Lancashire and South Cumbria
Health and Care Partnership

**Strategic Commissioning Committee (Formal)**

**9 September 2021, 1 pm – 3.00 pm**

**via MS Teams Videoconference**

# Agenda

| 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 meeting held on 15 July 2021, matters arising and actions to agree | Chair | Approve | Attached |
| 5. | Key Messages | Andrew Bennett | Discuss | Verbal |
| 6. | Terms of Reference | Andrew Bennett | Approve | Attached |
| **Managing 2021/22** | | | | |
| 7. | CCG Closedown | Denis Gizzi | Note | Attached |
| 8. | Quality and Performance | Kathryn Lord/ Roger Parr | Discuss / Note | Attached |
| **Building the system for 2021/22 and beyond** | | | | |
| 9. | New Hospitals Programme Quarter 1 Report | Jerry Hawker | Note | Attached |
| 10. | a) Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions<br>b) Commissioning Policy Development and Implementation Group<br>- Dilatation and Curettage Policy<br>- Male Circumcision Policy<br>- Carpal Tunnel Syndrome | Brent Horrell | Approve | Attached |
| **Reports from Sub-Committees** | | | | |
| 11. | CCG Transition Board | Roy Fisher | Note | Attached |
| 12. | Collaborative Commissioning Advisory Group | Peter Tinson | Note | Attached |
| 13. | Quality and Performance Sub-Committee | Kathryn Lord | Note | Attached |
| **Items for Information** | | | | |

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|---|---|---|---|---|
| 14. | Questions received for 15 July 2021 meeting | - | - | Attached |
| **Any Other Business** | | | | |
| 15. | Any Other Business | Chair | Note | Verbal |
| **Next meeting of the Strategic Commissioning Committee:-**<br>Thursday 11 November 2021, 1 pm – 3 pm, MS Teams (Formal meeting) | | | | |

Item 4

Subject to ratification at the next meeting

**Strategic Commissioning Committee**

| Minutes of Meeting | |
|---|---|
| **Date and time** | 15 July 2021, 1 pm – 3 pm |
| **Venue** | Microsoft Teams |
| **Chair** | David Flory |

| **Present** | | |
|---|---|---|
| David Flory | Independent Chair | Lancashire and South Cumbria ICS |
| Amanda Doyle | ICS Chief Officer/CCG Accountable Officer | Lancashire and South Cumbria ICS/NHS Blackpool, Fylde & Wyre CCG, West Lancashire CCGs |
| Andrew Bennett | ICS Executive Director of Commissioning | Lancashire and South Cumbria ICS |
| Gary Raphael | ICS Executive Director of Finance | Lancashire and South Cumbria ICS |
| Andy Curran | ICS Executive Medical Director | Lancashire and South Cumbria ICS |
| Jane Cass | NHS England Locality Director | NHS England and Improvement – North West |
| Nicola Adamson | NHS England Commissioning Representative | NHS England and Improvement – North West |
| Debbie Corcoran | Lay Member (Gtr Preston CCG) | Lancashire and South Cumbria ICS |
| David Swift | Lay Member (East Lancs CCG) | Lancashire and South Cumbria ICS |
| Lindsay Dickinson | CCG Chair | NHS Chorley & South Ribble CCG |
| Roy Fisher | CCG Chair | NHS Blackpool CCG |
| Geoff Jolliffe | CCG Chair | NHS Morecambe Bay CCG |
| Graham Burgess | CCG Chair | NHS Blackburn with Darwen CCG |
| Peter Gregory | CCG Chair | NHS West Lancashire CCG |
| Richard Robinson | CCG Chair | East Lancashire CCG |
| Kevin Toole | CCG Lay Member (attending on behalf of Adam Janjua) | NHS Fylde and Wyre CCG |
| Sumantra Mukerji | CCG Chair | NHS Greater Preston CCG |
| Denis Gizzy | CCG Accountable Officer | NHS Central Lancashire CCGs |
| Anthony Gardner | CCG Chief Operating Officer (attending for Morecambe Bay AO) | NHS Morecambe Bay CCG |
| Kevin McGee | ICS Provider Collaborative Representative | ICS Provider Collaborative |
| Ben Butler-Reid | Executive Clinical Director | Fylde Coast CCGs |
| **In Attendance** | | |
| Dr Deborah Lowe | National Clinical Director for Stroke | NHS England and Improvement |
| Jack Smith<br><br><br>Elaine Day | Director of Stroke Transformation Programme<br><br>Manager | Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) Programme |
| Phil Woodford | Chair | Patient & Carer ISNDN Assurance Group |
| Sharon Walkden | Project Manager | Lancashire and South Cumbria ICS |
| Fiona Ball | Working Planning Lead – Lancashire and South Cumbria | Health Education England |

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|---|---|---|
| Gareth Jones | Head of Finance – Greater Manchester and Lancashire | NHS England - North West |
| Roger Parr | Deputy Chief Officer | NHS Blackburn with Darwen CCG |
| Fleur Carney | Director Mental Health, Learning Disabilities & Autism Programme | Lancashire and South Cumbria ICS |
| Jane Scattergood | Director of Nursing and Quality | Lancashire and South Cumbria ICS |
| Jerry Hawker | Executive Director and SRO – New Hospitals Programme | Lancashire and South Cumbria ICS |
| Brent Horrell | Head of Medicines Commissioning | NHS Midlands and Lancashire CSU |
| Neil Greaves | Head of Communications and Engagement | Lancashire and South Cumbria ICS |
| Peter Tinson | Director of Collaborative Commissioning | Lancashire and South Cumbria ICS |
| Pam Bowling | Corporate Office Team Leader | Lancashire and South Cumbria ICS |
| Becky Higgs | Business Manager to Amanda Doyle | Lancashire and South Cumbria ICS |
| Sandra Lishman | Corporate Office Co-Ordinator (minute taker) | Lancashire and South Cumbria ICS |
| **Public Attendees** | | |
| 12 members of the public were present | | |

## 1. Welcome and Introductions

The Chair welcomed committee members and members of the public, observing the meeting, to the formal meeting of the Strategic Commissioning Committee (SCC), held virtually via Microsoft Teams videoconference.

The level of interest and engagement from members of public and other stakeholders in the Strategic Commissioning Committee's business was welcomed. A number of questions had been raised prior to today's meeting, some relating to items on the agenda. Presenters were aware of the questions and would reference the issue if possible, within the item. Questions unrelated to agenda items would not be answered in the meeting; all questions and responses would be published with the minutes of this meeting. The committee was committed to openness and transparency.

## 2. Apologies for absence

Apologies were noted from Adam Janjua, Beth Goodman, David Blacklock, Katherine Lord, Julie Higgins and Linda Riley.

## 3. Declarations of Interest

**RESOLVED: No additional declarations of interest were declared in relation to items on the agenda.**

## 4. Minutes of the previous informal meeting held on 13 May 2021

The Chair proposed the minutes be accepted as a correct record of the meeting held on 13 May 2021; Roy Fisher seconded.

**RESOLVED: The minutes of the meeting were approved as a correct record.**

## 5. Key Messages

Amanda Doyle reported that the second reading of the Health and Care Bill had now been passed in Parliament, enabling a range of developments to be able to be taken forward, including the ability to begin to recruit to designate posts in the new ICS structures.

Dr Doyle had recently been appointed to the role of NHS England's North West Regional Director. Andrew Bennett will act as the interim ICS lead for the L&SC partnership and continue his commissioning lead role for the Strategic Commissioning Committee. In addition, Andrew will act as the interim Chief Officer and Accountable Officer for Blackpool, Fylde and Wyre and West Lancashire CCGs.

The Chair expressed thanks to Dr Doyle for her leadership of the system whilst being the Accountable Officer at three CCGs and lead officer for the ICS. Lancashire and South Cumbria had been one of the first ICS sites in the country and was in a strong position to progress during this key period of reform. The process of appointment of a substantive ICS lead Chief Executive Officer would soon begin. On behalf of this committee and predecessor JCCCGs, the Chair expressed his thanks to Dr Doyle wishing her the very best for the future.

## 6. Enhanced Network model of Acute Stroke Care – Full Business Case

Jack Smith (JS) presented slides explaining that the purpose of discussion today was to seek approval to invest in acute stroke services and rehabilitation services in Lancashire and South Cumbria. The Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) had undertaken a significant amount of development work to ensure that local stroke services comply with national best practice and deliver high quality outcomes for residents. This work had led to the creation of a business case which contained proposals to enhance the model of acute stroke care and rehabilitation in Lancashire and South Cumbria. The full business case had been shared with members.

The total additional recurring revenue cost to Commissioning for delivery of the enhanced model of care would be £13.8 million and the additional capital expenditure required was £5.7 million. A phased investment plan was proposed, over the next 3 years, correlating with the time required to develop the additional stroke specialist workforce for delivery.

Further public engagement was recommended in 2021/22 in advance of the planned operational changes to patient pathways for Morecambe Bay residents expected by 2023.
Phil Woodford (PW) spoke from a patient experience perspective, being a stroke survivor and advised that the Patient Care Assurance Group fully supported this proposal and, on behalf of the group, thanked the ISNDN for involving them so transparently in each stage. Fellow carers and survivors in the Group were also thanked for their input into the proposal.

JS explained that the new proposed model includes robust stroke specialist triage and ambulatory care within each hospital Emergency Department 24/7; enhanced acute services with an operational model of 3 acute stroke centres, accessible 24 hours a day, 7 days a week at Royal Preston Hospital, Royal Blackburn Hospital and Blackpool Victoria Hospital; appropriate ambulance cover for patient transfers and repatriation; 7-day in-patient stroke rehabilitation; and integrated community stroke rehabilitation service available 7 days.

All existing stroke units would remain open, albeit with some changes involved. Patients ordinarily attending Furness General Hospital would continue to present for initial triage and treatment, prior to transferring to the Comprehensive Stroke Centre in Preston for 24-hour care, for up to 3 days. Residents ordinarily attending Royal Lancaster Infirmary would be directly diverted to the Preston Stroke Centre for the triage and initial treatment process along with 24-hour care, for up to 3 days.

The clinical model and phased investment plan had been assured in multiple stages. The risks and mitigations were outlined which included financial affordability given the current system financial deficit, hence a phased investment plan was proposed. The ISNDN Board had approved the implementation plan and would report to the Provider Collaborative Board in taking forward the plans. A dedicated operational implementation group would also be established.

A significant amount of engagement had taken place over the last 3 years developing an enhanced model of care and phased investment plan. Wider engagement would be required prior to the enhancement of acute stroke service changes in 2023. Deborah Lowe (DL) supported the proposed enhancements described to save lives, reduce disability and tackle the health inequalities gap. The enhanced service would enable a sustainable world class model of care delivery and was supported by NHS England/Improvement.

