CCG follows the definitions used in NICE guidance NG59. The groups are as follows: **A) Radicular pain** - Patients with nerve root compression irritation and/or inflammation. Patients typically present with predominantly leg pain or sciatica. The two most common causes of radicular pain are prolapsed (herniated) intervertebral disc and spinal canal stenosis. Patients should be managed on an explicit care pathway with explicit review and decision points. Injection therapy for radicular pain in a carefully selected patient is an appropriate procedure and is therefore funded in certain circumstances. See section 2.4 for eligibility criteria. **B) Low back pain** – is low back pain not attributable to a specific pathology or cause. It is not associated with potentially serious causes (e.g. infection, tumour, fracture, structural deformity, inflammatory disorder, radicular syndrome, or cauda equina syndrome). The management of non-specific low back pain represents a challenge in health care provision. Low back pain has been described in the literature as 'non-specific', 'mechanical', 'musculoskeletal' or 'simple' low back pain (NG59). Injection therapy is not an appropriate procedure for low back pain, as advised by NICE NG59, and is therefore not funded.
3.5	Relevant evidence and guidelines have been reviewed including the recommendations of: • NICE quality standard published 27July 2017 https://www.nice.org.uk/guidance/qs155 • NICE guidance NG59 published 30 November 2016[1] https://www.nice.org.uk/guidance/ng59 • National Low Back and Radicular Pain Pathway. Third Ed. 3.0 30th June 2017[2]

	• Evidence-Based Interventions Guidance[3,4]
4	**Appropriate Healthcare**
4.1	Spinal injections of steroid and anaesthetic are invasive treatments that are used in two ways: - First (**Diagnostic**): Selective nerve root block can be used to diagnose the source of radicular back pain. Medial branch block is recognised as a diagnostic tool to identify the source of the pain. - Second (**Therapeutic**): epidural injections and radiofrequency denervation have been used as treatments to relieve radicular pain and specific back pain respectively.
4.2	The CCG regards the achievement of this purpose as according with the Principle of Appropriateness. Therefore, this policy does not rely on the principle of appropriateness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question before confirming a decision to provide funding.
5	**Effective Healthcare**
5.1	The CCG has considered NICE guidance (NG59) which states that spinal injections have a role in the treatment of acute sciatica in specified circumstances and similarly that radiofrequency denervation is effective in certain circumstances. The CCG has considered the role of spinal injections in the management of low back pain (excluding sciatica) and found that no consistent good quality evidence recommended the use of spinal injections for the management of low back pain; therefore they do not meet the principle of effectiveness. This policy relies on the Principle of Effectiveness. Nevertheless, if a patient is considered exceptional in relation to this principle, the CCG may consider whether the treatment is likely to be effective in this patient in deciding whether or not to provide funding.
6	**Cost Effectiveness**
6.1	The CCG has not considered the cost-effectiveness of spinal injections since they do not meet the principle of effectiveness and therefore this policy does not rely on the Principle of Cost-Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be cost-effective in this patient before confirming a decision to provide funding. The CCG has noted NICE guidance (NG59) states that the length of pain relief after radiofrequency denervation is uncertain. Pain relief for more than 2 years would not be an unreasonable clinical expectation. The economic model presented suggested that radiofrequency denervation is likely to be cost effective if pain relief is above 16 months.

7	**Ethics**
7.1	The CCG has not called into question the ethics of spinal injections since they do not meet the principle of effectiveness and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
8	**Affordability**
8.1	The CCG has not called into question the affordability of spinal injections since they do not meet the principle of effectiveness and therefore this policy does not rely on the Principle of Affordability. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient before confirming a decision to provide funding.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
9.2	In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
10	**Force**
10.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
10.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: - If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. - If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
11	**References**
	[1] NICE Guidance NG59 (November 2016) Low back pain and sciatica in over 16s assessment and management https://www.nice.org.uk/guidance/ng59/resources/low-back-pain-and-sciatica-in-over-16sassessment-and-management-1837521693637

	[2] National Low Back and Radicular Pain Pathway. Third Edition 3.0 30th June 2017.https://ba17bc65-2f2f-4a2f-9427-cd68a3685f52.filesusr.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf [3] Evidence-Based Interventions: Guidance for Clinical Commissioning Groups CCGs). NHS England and NHS Improvement. 20 November 2018. https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ccgs/ [4] Evidence-Based Interventions. List 2 Guidance. Academy of Royal Colleges. November 2020 https://www.aomrc.org.uk/wp-content/uploads/2020/12/EBI_list2_guidance_050121.pdf

Appendix 1: Associated OPCS codes

The codes applicable to this policy are:

OPCS codes
A521, A522, A528, A529, A573, A574, A575, A577, V485, V486, V487, V488, V489, V544, W903, X382 Z675, Z676, Z677, Z993

Appendix 2: Terms and abbreviations

Term or abbreviation	Definition as used in the policy
Epidural injection	The introduction of a drug (in this case anaesthetic or steroid) into the space around the dura mater of the spinal cord via a needle or canula.
Facet joints	The small joints in between the vertebrae, two connections above each vertebra, one on each side, and two below
Facet joint injections	Injections of local anaesthetic or steroid into the facet joints.
Low back pain	Soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.
Lumbar	Relating to the major component lower spine. The lower spine also contains the sacrum and coccyx.
Medial branch blocks	Injections of local anaesthetic on to the medial branch nerves that serve the facets joints.
NICE	National Institute for Health and Care Excellence
Low back pain	Low back pain not associated with cancer, fracture, infection or an inflammatory disease process. Also described as mechanical, musculoskeletal or simple low back pain. Includes paraspinal pain. Covers about 90% of low back pain.
Radicular pain/ radicular syndromes/ radiculopathy	Pain felt along the sensory distribution of a nerve due to inflammation or pressure at the nerve root. For example, pressure of the L5 nerve root can cause pain felt down the leg and into the big toe.
Radiofrequency denervation, aka radiofrequency lesioning (RFL)	A minimally invasive and percutaneous procedure, where radiofrequency energy is delivered along a needle in contact with the target nerve to denature it. The nerves may regenerate over time.
Sciatica	Leg pain secondary to lumbosacral nerve root pathology. A form of radiculopathy.
Spinal injections	A broad term encompassing injections into various parts of the spine, including joints and nervous tissue.

Date of adoption
Date for review