The Chair thanked Phil, Jack and Deborah for their contributions along with Elaine and reminded members that they had previously given detailed consideration of this matter. Members were familiar with the financial proposal and critical issues within the case for change and should have confidence therefore in the professionalism, thoroughness, leadership and engagement undertaken to get to this point.

Geoff Joliffe (GJ) reported that Morecambe Bay were in support of this very timely proposal, however, raised concern regarding the recent change relating to the Royal Lancaster Infirmary. It was recognised that this was an ICS decision for implementation across the system, however, there was a need to understand how the clinical pathways would work in Morecambe Bay and to ensure there would be adequate ambulance capacity. It was suggested that the ISNDN take this forward with due regard to engagement with the clinical bodies in Morecambe Bay and be mindful that the Overview and Scrutiny Committee may request further public engagement. Dr Joliffe asked that he be involved in the implementation work.

Roy Fisher (RF) congratulated the team on the presentation and asked that as implementation and delivery would be through the ISNDN Board and Provider Collaborative, update reports be provided to the Strategic Commissioning Committee for awareness of issues raised.

JS responded that wider engagement had been planned with Morecambe Bay clinicians and public forums; it was the responsibility of the ISNDN working with partners to ensure this occurred. The ISNDN Board and/or Provider Collaborative Board would provide regular update reporting to this Committee, to ensure Commissioners could influence any issues raised.

Kevin Toole supported the proposal and asked how the programme would dovetail with the New Hospitals Programme. JS responded that the executive sponsor for the ISNDN also sits on the New Hospital Programme Board and decisions taken through the Provider Collaborative would ensure any interdependencies between the New Hospitals Programme and Acute Stroke Units would be fully understood. The New Hospitals Programme vision had been considered when looking at the number of stroke centres.

Debbie Corcoran (DC) commented that the evidence base for the proposal was strong, the engagement approach had been exemplary and echoed the recommendations of Phil Woodford and the Stroke Patient and Carer Assurance Group in supporting the new service delivery.

Peter Gregory offered his support to the service model and referred to discussion at a recent primary care sub-cell meeting. Disappointment had been expressed that there had not been earlier engagement with primary care and concerns noted about the distance of travel for people in Barrow and Morecambe Bay and the impact this may have on deprived individuals. The Group had also discussed the ethos as an ICS. Significant financial investment was required and whilst hyper acute services were necessary for the future, the challenge was how to tackle these issues in a preventative way.

Nicola Adamson shared a view from NHS England specialised commissioning that it would take longer in Lancashire and South Cumbria than in other areas to get a thrombectomy service to a 24-hour, 7-day week, however, they were very supportive to move forward and put the service in place.

The Chair sought the Committee's approval to the recommendations, confirming that whilst a new set of statutory arrangements would be in place for Commissioning from April 2022, subject to legislation, a decision was required by this Committee at this meeting today.

**RESOLVED: The Strategic Commissioning Committee:**

- **Approve 3-year financial revenue and capital funding requirement**
- **Agreed to instruct the ISNDN Board to take responsibility for implementation delivery under the assurance oversight of the Lancashire and South Cumbria Provider Collaborative Board**
- **Approve the communication and engagement plan including further public engagement about the changes proposed to patient pathways.**

Following the resolution, the Chair added that there was a need to be mindful of the questions raised at this meeting, when taking forward the communications and engagement exercise and to be reactive to discussions that take place. Colleagues should listen to concerns raised and bring them back to this table, and other forums, to ensure they are addressed through implementation. The Health Overview and Scrutiny Committees would play an important role in this. JS and PW added that they had met with local MPs in

Morecambe Bay who were very supportive, and arrangements were in place to meet with Cumbria and Lancashire County Councils. The Chair continued that the quality of the work undertaken to this stage demanded a comprehensive communications and engagement plan.

JS thanked the Committee for their support to what was a big step in the journey and expressed his appreciation to the team for their work and made a commitment to the further public engagement and listening exercise.

## 7. New Hospitals Programme Case for Change

Jerry Hawker (JH) presented the report and explained the background to the development of the New Hospitals Programme case for change and the opportunities and impact it would have in Lancashire and South Cumbria. As part of the assurance process, NHS England had supported the case for change, asking for a number of amendments to the previous draft which included strengthening the relationship between the New Hospitals Programme and the ICS Strategy, ensuring it was clear that the New Hospitals Programme included options to rebuild and refurbish facilities as well as developing new hospitals and strengthened detail around Furness General Hospital and clinical remote dependency as assets in this area remained a strong and viable hospital. Visual aspects of the document had been improved to ensure it was easier for the public to read. The next steps would be around engagement with the public, using social media and focus groups working with Healthwatch and insight services. The 'Big Chat' was being expanded as a mechanism for staff support.

The Chair thanked Jerry and the team for their work on the document and invited questions and comments.

Members felt that overall, the document had improved in a short period of time and shared the following discussion points. Debbie Corcoran (DC) commented on this being a clear, well written and compelling case for change which demonstrated positive pre-engagement and opportunities for public and staff to share their views prior to moving to the public engagement phase. DC suggested that key themes from the public engagement be included such as 'You Said…We Heard'. DC also expressed disappointment that the draft case for change was not able to be shared with the public seven days prior to this meeting, along with the other Committee papers. DC asked if planning and timings of Committee meetings could be considered to synchronise the New Hospitals Programme to ensure there would be public engagement going forward. JH responded that timing was being looked at.

In response to a question as to whether the document has been 'tested' with members of the public in terms of it being credible and easy to understand, it was confirmed that members of the public, Non-Executive Directors and Lay Members had been given the opportunity to scrutinise the case for change and, as a result, presentational changes had been made. It was confirmed that a summary and an 'easy read' version of the case for change would be produced and an external PR support company had been secured to support the engagement process.

David Swift (DS) commented that this was a very good and readable report, adding that one of the key features in the approval of the New Hospitals Programme would be around a green eco-friendly environment and asked if this matter was sufficiently addressed in the case for change. JH responded that more reference would be made to this in the business case and that work was underway with the national team around modern methods of construction.

Action: JH to check the deficit figures on pages 69 and 70, differing by £40m. **ACTION: Jerry Hawker**

**RESOLVED: Members of the ICS Board:-**

- **Approved the material changes within the case for change, in line with feedback received**
- **Noted that this case for change would be made available to key stakeholders and the public week commencing 12 July 2021**
- **Noted that a summary version of this case for change would be published over the coming weeks.**

## 8. Quality and Performance Report

Roger Parr (RP) presented the paper which attempted to bring together collective oversight for quality and performance. The NHS System Oversight Framework had been published after the paper had been written and would be a focus incorporated in future papers. Deep dive reporting on elective care and mental health had been circulated with the meeting report. The focus would be on urgent care and cancer at the next meeting.

RP highlighted the following key issues from within the report. With regard to urgent care, activity levels in April 2021 were at pre-pandemic levels. May's position against the 4-hour target was over 81%. High occupancy levels had driven an increase in ambulance turnover delays. The number of 12-hour mental health breaches continued to increase whilst physical health 12-hour breaches remained stable. COVID bed occupancy had increased in June compared to May, however, numbers were low compared to summer 2020. Each Trust had now agreed a set of initiatives for urgent care recovery with an implementation/monitoring process being co-ordinated via the GOLD command hub. Challenges were reported in performance against the cancer waiting times targets which were directly related to COVID-19 pressures and diagnostic capacity. Diagnostics had shown a steady increase in numbers on the waiting list, despite an increase in demand improvement in performance against the diagnostic 6-week target.

Jane Scattergood (JS) advised work was underway to include enhanced quality narrative to these reports in the future and added that many of the quality themes in the report were due to impact of COVID and the pandemic, including any harm caused by delayed treatment and the impact on workforce of staff self-isolating. Other themes had emerged such as the negative impact of lockdowns on mental health and wellbeing and significant demand on safeguarding. Whilst JCVI guidance was awaited, ICPs were working up plans for Phase 3 of the vaccination programme with the aim of beginning this in early September.

The Chair sought assurance regarding actions taking place to address shortcomings and variations in the different parts of the patch. JS advised that CCG Quality and Performance Committees continued to meet to monitor performance and quality standards in all areas and the enhanced quality narrative to these reports would provide assurance to the SCC that action was being taken to address any shortcomings. In addition, it was confirmed that the monthly focus report would provide a more in-depth analysis of performance and quality including areas of challenge and improvement measures taken.

Amanda Doyle (AD) commented on the improved style of the report and highlighted that currently and traditionally, intra-Lancashire comparison was used to look at performance and quality, which provided assurance; in future, comparison of variation would need to be made with places outside of Lancashire and South Cumbria. Some measures could be compared by ICP.

The Chair referred to the elective care focus, in particular trauma and orthopaedics with a high percentage of 52-week waiters. AD responded that during the past year due to the pandemic, only urgent patients had been seen, resulting in waiting lists for less urgent patients being significantly larger than in previous years. The availability of critical care and anaesthetists was also a contributor. Waiting list reduction was proving to be a significant challenge and assurance was provided that the time for people awaiting routine trauma and orthopaedic procedures would be the same across the whole of Lancashire and South Cumbria.

Debbie Corcoran (DC) commented on a need to be clear about the problems, the actions and what difference those actions would make and suggested reviewing data relating to customer complaints. Dr Mukerji referred to the importance of anticipating challenges and prevention.

Kevin McGee reassured members that work was being undertaken as a provider collaborative to achieve consistency of performance across the system, tackling variation and gaining a consistent approach to quality and improvement across Lancashire and South Cumbria.

It was recognised that this committee cannot fix the problems but needed to be clear about who is doing this, and that there are action plans in place to make the necessary improvements. Anthony Gardner (AG) added that it was particularly important during emerging transition to be clear about this and that assurance is provided through the Quality and Performance Committee that action plans are being delivered. Trajectories for improvement need to be set and performance monitored against those trajectories. The role of the Committee is to intervene and support when not delivering. AG confirmed that work on this would continue.

A request was made for data on electives for children and young people to be shown separately to adult services. In response it was noted that this detail would be provided in future deep dive reports.

**Elective Care Services Update**

Roger Parr presented the report which provided a more in-depth analysis of performance and quality and highlighted the key points contained therein. The report focussed on demand, activity, 18 weeks Referral to Treatment, incomplete pathways and 52+ week waiters. In March, general practice referrals had returned to pre-pandemic referrals. The national planning letter received on the 25 March 2021 set clear activity targets for the first half of the financial year and from April 2021, ICSs were required to 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. Additional monies were available via the Elective Recovery Fund (ERF) for performance at Core+ and Accelerator level. Early indication weekly activity had been used by the Elective Care Recovery Group to highlight the position in May 2021 against the Core, Core+ and Accelerator targets. The pace of restoration had been different between the individual providers within the ICS for both April 2021 and May 2021. An increase in the number of patients waiting to start hospital treatment had been seen in April 2021, compared to 2020. There had been a decline in over 52-week waiters in April whilst waiters in other time bands had increased; 104-week waiters were expected to increase in June.

**Mental Health Update**

Fleur Carney (FC) provided an update regarding performance against key nationally monitored metrics, current key pressures within Lancashire and South Cumbria's mental health provision, the current mitigations for the pressures and plans for sustainable solutions to these issues. There had been suppression of non-urgent demand (lower referrals from primary care at times of social restrictions) and surges in demand particularly in crisis pathways such as Home Treatment Teams, A&E and acute inpatient admissions.

Highlights from the report included:

- Home community treatment teams had seen an increase in demand, particularly in young people and children with eating disorders. Access to psychological therapy and children and young people with eating disorders were key performance indicators not being achieved.
- There was concern regarding out of area placements.
- The urgent access key performance indicator was being achieved; children presenting with issues were being seen quickly.
- The pathway for all age eating disorders was being reviewed; patients on the waiting list were being monitored, with more support provided if required.
- Additional capacity had been brought in to help reduce waiting times and lists, alongside pathways.
- IAPT performance indicator was expected to be achieved by the end of the year due to a review of pathways.
- Significant investment had been made for trainees.
- A three-year Community Mental Health Transformation programme was underway to support patients in the community and closer to home.

Members welcomed the detailed report and noted the transformation taking place across the system.

In response to a question about the targets for reducing out of area placements, it was confirmed that a capital programme was planned over the next 2 years with commitment to deliver the right number of beds for the population base with the aim of achieving the target trajectory of zero out of area placements by 2023, sooner if possible. Currently, the independent sector had been commissioned for block booking to ensure beds were available for the system.

Debbie Corcoran welcomed this detailed report and hoped to see more of the detail in the routine report in future. In addition, DC asked if the work and investments taking place were enough and if things needed to be done differently. In response it was confirmed that as a system priorities and investments had been agreed and work was taking place to triangulate the investments with outcomes and to join up delivery, finance and quality.

**RESOLVED: The Strategic Commissioning Committee noted the Quality and Performance report.**

## 9. Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions

Brent Horrell explained that the purpose of this report was to apprise the Committee of the work undertaken by the Lancashire and South Cumbria Medicines Management Group (LSCMMG) to develop commissioning recommendations to four local recommendations and a number of NICE technology appraisals. The four local policy recommendations had been developed in line with processes developed by the committee. Risks included technology appraisals; the committee was assured that medications were monitored and would only be used if there was an appropriate benefit.

**RESOLVED: The Committee approved the collaborative LSCMMG recommendations on the following:**

- **Insulin Lispro (Lyumjev) for the treatment of diabetes mellitus in adults**
- **IV infusion ketamine for chronic non-cancer pain in adults**
- **Metolazone for the treatment of patients with chronic heart failure with resistant volume overload**
- **Zonisamide for migraine prophylaxis**
- **NICE Technology Appraisals (February to May 2021).**

## 10. Development of Lancashire and South Cumbria (LSC) Clinical Commissioning Policies

Brent Horrell presented the revised policy (V1.2) for the Management of Otis Media with Effusion (OME) using Grommets and Adenoidectomy developed by the LSC Clinical Policy Development and Implementation Group (CPDIG) and assured the SCC of the process taken. The existing policy was ratified by the JCCCGs in September 2019. The revised policy aligns criteria to those defined by the Evidence Based Interventions (EBI) and the EBI criteria included in the revised policy were accepted by the Clinical Lead for ENT at University Hospitals of Morecambe Bay on 28 April 2021. On 17 June 2021, the LSC CPDIG agreed that the revised policy should be presented to the SCC for ratification. Given the consultation undertaken in 2019, the small number of responses received at that time and the small number of changes required to bring the policy in line with EBI list, the CPDIG also agreed that further clinical or public consultation was not required.

**RESOLVED: That the Committee:**

- **Noted the content of the revised policy**
- **Approved the content of the revised policy**
- **Approved the process taken to develop the policy**
- **Agreed that no further involvement was required in terms of wider engagement or consultation.**

## 11. Strategic Commissioning Committee Workplan 2021/22

Andrew Bennett presented the final copy of the proposed workplan for 2021/22, following the draft presented at the June meeting, setting out the areas for collective decision making. Nicola Adamson had appended reference to the specialised services 2021/22 workplan where this related to Lancashire and South Cumbria to allow joined up discussion.

**RESOLVED: That the Strategic Commissioning Committee:**

- **Agreed the proposed workplan and schedule for delegated decision-making**
- **Agreed that the workplan be shared with each CCG's Governing Body.**

## Reports from Sub-Committees

## 12. CCG Transition Board

**RESOLVED: Members of the Committee acknowledged the report.**

## 13. Collaborative Commissioning Advisory Group

**RESOLVED: Members of the Committee acknowledged the report.**

## 14. Quality and Performance Sub-Committee

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| **RESOLVED: Members of the Committee acknowledged the report.** |
| **Items for Information** |
| **15. Questions received for 13 May 2021 meeting** |
| The questions and responses from the SCC meeting held on 13 May 2021 were noted. |
| **16. Any Other Business** |
| No further business was raised. |

**Next meeting:**
**9 September 2021, 1 pm – 3 pm (Formal)**

# Strategic Commissioning Committee

## Formal Action Log

Updated 4 August 2021

| Item Code | Action | Responsible Lead | Status | Due Date | Progress Update |
|---|---|---|---|---|---|
| SCC150721-07 | **New Hospitals Programme Case for Change –** Discrepancy with deficit figures on pages 69 and 70; J Hawker to check and amend if necessary. | Jerry Hawker | Closed | 22 July 2021 | Complete – the discrepancy has been corrected in the final published version |

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9 September 2021** |
| **Title of paper** | **Strategic Commissioning Committee Draft Terms of Reference** |
| **Presented by** | **Andrew Bennett, Interim ICS Lead** |
| **Author** | **Becky Higgs** |
| **Agenda item** | **6** |
| **Confidential** | **No** |

| **Purpose of the paper** | | | | |
|---|---|---|---|---|
| For approval. | | | | |
| **Executive summary** | | | | |
| Membership review following Amanda Doyle's departure as ICS Lead and other interim ICS Executive Director appointments | | | | |
| **Recommendations** | | | | |
| For approval | | | | |
| **Governance and reporting** (list other forums that have discussed this paper) | | | | |
| **Meeting** | **Date** | | **Outcomes** | |
| | | | | |
| **Conflicts of interest identified** | | | | |
| | | | | |
| **Implications** | | | | |
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | | |
| Equality impact assessment completed | | | | |
| Privacy impact assessment completed | | | | |
| Financial impact assessment completed | | | | |
| Associated risks | | | | |
| Are associated risks detailed on the ICS Risk Register? | | | | |

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|---|---|
| Report authorised by: | |

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# STRATEGIC COMMISSIONING COMMITTEE

# TERMS OF REFERENCE

| Document Control | | | |
|---|---|---|---|
| **Title** | Lancashire and South Cumbria<br>STRATEGIC COMMISSIONING COMMITTEE<br>Terms of Reference | | |
| **Responsible Person** | Independent Chair | | |
| **Date of Approval** | | | |
| **Approved By** | Clinical Commissioning Group Governing Bodies | | |
| **Author** | Jerry Hawker | | |
| **Date Created** | 12th February 2021 | | |
| **Date Last Amended** | 13th August 2021 | | |
| **Version** | 5 | | |
| **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** |
| 2 | 25/01/2021 | Updated wording to incorporate change to a Strategic Commissioning Committee |
| 3 | 15/04/2021 | Strategic Commissioning Committee approved |
| 4 | 15/04/2021 | Membership CCG representatives clarified |
| 5 | 12/8/2021 | Membership review following Amanda Doyle's departure as ICS Lead and other interim ICS Executive Director appointments |

| 1. | The Purpose of the Strategic Commissioning Committee |
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| 1.1 | The primary role of the Strategic Commissioning Committee (SCC) will be to focus on delivery and decision making for the LSC population (transition to ICS and Place Partnerships) operating in a shadow ICS Committee role, but with the authority to make decisions at a Lancashire and South Cumbria level through the statutory vehicle of the Joint Committee of CCGs. This maximizes the potential of "One decision – One committee".<br><br>The establishment of the Committee continues to comply with and supports each statutory commissioning organisational requirements in 2021/22.<br><br>The decision-making role of the LSC Strategic Commissioning Committee (using JCCCG as the statutory vehicle for single decision making) are:<br><br>• Strategic commissioning decisions for all ICS Priority Programmes<br>• ICS level Quality and Performance assurance and oversight<br>• ICS level financial, activity and contract assurance and sign-off<br>• NHSE "Single point of Contact" for assurance framework<br>• Consultation oversight and approval<br>• Delegation and funding arrangements to place (via "place representatives")<br>• Strategic co-ordination of joint commissioning arrangements with Local Authorities (s75/BCF etc.)<br>• Approval of the annual commissioning work programme<br>• Assurance and oversight of CCG Transition Management (statutory transition).<br><br>The purpose of the Committee is to bring together the leadership of the eight Lancashire and South Cumbria Clinical Commissioning Groups (JCCCGs) together with ICS strategic commissioning leaders who have collectively committed to improve and transform health and care services across the area, delivering the highest quality of care possible within the resources available.<br><br>The work of the Committee is designed to deliver on the ambitions, commitments and priorities set out in the NHS Long Term Plan and the Lancashire and South Cumbria ICS Strategy.<br><br>The Strategic Commissioning Committee will aim to:<br><br>a. Reduce unwarranted variation in the range and quality of services available to people living in different boroughs in Lancashire and South Cumbria by improving outcomes in areas that are below average and driving up outcomes overall<br>b. Ensure key clinical standards are consistently met across the patch, so that all people receive the highest possible care and best outcomes<br>c. Provide a joined-up approach to the commissioning of acute, community and mental health services, enabling the commissioners to work effectively with major health and care providers to ultimately improve quality of outcomes for patients<br>d. Work collectively to ensure progress towards and ultimately delivery of financial sustainability (agreed control totals) at both ICP and ICS levels<br>e. Provide leadership in developing new ways of working as set-out in the NHS Plan including: |

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| | i. Supporting the continuing establishment of the Lancashire and South Cumbria ICS<br>ii. Reform of the commissioning system<br>iii. Development of integrated care partnerships. |
| 1.2 | The primary purpose of the Committee is to take collective commissioning decisions about services provided to the Lancashire and South Cumbria population. |
| 1.3 | Decisions will be taken by the Committee in accordance with delegated authority from their respective organisation. |
| 1.4 | Guiding principles:<br><br>The Lancashire and South Cumbria Strategic Commissioning Committee will adhere to the following principles already adopted by the Healthy Lancashire and South Cumbria (HLSC) Programme:<br><br>• People and patients come first – delivering parity of esteem and outcomes – fairness and timeliness of access to support<br>• Delivering a clinically and financially sustainable health and care system across HLSC<br>• Clinically-led, co-design and collaboration across HLSC health and care system, delivering integrated support<br>• Aligning priorities across local health and care systems and organisations – managing sovereignty and risk<br>• Prioritised effort on greatest benefit – improving quality and outcomes efficiently and effectively<br>• Ensuring Value for Money. Getting it right first time<br>• Alignment of effort and resource across the system<br>• Built upon innovation, international evidence and proven best practice<br>• Subsidiarity with clear framework of mutual accountability. |
| 1.5 | The Committee will meet collaboratively with NHS England (NHSE) to make decisions in respect of those services within the ICS, which are directly commissioned by NHSE. |

| **2.** | **Geographic Coverage** |
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| 2.1 | The Committee shall cover the geographic footprint of the Lancashire and South Cumbria Integrated Care System (ICS) |
| 2.2 | The Strategic Commissioning Committee acts wholly and entirely as a vehicle to discharge the same delegated authority as the preceding Joint Committee of Clinical Commissioning Groups ('**JCCCGs**') and therefore must retain membership from:<br><br>• NHS Blackburn with Darwen CCG;<br>• NHS Blackpool CCG;<br>• NHS Chorley & South Ribble CCG;<br>• NHS East Lancashire CCG;<br>• NHS Fylde & Wyre CCG;<br>• NHS Greater Preston CCG;<br>• NHS Morecambe Bay CCG; |

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| | • NHS West Lancashire CCG. |
| 2.3 | Specialised services commissioned by NHS England for the population of Lancashire and South Cumbria whilst outside the delegated authority of the Committee will be involved through a collaborative commissioning arrangement. |
| 2.4 | Services commissioned by Local Authorities for the population of Lancashire and South Cumbria whilst outside the delegated authority of the Committee will be involved through, wherever appropriate, a collaborative commissioning arrangement (including BCF/iBCF/Section 75s etc.) |

| **3.** | **Accountability & Responsibility - Statutory Framework** |
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| 3.1 | The NHS Act 2006 (as amended) was amended through the introduction of a Legislative Reform Order (LRO 2014/2436) to form joint committees. This means that two or more CCG's exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 of the NHS Act, which created s.14Z3 (2A). Joint committees are statutory mechanisms which enable CCGs to undertake collective decision making. |
| 3.2 | The CCGs named in paragraph 2.2 above, have delegated the functions set out in Schedule 1 to the Strategic Commissioning Committee for commissioning services and functions as set-out in section 1.1. |
| 3.3 | Joint committees are a statutory mechanism, which gives CCGs an additional option for undertaking collective strategic decision making. Whilst NHSE will make decisions on Commissioning Specialised services separate from the Joint Committee, it has been decided that decisions on those services will be undertaken on a collaborative basis. This will allow sequential decisions to be undertaken allowing clarity of responsibility, but also recognising the linkage between the two decisions. |
| 3.4 | Individual CCGs and NHSE will still always remain accountable for meeting their statutory duties. The aim of creating a Strategic Commissioning committee is to support strong collaborative and integrated relationships and decision-making between partners. |

| **4.** | **Role of the Strategic Commissioning Committee of CCGs** |
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| 4.1 | The overarching role of the Committee is to take collective commissioning decisions about services provided for the Lancashire and South Cumbria population. Decisions will be taken by the Committee in accordance with delegated authority from their organisation. Members will represent the whole Lancashire and South Cumbria population and make decisions in the interests of all patients. |
| 4.2 | Decisions will support the strategy, aims and objectives of the Lancashire and South Cumbria ICS and will contribute to the sustainability and transformation of local health and social care systems. The Committee will at all times, act in accordance with all relevant laws and guidance applicable to the membership. |
| 4.3 | The role of the committee will be to exercise the collective functions of the Membership with respect to: |

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| | a) Delegated decision-making authority (level 1) on commissioning services across Lancashire and South Cumbria as agreed within these terms of reference and each member CCG Scheme of Reservation & Delegation<br>b) Making collective recommendations (level 2) to each member CCG Governing Body on commissioning services across Lancashire and South Cumbria which fall outside of the CCG Schemes of Reservation and Delegation<br>c) Making collective recommendations (level 2) to each member CCG Governing Body on developing new ways of working as set-out in the NHS Plan, including;<br>i. supporting the continuing establishment of the Lancashire & South Cumbria ICS<br>ii. future options for the reform of commissioning<br>iii. development of integrated care partnerships. |
| 4.4 | The Committee will develop an annual work programme (Example in Schedule 3) which will be agreed and approved by the Committee and shared with each CCG Governing Body and partner. |
| 4.5 | The role described in 4.3 includes, but is not limited to the following activities, which are aligned to those set-out in Appendix 1.<br>• Acting to secure continuous improvement in the quality of commissioned services, including outcomes for patients, safety and patient experience<br>• Duty to promote the NHS Constitution<br>• Due regard to the finance duties imposed on CCGs and partner organisations under the NHS Act 2006 including ensuring the means of meeting expenditure out of public funds<br>• Duty to ensure that process and decisions comply with the NHS Guidance on Planning, assuring and delivering service change for patients (including but not limited to Case for changes, service models and decision-making business cases)<br>• Statutory duties with respect to public engagement and consultation (including Local Authorities and associated committees)<br>• Complying with public sector equality duty. |

| **5.** | **Decision Making** |
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| 5.1 | The primary purpose of the Committee is to take collective commissioning decisions about services provided to the Lancashire and South Cumbria population. |
| 5.2 | Committee members will make decisions in the best interests of the whole Lancashire and South Cumbria population, rather than the population of the CCG Governing Body or partner organisation they are drawn from. |
| 5.3 | At all times, the Committee, through undertaking the decision-making function of each member, will act in accordance with the terms of their Constitutions, Scheme of Reservation & Delegation and the functions set-out in Schedule 1. |
| 5.4 | The decision of the Committee will be binding on all member organisations. |
| 5.5 | ***Decision making authority level definition:*** |

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| | ***Level 1:*** *where decision making authority is within the delegated authority of the Committee as outlined within its Terms of Reference (section 1.1) and where a decision(s) undertaken by the Joint Committee will be final and binding on all member organisations.*<br>***Level 2:*** *Any decision that effects the statutory authority of an organisation and deemed outside the delegated authority of the Committee.*<br><br>*In the case of CCGs the following areas are considered to be level 2 and will continue to be reserved for decisions solely to be made by individual Governing Bodies or their Membership Councils (or equivalents). This includes all non-delegable duties:*<br>• *Statutory sign-off of 2020/21 CCG Annual Report and Accounts*<br>• *Statutory sign-off of ICS determined 2020/21 allocations and budget*<br>• *CCG Primary Care Commissioning*<br>• *Statutory sign-off of CCG transitional arrangements*<br>• *Statutory sign-off off 2021/22 CCG Annual Report & Accounts*<br>• *External / Internal Audit requirements*<br>• *Mandatory/statutory duties for staff*<br>• *Changes to CCG Constitutions.* |

| **6.** | **Voting** |
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| 6.1 | The Committee will aim to make decisions by consensus wherever possible. Where consensus is not reached the committee will determine a decision by a vote of the voting membership (or their deputies). |
| 6.2 | Recommendations can only be approved if there is approval by more than 75% of the voting membership (or their deputies) in attendance at the meeting. |

| **7.** | **Membership** |
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| 7.1 | Membership of the committee will combine both voting and Non-voting members and will comprise of: - |
| 7.2 | Voting members:<br>• All CCG Chairs (includes minimum four Clinical Chairs)<br>• All CCG AOs<br>• ICS Chief Officer<br>• Lead CFO<br>• ICS Executive Director of Nursing and Quality<br>• 2 x CCG Lay Members<br>• ICS Director of Finance<br>• ICS Executive Director of Commissioning<br>• ICS Medical Director<br>• Local Authority Commissioning Representative(s)<br>• NHSE Commissioning Representative<br><br>• A vice chairman to be elected from the membership of the CCG Chairs by the members and who will retain their voting rights<br>• A CCG Audit Chair who will act as the Conflicts of Interest Guardian to be elected from the membership and who will retain their voting rights. |

 

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| 7.3 | Non-voting members:<br><br>• The Independent Chair of the Strategic Commissioning Committee<br>• ICS Director of HR and OD<br>• ICS Director of Provider Sustainability<br>• Group Commissioning Support Representative (MLCSU)<br>• ICS Provider Collaborative Representative<br>• NHS England Locality Director<br>• A Healthwatch representative nominated by the local Healthwatch groups<br>• Other such representation as the Committee deems appropriate. |
| 7.4 | Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the secretariat informed of any agreement to deputise, so that quoracy can be maintained. |
| 7.5 | No person can act in more than one role on the Committee, meaning that each deputy needs to be an additional person from outside the Committee membership. |

| **8.** | **Meetings** |
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| 8.1 | The Committee shall adopt the standing orders of Blackpool CCG, insofar as they relate to the:<br>a) notice of meetings<br>b) handling of meetings<br>c) agendas<br>d) circulation of papers<br>e) conflicts of interest.<br><br>Notice of Meetings and the Business to be transacted<br>(1) Before each meeting of the Committee, a clear agenda and supporting documentation, specifying the business proposed to be transacted shall be sent to every member of the committee at least six clear days before the meeting.<br>The agenda and papers will also be published on the Healthier Lancashire and South Cumbria website.<br>(2) No business shall be transacted at the meeting, other than that specified on the agenda, or emergency motions allowed under Standing Order 3.8.<br>(3) Before each public meeting of CCG Governing Body meetings, a public notice of the time and place of the next Committee meeting and the public part of the agenda shall be displayed on the CCG's website, at least three clear days before the meeting. |

| **9.** | **Quorum** |
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| 9.1 | At least one voting member (or nominated deputy) from each CCG must be present for the meeting to be Quorate.<br><br>At least 75% of the voting members must be present for the meeting to be Quorate.<br><br>It is the responsibility of each organisation to ensure that they have a voting member present at all Committee meetings. In the exceptional circumstances that an organization cannot |

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| | field a representative, the organisation must communicate this information to the independent chair in advance of the meeting. |
| **10.** | **Frequency of Meetings** |
| 10.1 | Frequency of meetings will usually be monthly, but as and when required, in line with priorities. |

| **11.** | **Meetings of the Committee** |
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| 11.1 | Meetings of the Committee shall be held in public, unless the Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings), whenever publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution and arising from the nature of that business, or of the proceedings, or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. |
| 11.2 | Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability and endeavor to reach a collective view. |
| 11.3 | The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions. |
| 11.4 | The Committee has the power to establish sub-committees and working groups and any such groups will be accountable directly to the Committee. |
| 11.5 | Members of the Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above, unless separate confidentiality requirements are set out for the Committee, in which event these shall be observed. |

| **12.** | **Secretariat Provisions** |
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| 12.1 | The agenda and supporting papers will be circulated by email, five working days prior to the meeting. The agenda and papers will be published on each member's website and the Healthier Lancashire and South Cumbria website. |
| 12.2 | Papers may not be tabled without the agreement of the Chair. |
| 12.3 | Minutes will be taken and distributed to the members within 14 working days after the meeting. |
| 12.4 | Minutes will be published in the public domain, unless there are discussions which need to be recorded confidentially - in which case there will be recorded separately and will not be made public. |
| 12.5 | Agenda and papers to be agreed with the Chairman seven working days before the meeting. |

| 13. | Reporting |
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| 13.1 | The Committee will hold annual engagement events to review aims, objectives, strategy and progress. The Committee will also publish an annual report on progress made against objectives. |

| 14. | Decisions |
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| 14.1 | The Committee will make decisions within the bounds of the scope of the functions delegated. |
| 14.2 | The decisions of the Committee shall be binding on all member CCGs, which are:<br>Blackburn with Darwen CCG; Blackpool CCG; Chorley and South Ribble CCG; East Lancashire CCG; Fylde and Wyre CCG; Greater Preston CCG; Morecambe Bay CCG; West Lancashire CCG. |
| 14.3 | All decisions undertaken by the Committee will be published by the Clinical Commissioning Groups and all other member organisations. |

| 15. | Conflicts of Interest |
|---|---|
| 15.1 | The Committee shall hold and publish a register of interests. Each member and attendee of the committee will be under a duty to declare any such interests. Any interest related to an agenda item should be brought to the attention of the Chair in advance of the meeting or notified as soon as the interest arises and recorded in the minutes. Any changes to these interests should be notified to the Chair. |
| 15.2 | To further strengthen scrutiny and transparency of the' decision-making processes, the Committee will have a Conflicts of Interest Guardian (akin to a Caldecott Guardian). This role should be undertaken by a nominated CCG audit chair, provided they have no provider interests, as audit chairs already have a key role in conflicts of interest management.<br><br>The role of the Conflicts of Interest Guardian will be in-line with the requirements set-out in NHS England's "Managing Conflicts of Interest: Revised Statutory Guidance for CCG's 2017". |
| 15.3 | All members of the Committee and participants in its meetings shall comply with, and are bound by, the requirements in the relevant organisations Constitutions, Policies, and the Standards of Business Conduct for Public Sector staff and NHS Code of Conduct. |

| 16 | Review of Terms of Reference |
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| 16.1 | These terms of reference will be formally reviewed by the Committee at least annually, taking the date of the first meeting, following the year in which the committee is created and may be amended by mutual agreement between the committee members at any time to reflect changes in circumstances as they may arise. |

| 17. | Withdrawal from the Committee |
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| 17.1 | Should this joint commissioning arrangement prove to be unsatisfactory, the Governing Body of any of the member organisations can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year. |

**Schedule 1 - Delegation by CCGs to the Strategic Commissioning Committee**

**A.** As required to achieve the purpose of the Committee the following CCG functions will be delegated to the Strategic Commissioning Committee by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended). S.14Z3 allows CCGs to make arrangements in respect of the exercise of their functions and includes the ability, in s.14Z3 (2A), for two or more CCGs to create a Joint Committee to exercise functions. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions.

**B.** The Lancashire and South Cumbria ICS focuses on achieving clinical quality standards in the services listed below provided by the NHS Trusts (and other providers) within the ICS. As part of this work, it is necessary to consider interdependencies between these services and any other services that are affected. The relevant services are:

a. All elements of the programme, including the Case for Change, evaluation criteria, options, communications plan and such like.
b. Such other services not set out above, which the CCG members of the Committee determine should be included in the programme of work.

**C.** Each member CCG shall also delegate the following functions to the Committee, so that it can achieve the purpose set out in (A) above:

a. Acting with a view to securing continuous improvement to the quality of commissioned services in so far as these services are included within the scope of the programme. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework.
b. Promoting innovation, in so far as this affects the services included within the scope of the programme, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.
c. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act').
d. The requirement to ensure process and decisions comply with the five key tests for service change introduced by the last Secretary of State for Health, which are:
    - Support from GP commissioners;
    - Strengthened public and patient engagement;
    - Clarity on the clinical evidence base;
    - Consistency with current and prospective patient choice.
e. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.
f. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:
   13C and 14P - Duty to promote the NHS Constitution

13D and 14Q - Duty to exercise functions effectively, efficiently and economically
13E and 14R – Duty as to improvement in quality of services
13G and 14T - Duty as to reducing inequalities
13H and 14U – Duty to promote involvement of each patient
13I and 14V - Duty as to patient choice
13J and 14W – Duty to obtain appropriate advice
13K and 14X – Duty to promote innovation
13L and 14Y – Duty in respect of research
13M and 14Z - Duty as to promoting education and training
13N and 14Z1- Duty as to promoting integration
13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs
13O - Duty to have regard to impact in certain areas
13P - Duty as respects variations in provision of health services
14O – Registers of Interests and management of conflicts of interest
14S – Duty in relation to quality of primary medical services

g. The Committee must also have regard to the financial duties imposed on CCGs under the NHS Act 2006 and as set out in:
   - 223G – Means of meeting expenditure of CCGs out of public funds
   - 223H – Financial duties of CCGs: expenditure
   - 223I - Financial duties of CCGs: use of resources
   - 223J - Financial duties of CCGs: additional controls of resource use.

h. Further, the Committee must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).

i. The expectation is that CCGs will ensure that clear governance arrangements are put in place, so that they can assure themselves that the exercise by the Committee of their functions is compliant with statute.

j. The Committee will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated regulations.

k. To continue to work in partnership with key partners e.g. the Local Authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.

l. The Committee will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The Joint Committee will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups and NHS England under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

**D.** The role of the Committee shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme. This includes, but is not limited to, the following activities:

- Determine the options appraisal process;
- Determine the method and scope of the engagement and consultation processes;
- Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for relevant consultation by the applicable Local Authorities;
- Make any necessary decisions arising from a pre-consultation Business Case (and the decision to run a formal consultation process);
- Approve relevant consultation plans;

- Approve the text and issues on which the public's views are sought in all documentation associated with the formal consultation process;
- Take or arrange for all necessary steps to be taken to enable the CCG to comply with its public sector equality duties;
- Approve the formal report on the outcome of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision;
- Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to the consultation process. This should include consideration of any recommendations made by the ICS Board, or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations and stakeholders.

At all times, the Committee, through undertaking the decision-making function of each member CCG will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

**Schedule 2 - List of Voting Members**

| Organisation | Representative |
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| **Blackburn with Darwen CCG** | Graham Burgess<br>Dr Julie Higgins |
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| **Blackpool CCG** | Roy Fisher<br>TBC |
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| **Chorley & South Ribble CCG** | Dr Lindsey Dickinson<br>Denis Gizzi |
| | |
| **East Lancashire CCG** | Dr Richard Robinson<br>Dr Julie Higgins |
| | |
| **Fylde & Wyre CCG** | Dr Adam Janjua<br>TBC |
| | |
| **Greater Preston CCG** | Dr Sumantra Mukerji<br>Denis Gizzi |
| | |
| **Morecambe Bay CCG** | Dr Geoff Joliffe<br>Anthony Gardner/Hilary Fordham |
| | |
| **West Lancashire CCG** | Dr Peter Gregory<br>Paul Kingan |
| | |
| **Lancashire & South Cumbia ICS** | Andrew Bennett<br>(ICS Director of Commissioning – vacant position)<br>Andy Curran<br>Gary Raphael<br>Jane Scattergood (representing L&SC Chief Nurses) |
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| **NHSEI** | Nicola Adamson |

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| **Local Authority Representatives** | TBC |
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| **2 x CCG Lay Member** | David Swift (Conflicts of Interest Guardian)<br>Debbie Corcoran |
| | |
| **Lead CFO** | Paul Kingan |

**Schedule 3: EXAMPLE OF A WORK PROGRAMME AND DELEGATION LEVELS**

| Service/ Subject | Executive Sponsor | Description | Key Output | Level of Decision making |
|---|---|---|---|---|
| Urgent Care | David Bonson | Approve updated Urgent and Emergency Care strategy for Lancashire and South Cumbria which will be developed in response to the national strategy. | Strategy Document | Level 1 |
| SEND | Julie Higgins | Collaborative work between CCGs and Lancashire County Council to deliver the 2019-2020 Lancashire SEND partnership improvement plan with specific delivery of a commissioning plan, evaluation and monitoring system, implementation of the neuro developmental diagnostic pathway; speech and language and occupation therapy service reviews; consistency in multiagency school readiness pathway. | | Level 1 |
| Mental Health | Andrew Bennett | Agree action plan for commissioners which may arise from the external review of the urgent care mental health system in Lancashire being undertaken by Northumberland Tyne and Wear NHS Foundation Trust. | Action Plan | Level 1 |
| Individual Patient Activity (IPA) | Jerry Hawker | Agree a single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICPs and neighbourhoods.<br><br>Agree a single governance, business intelligence and delegated financial | Proposed Commissioning Model | Level 1<br><br>Level 1 |

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| | | framework with accountability to the ICS and JCCCGs. | | |
| Cancer | Denis Gizzi | Agree recommendations for commissioners which arise from Cancer transformation programme. | Set of Recommendations | Level 1 |
| Cancer/ Workforce | Denis Gizzi | Agree the Outline Business Case for Oncology Advanced Clinical Practitioners. | Outline Business Case | Level 1 |
| Specialist weight management services | Clare Thomason | Approve a case for change for multi-agency action in relation to obesity and specialist weight management. | Case for Change | Level 1 |
| Stroke | Andrew Bennett | Agree options for the configuration of Hyper Acute and Acute stroke services.<br><br>Review and approve outline business case.<br>Decide on requirement and readiness to consult.<br><br>Approve full business case .<br>Review outcomes of consultation.<br>Consider and approve commissioning approach and approve delivery plan. | Case for Change<br><br>Outline Business Case<br><br>Full Business Case | Level 1<br><br>Level 1<br><br>Level 1 |
| Commissioning Policies | Andrew Bennett | Agree updated commissioning policies developed collectively for all CCGs.<br>Agree updated medicines management policies developed collectively for all CCGs. | Policy Documents | Level 1 |
| Vascular | Talib Yaseen | Agree operating model for vascular services across Lancashire and South Cumbria. | Case for Change<br><br>Service (operating) model | Level 1 |
| Commissioning development | Andrew Bennett | Agree recommended operating models and implementation plans arising from Commissioning Development Framework programme. | Commissioning Framework | Level 1 |
| Children and Young People's Mental Health | TBA | Approve clinical model for CYP Mental Health services across Lancashire and South Cumbria.<br><br>Approve transition and implementation plan for clinical model. | Clinical Model and implementation plan | Level 1 |
| Children and Maternity | Arif Rajpura | Approve case for change for paediatric services. | Case For Change | Level 1 |
| Primary Care | Amanda Doyle | Approval of ICS Strategy for Primary Care. | ICS Strategy | Level 1 |
| Planned Care | Andrew Harrison | Agree prioritised list of pathways and timeline for development of outcome | Clinical Pathways | Level 1 |

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| | | based consistent clinical pathways across Lancashire and South Cumbria. | | |
| Learning Disability | Andrew Bennett | Agree clinical model of non-secure, specialist inpatient provision for Learning Disabilities and Autism within the Lancashire and South Cumbria footprint. | Clinical Model | Level 1 |
| Integrated Commissioning (on LCC footprint) | Julie Higgins/Jerry Hawker | Collaborative work between CCGs and Lancashire County Council to build a common platform for integrated commissioning at an ICP level: Initiation to proof of concept phase:-<br>scope principles, commitment and approaches, for the integration agenda building on BCF; test two areas for "in view" budget management leading to transformation for intermediate care and mental health section 117. | Integrated Commissioning platform | Level 2 |

**Decision making authority level definition:**

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

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

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9 September 2021** |
| **Title of paper** | **CCG Closedown update** |
| **Presented by** | **Denis Gizzi, Chief Officer NHS Chorley and South Ribble and NHS Greater Preston CCGs and Accountable Officer Sponsor for CCG Closedown** |
| **Author** | **Helen Curtis, Deputy Chief Officer NHS Chorley and South Ribble and NHS Greater Preston CCGs and Executive Programme Director for CCG Closedown**<br><br>**Sarah Mattocks, Head of Governance NHS Chorley and South Ribble and NHS Greater Preston CCGs** |
| **Agenda item** | **7** |
| **Confidential** | **No** |

| **Purpose of the paper** |
|---|
| The purpose of producing this paper is to update the committee on the progress of the closedown of CCGs. |
| **Executive summary** |
| Progress has been made in the following areas in the CCG closedown programme:<br><br>- Governance leads group established and meets three weekly<br>- Governance leads group have established an Information Governance (IG) /Information Technology (IT) sub-working group which will ensure all considerations of this remit are taken for closedown including the organisation and retention of files for transfer. A transition document has been developed by Midlands and Lancashire Commissioning Support Unit (MLCSU) IG team to support this.<br>- Executive leads group established and meets monthly<br>- A 'receiver' point of contact has been identified for the closedown workstream to ensure a smooth transition. The executives closedown group will now incorporate this into its remit by reserving the second half of the meeting for items related to the 'receiver'.<br>- Mersey Internal Audit Agency (MIAA) had developed an outline programme plan based on the anticipated due diligence checklist which has now been published as part of the national guidance and is attached at appendix 5.<br>- Governance leads group have finalised a closedown risk register.<br>- This paper describes the progress against those deliverables in the existing critical path via the appended document at appendix 1, it is anticipated that imminently a new national critical path will be issued and a review will then take place of the existing critical path to reconcile in line with national guidance. |

Lancashire and South Cumbria
Health and Care Partnership

- This paper includes the national guidance published 19th August 2021 at the appendices (2-5)

The above progress will be outlined in further detail in this paper.

| **Recommendations** | | | | |
|---|---|---|---|---|
| The committee are asked to note the paper. | | | | |
| **Governance and reporting** (list other forums that have discussed this paper) | | | | |
| **Meeting** | **Date** | | | **Outcomes** |
| **Transition Board** | **07.09.2021** | | | **To note** |
| **Conflicts of interest identified** | | | | |
| **NA** | | | | |
| **Implications** | | | | |
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | X | |
| Equality impact assessment completed | | | X | |
| Privacy impact assessment completed | | | X | |
| Financial impact assessment completed | | | X | |
| Associated risks | X | | | Captured on closedown risk register |
| Are associated risks detailed on the ICS Risk Register? | X | | | |

| Report authorised by: | Denis Gizzi |
|---|---|

Lancashire and South Cumbria
Health and Care Partnership

# CCG CLOSEDOWN UPDATE

## 1. Introduction

1.1 Progress has been made in the following areas in the closedown programme:

- Governance leads group established and meets three weekly
- Governance leads group have established an Information Governance (IG) /Information Technology (IT) sub-working group which will ensure all considerations of this remit are taken for closedown including the organisation and retention of files for transfer. A transition document has been developed by Midlands and Lancashire Commissioning Support Unit (MLCSU) IG team to support this.
- Executive leads group established and meets monthly
- A 'receiver' point of contact has been identified for the closedown workstream to ensure a smooth transition. The executives closedown group will now incorporate this into its remit by reserving the second half of the meeting for items related to the 'receiver'.
- Mersey Internal Audit Agency (MIAA) had developed an outline programme plan based on the anticipated due diligence checklist which has now been published as part of the national guidance and is attached at appendix 5.
- Governance leads group have finalised a closedown risk register.
- This paper describes the progress against those deliverables in the existing critical path via the appended document at appendix 1, it is anticipated that imminently a new national critical path will be issued and a review will then take place of the existing critical path to reconcile in line with national guidance.
- This paper includes the national guidance published 19th August 2021 at the appendices (2-5)

1.2 The above progress will be outlined in further detail in this paper.

## 2. Closedown groups update

2.1 The executive leads group met on 10.08.2021. The group reviewed the critical path which will be a standing item at all meetings to ensure that deliverables remain on track. The group identified that emergency planning and on-call arrangements prior to transition need to be considered, and this will be discussed with the Integrated Care System (ICS) executive team. The group were updated that the closedown risk register has been completed, to date this consists of 6 risks as follows; quality and safety, staffing, functions, guidance, shifting to new ways of working, and engagement of CCG leaders. The group

specifically approved the action plan for the staffing risk as this requires the support of all accountable officers. The group also discussed that a 'receiver' point of contact has been identified for the closedown workstream to ensure a smooth transition, therefore the group will now incorporate this into its remit by reserving the second half of the meeting for items related to the 'receiver' to ensure a smooth transition between 'sender' and 'receiver'.

2.2 The governance leads group met on 10.08.2021. The group reviewed the critical path which will be a standing item at all meetings to ensure that deliverables remain on track. The group agreed the latest version of the closedown risk register. This will also now be a standing item at all meetings to ensure these risks are reviewed and mitigation reflected and gaps thereof. The group members who are establishing the IG/IT sub-working group updated that a transition document has been developed by MLCSU IG team to support this, and that IG and IT representatives will be members of this group to ensure the smooth transition of CCG files. The group also discussed that some Governing Body members, particularly non-executives, will need to remain working for CCG closedown beyond March 2021 for approval of items such as annual reports and annual accounts. The group noted that the expected imminent guidance should clarify what will be required so that this can be planned for in advance.

2.3 Prior to this meeting the governance leads also reviewed and provided input to an infographic to outline the governance structure in place for closedown, and reviewed an organisational memory document and agreed this would work for all organisations to capture organisational memory consistently prior to transition.

## 3. Risk Register

3.1 National guidance recognises that planning for CCG closedown should involve the identification and management of risks associated with transition, it particularly emphasises the importance of quality and patient safety being considered throughout the transition period. This work has already been undertaken as follows:

3.2 The Governance Leads Group has finalised a risk register which reflects the key risks to the programme to date:

- Quality and safety during closedown

- Sufficient workforce during closedown

- Functions may be lost if not identified, or may follow with reduced expertise and staffing due to current roles covering multiple remits.

- Process to date not being in line with national guidance when it is released

3.3 The content of these risks has now been finalised and submitted to the NHS LSC risk register and shared within the CCGs.

3.4 The group also reviewed and updated the other two risks on the risk register as follows:

- Reluctance / difficulty in shifting to new ways of working RISKS duplication of effort, with activities being done multiple times (i.e. in each CCG) when could be done once

- Current CCG Senior leaders do not have a secure future in the new ways of working which risks a reduction in their level of commitment to current challenges

These risks were reviewed and updated by the governance leads meeting in August.

3.5 Progress against this risk register will be overseen by the Governance Leads Group and any concerns or risks scoring 15 or above, or whereby specific actions require executive attention, these will be escalated to the Executive Group for closedown.

## 4 Functions

4.1 There are multiple work streams which include accelerator functions, strategic functions and a number of corporate functions which require consideration of how they might transfer to the NHS ICS NHS Body and whether redesign of the function is required.

4.2 There are also some functions currently delivered or commissioned by CCG's that do not appear to align with the strategic functions of an ICS NHS Body and may fit elsewhere in the ICS system i.e. as part of the provider collaborative or at place. A discussion paper has been requested by system leads to explore this.

4.3 A format has been agreed to ensure functional groups cover the closedown remit. This will minimise duplication and maximise the capacity of available resource ensuring smooth transition from the current landscape arrangements to the future ICS landscape arrangements.

## 5 Finance

5.1 The executive lead for closedown of finance is linked into the structure in place for closedown via attendance at the executive leads group. A finance project plan is in place and will be inserted into the programme plan via the due diligence checklist.

## 6. Update against deliverables from Q1 and Q2

6.1 The progress against the deliverables has been included in an updated critical path which is appended to this paper at Appendix 1. It is anticipated that imminently a new national critical path will be issued and a review will then take place of the existing critical path to reconcile in line with national guidance

## 7. Guidance

7.1 A series of national guidance was released on 19th August 2021 directly pertinent to closedown as follows:

- ICC implementation guidance
- ICB readiness to operate statement guidance
- Readiness to operate statement checklist
- CCG Closedown and ICB establishment Due Diligence Checklist

7.2 This guidance is contained within the appendices of this paper at appendix 2-5.

7.3 In addition the following were also released:

- HR framework for developing integrated care boards, which can be accessed here:
https://www.england.nhs.uk/wp-content/uploads/2021/06/B0790_ICS_HR-Framework-Technical-Guidance_FINAL18Aug.pdf
The HR framework provides national policy ambition and practical support for NHS organisations affected by the proposed legislative changes as they develop and transition towards the new statutory integrated care boards.

- Interim guidance on the functions and governance of the integrated care board, which can be accessed here:
Interim guidance on the functions and governance of the integrated care board

This interim guide covers the expected governance requirements for integrated care boards as outlined in the Health and Care Bill and the Integrated care systems design framework. In addition a draft model constitution and 'List of statutory CCG functions to be conferred on ICBs' were released on the Future NHS Collaboration Platform.

- Building strong integrated care systems everywhere: guidance on the ICS people function, which can be accessed here: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0662_Building-strong-integrated-care-systems-everywhere-guidance-on-the-ICS-people-function-August-2021.pdf
This guidance builds on the priorities set out in the People Plan. It is intended to help NHS system leaders and their partners support their 'one workforce' by delivering key outcome-based people functions from April 2022.

-Working together at scale: guidance on provider collaboratives, which can be accessed here: https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf
The ICS Design Framework set an expectation that provider collaboratives will be a key component in enabling ICSs to deliver their core purpose. This guidance outlines minimum expectations for how providers should work together in provider collaboratives, offering principles to support local decision-making and suggesting the function and form that systems and providers may wish to consider.

## 8. Programme plan

8.1 Included in the national guidance that was released 19th August 2021, was a due diligence checklist which will now form the basis of the programme plan. Project support has been identified by MIAA who will work directly with the Programme Director for Closedown to ensure rapid population of the programme plan with a view to this being completed by end of September 2021. This meets the requirement of the national guidance to have this plan in place 6 months prior to the date of transfer and legal establishment of ICBs. Several project plans are already in place which will feed into this programme plan, for example finance.

8.2 In relation to due diligence, the national guidance recognises that there are three different starting points and corresponding levels of complexity for CCGs in implementing the ICS implementation programme. The level of due diligence

to be undertaken reflects the starting point. Having reviewed the guidance, Lancashire and South Cumbria CCGs meet the level 2 criteria where there are no ICS boundary changes but there are multiple CCGs within an ICS, requiring the need for coordination. This is already in place via the established closedown structure.

## 9. Next steps

9.1 The governance leads and executive groups will continue to monitor the progress of closedown against the critical path and programme plan, and reconcile the national guidance released against the agreed actions of progress to ensure compliance.

## 10. Recommendations

10.1 The committee are asked to note the update outlined in this paper.

Helen Curtis/Sarah Mattocks

August 2021

## Appendices

Appendix 1 – updated critical path

Critical Path_CCG close down_template

Appendix 2 – ICS implementation guidance

B0757_ICS Establishment Guidan

Appendix 3 - ICB readiness to operate statement guidance

B0803_ICB Readiness to Operate Statement

Appendix 4 - Readiness to operate statement checklist

Copy of Readiness to Operate Statement Cl

Appendix 5 - CCG Closedown and ICB establishment Due Diligence Checklist

Copy of CCG Close down and ICB Establis

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9th September 2021** |
| **Title of paper** | **ICS Quality and Performance Report** |
| **Presented by** | **Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs**<br>**Kathryn Lord, Director of Quality and Chief Nurse from Pennine Lancashire CCGs** |
| **Author** | **Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs**<br>**Kathryn Lord, Director of Quality and Chief Nurse from Pennine Lancashire CCGs** |
| **Agenda item** | **8** |
| **Confidential** | **No** |

| **Purpose of the paper** |
|---|
| For information and discussion |
| **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.<br>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 Quality and Performance Sub-Committee and Strategic Commissioning Committee. |
| **Recommendations** |
| The Quality and Performance Sub-Committee is requested to note the contents of this Quality and Performance Report and support its development. |

**Governance and reporting** (list other forums that have discussed this paper)

| **Meeting** | **Date** | **Outcomes** |
|---|---|---|
| | | |

| **Conflicts of interest identified** |
|---|
| |

**Implications**

| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
|---|---|---|---|---|
| Quality impact assessment completed | | | ✓ | |
| Equality impact assessment completed | | | ✓ | |

| | | | | |
|---|---|---|---|---|
| Privacy impact assessment completed | | ✓ | | |
| Financial impact assessment completed | | | ✓ | |
| Associated risks | | | | |
| Are associated risks detailed on the ICS Risk Register? | | | ✓ | |

| | |
|---|---|
| Report authorised by: | Roger Parr |

# ICS Quality and Performance Report

## September 2021

## 1. Introduction

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

1.2. This paper from the Q&P work stream attempts to bring together collective oversight for commissioning following feedback from SCC 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. Appended to this report is the dashboard relating to NHS Constitutional targets. These have understandably been impacted by the pandemic. Whilst some of the indicators are attributed to providers, clearly the wider system has responsibility for delivery.

1.4. The focus areas in this month's report are Urgent Care and Cancer.

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

1.6. The Q&P will escalate areas of concern into the SCC as necessary. 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 Quality and Performance:**

- Urgent Care (Focus Area)
- Cancer Services (Focus Area)
- Diagnostics
- Elective Care
- Nosocomial Infections
- Individual Patient Activity and Continuing Healthcare
- Safeguarding
- Learning Disabilities and Autism
- Glossary
- 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)

## 3. Urgent Care - Focus Area

3.1. Introduction

3.1.1. The HLSC Clinical Strategy (approved in December 2020) listed UEC as one of its 6 strategic priorities. One of the objectives agreed was to put in place a consistent system which provides intelligence about how the UEC services are performing.

3.1.2. The purpose of this section is to provide the SCC, and Q&P Sub-Committee with:

- a focused overview of our UEC services,
- the key metrics to consider that provide assurance on both the quality and performance of the services delivered,
- the key challenges, learning, and plans in place to address.

3.2. Understanding the wider Urgent and Emergency Care System

The performance of a UEC system is a barometer of wider system challenges as the flow into and out of the UEC services are fully interdependent on the performance of the wider Health and Social Care system surrounding it. Unfortunately, full system urgent care data is not yet readily available, but this is something the system is working towards as partnerships further develop and mature.

3.3. Future Reporting Developments

3.3.1. NHS Oversight metrics for 2021/22

In June 2021 the NHS published the 3 metrics to support standard approach to the assessment of quality, access and outcomes for urgent care[1]. Newly published these have been incorporated into the urgent care reporting workplan.

National Quality Board quality metrics for Urgent Care (June 2021)

| **Oversight Theme** | **NHS Long Term Plan Area** | **2021/22 Planning guidance deliverable** | **Metric** |
|---|---|---|---|
| Quality, access and outcomes | Emergency care: on agreed trajectory for same day emergency care (SDEC) and integrated urgent care services (IUC) | Maximise the use of booked time slots in A&E | % of patients referred to an emergency department by NHS 111 that receive a booked time slot to attend |
| | | Increase % of patients seen and treated on the same day or within 12 hours if this spans to midnight | % of zero-day length of stay admissions (as a proportion of total) |
| | | Reduce avoidable A&E attendances by directing patients to more appropriate urgent care settings | % of unheralded patients attending EDs |

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0693-nhs-oversight-metrics-for-2021-22.pdf

3.3.2. New UEC standards

Data testing through the revised ECDS has been in place since Oct 2017 designed to capture how and why people access A&E departments. 5 of the 10 new measures will be reported from ECDS and sites have been tasked with rolling out ECDS to all services seeking to capture the following:

- time to initial assessment
- proportion of patients spending >12hours from arrival time
- proportion of patients spending >1hour in A&E after they have been declared (Clinically ready to proceed).
- average (mean) time in department – admitted patients
- average (mean) time in department – non-admitted patients

Four additional measures will reflect the activity in the pre-hospital arena:

- Response times for ambulances
- Conveyance rates to EDs by 999 ambulances
- Proportion of contacts via NHS 111 that receive clinical input
- % of ambulance handovers within 15 mins

The 10th measure for Critical Time Standards has yet to be defined but will be introduced once further information is available.

Work is already underway to progress how we report this via an automated process planned for implementation on 1st October 2021. A number of these metrics have been included in this report.

3.3.3. Understanding crowding and it impact on the quality of service we deliver

Crowding is the situation where the number of patients occupying the emergency department is beyond the capacity for which the emergency department is designed and resourced to manage at any one time.

There is no internationally agreed and widely used definition of crowding but good markers of crowding and therefore the ability to deliver a high-quality service include:

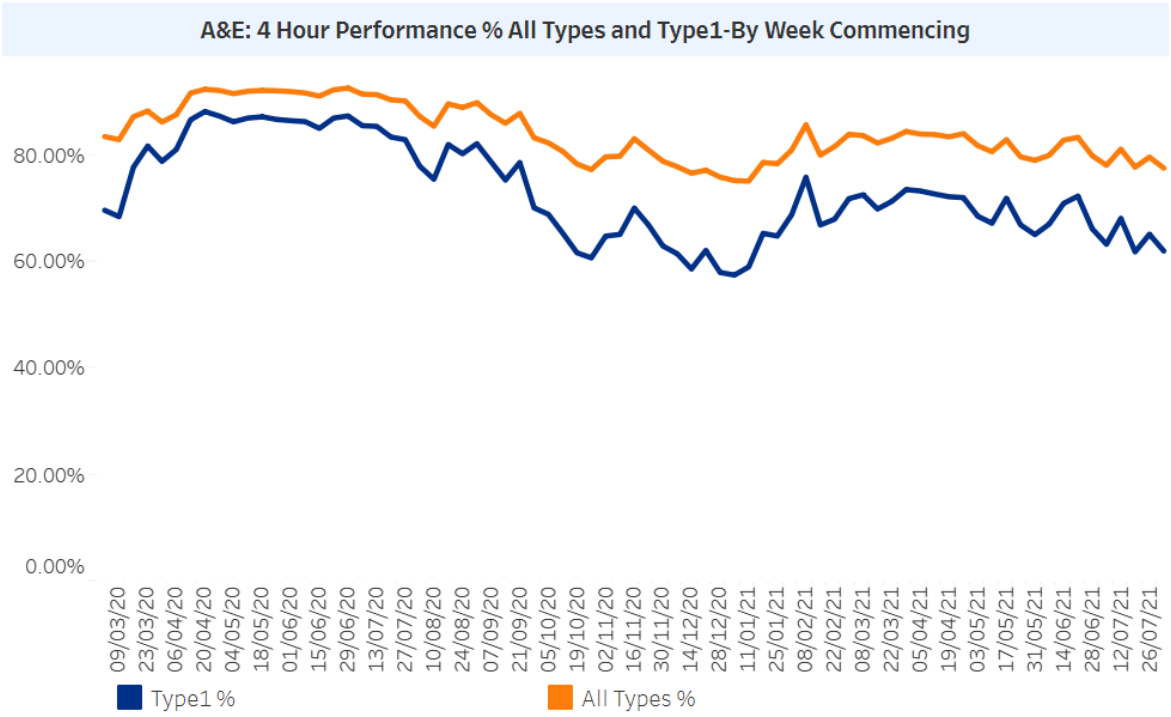
1. Occupancy of available resuscitation and trolley spaces greater than 100%.
2. Prolonged Ambulance offload times (e.g. > 15 minutes).
3. Long waits for patients to be assessed by Emergency Department clinicians
4. Delays between request for a bed and that bed being made available (e.g. > 1 hour).
5. High proportion of patients in ED awaiting placement on an inpatient ward.

This report shall explore how HLSC performs against these quality markers.

## 3.4. Quality and Performance Overview

### 3.4.1. 4-hour Performance

The below graph shows the 4-hour performance of the ICS looking at both type 1 and all-type performance. The July 2021 position for all type A&E performance across L&SC was 79.2% compared to 67.9% in GM and 73.5% in C&M. Cumulatively since April 2021 till the end of July 2021 HLSC performance is 81.4% with GM at 74.0% and C&M at 78.2%.




*Type 1 refers to a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency, type 3 is typically a Urgent Treatment Centre (UTC) that treats at least minor injuries and illnesses (sprains for example) which can be routinely accessed without appointment[2]. All type refers to both type 1 and type 3.*

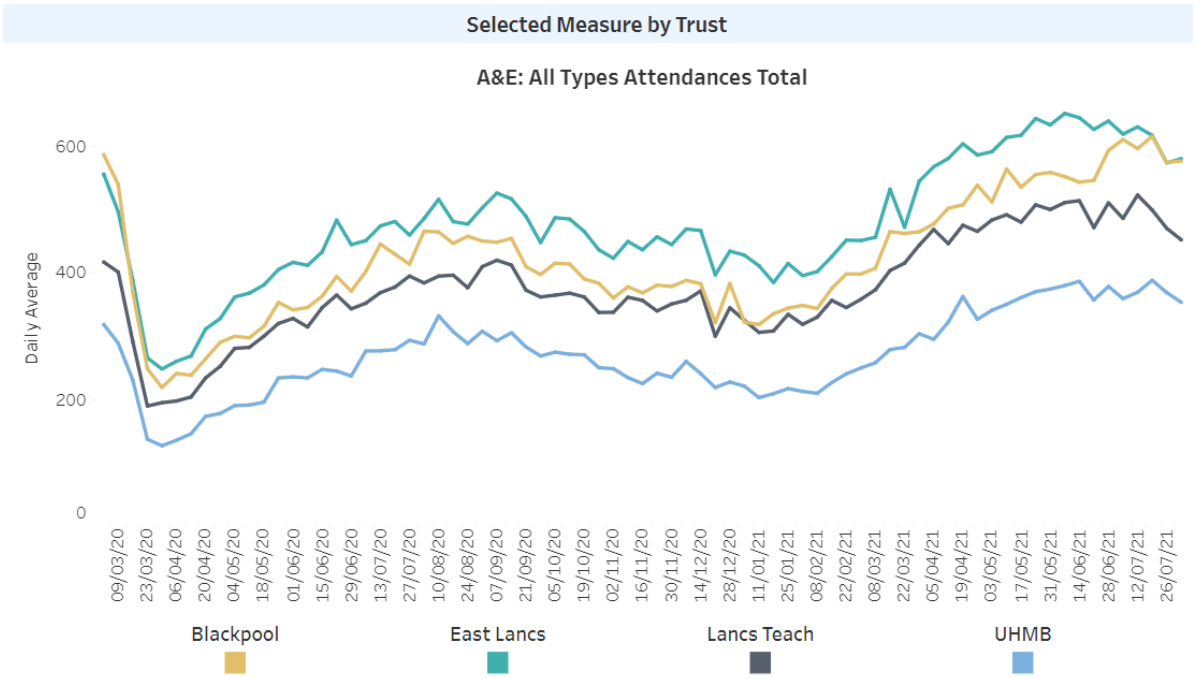
When looking at individual Trust performance for type 1 and all type data the 4 acute providers follow a similar trend demonstrating that the impact is a result of wider system challenges rather than within individual Trusts.

### 3.4.2. Attendances

The below chart shows that as an ICS there has been a significant increase in the number of people attending for UEC within the 4 acute providers since the beginning of March although in July 21 this peak has reduced. A proportion of this increase are categorised as 'majors' indicating that there are more patients requiring high acuity care that will likely need admission. An audit of ELHT Early Warning Scores on arrival has been carried out which shows that scores are higher than in previous years, demonstrating greater acuity reflective of the above system data. From mid-April 21 the number of higher acuity patients attending UEC is higher than pre-COVID levels.

In terms of attendances at UTCs or attendances at type 1 EDs for minor injury or illness, these have also risen from early March 2021 with activity returning to the pre-COVID levels.

[2] AE-Attendances-Emergency-Definitions-v2.0-Final.pdf (england.nhs.uk)




Trusts in COVID surge areas are reporting challenges in management of both COVID and non-COVID pathways as the separation requires additional staff to support the separation of the areas (zoning). Trusts have responded to the additional pressure through the opening of escalation areas however this is limited by staffing availability.

The L&SC Gold Command Function is monitoring the number of patients in the departments throughout the day against the expected pre-COVID norm. If the number of patients in the ED are above the expected number, then system actions are taken to try to decompress the department.

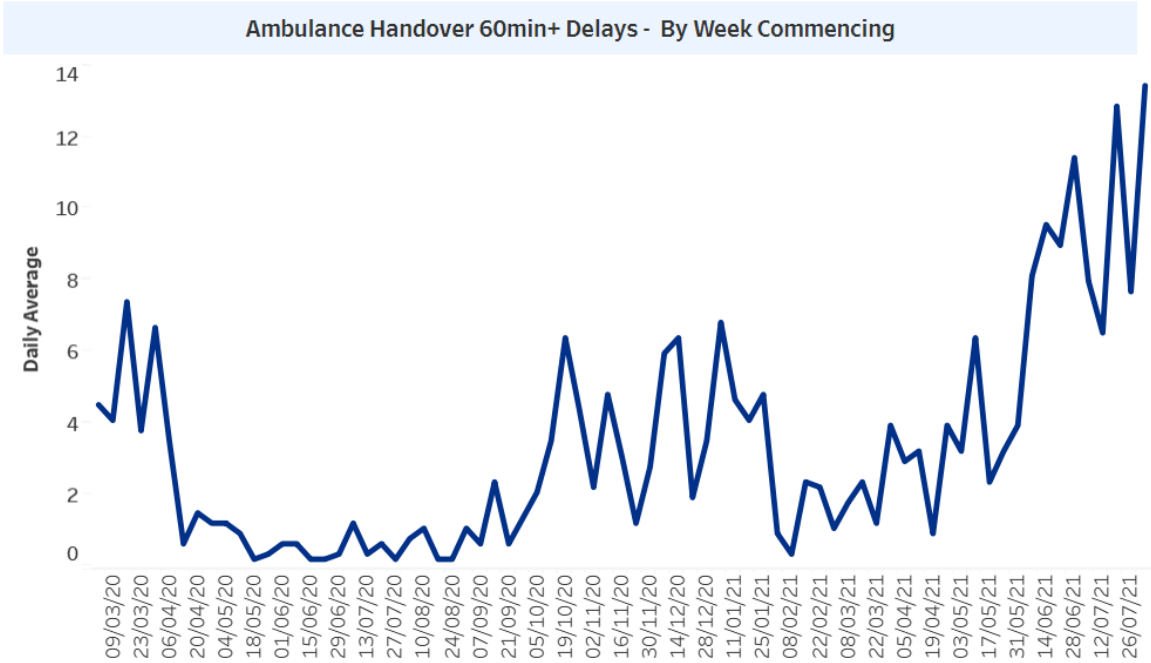
3.4.3. Ambulance Handover

Ambulance waits at EDs are a good indicator of the quality of care provided as it can:

- Highlight that the ED is full as there are no clinical spaces (cubicles) available.
- There may be patients waiting in the corridor which is a very poor experience for the patient in terms of maintaining their privacy and dignity.
- They could be a delay in patients receiving an initial clinical assessment and therefore not being prioritised for clinical need.
- Impact the ability of NWAS to respond to 999 calls in the community.

The below chart shows that there has been a significant increase in the number of ambulances waiting over 60 minutes at EDs since the 17th of May 2021. On analysis of individual provider data LTHT has been mostly impacted by an increase in 60-minute handover delays contributing to the below system position.

60+ minute handover delays




In terms of how quickly most of the ambulances are released from the ED this is measured by the 15-minute handover and 30-minute turnaround targets respectively. July 2021 system performance is just above the NW regional average.

Joint improvement plans with NWAS have been developed as part of improvement plans such as piloting frailty initiatives to improve risk management of older people alongside a continue focus on clinical recruitment.

3.4.4. NWAS/NHS 111

Response Times

The below charts compare the NWAS performance with London and the West Midlands. NWAS have achieved the 15 minutes below 90th percentile for Category 1 (C1) response since April 2018 however are struggling to meet the Category 2 (C2) target of 40 minutes. C2 has a higher number of calls therefore more individuals are being impacted.

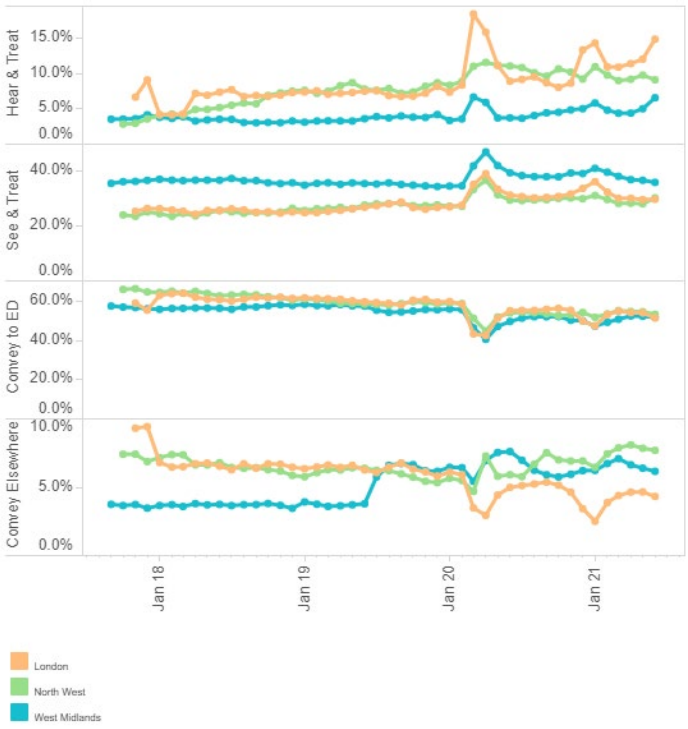
Nationally for C2 most Trusts have failed to meet the mean standard for several months and generally deteriorated since March 2021. NWAS have experienced a 13% increase in C2 calls since Feb (daily ave 1591) to June (daily ave 1800). Nationally C1 and C2 has increased over the last 3-4 months but C3 ad C4 (less urgent) have both decreased, suggesting that it is a change in presenting acuity that is driving the challenge.


**C1 response is an immediate response to a life-threatening condition, such as cardiac or respiratory arrest. The response target is for C1 patients to be responded to within 15 minutes 90% of the time.*
***C2 respond to a serious condition, such as a stroke or chest pain, which may require rapid assessment and/or urgent transport. The response target is for C2 patients to be responded to within 40 minutes 90% of the time.*

## Disposition

NWAS Hear and Treat has demonstrated a good use of resources to deflect activity not needing a 999 response. See and Treat peaked in Apr 2020 at 36.5% and broadly hovers around 30%. Patients are having a face-to-face clinical assessment and not going to the ED but maybe referred to more appropriate care.

On average 53% of patients are being conveyed to an ED which has not returned to pre COVID conveyance levels. Since the start of COVID there has been an increase in conveyance to non ED, which will capture specialist centres as well as type 3/UTC activity.



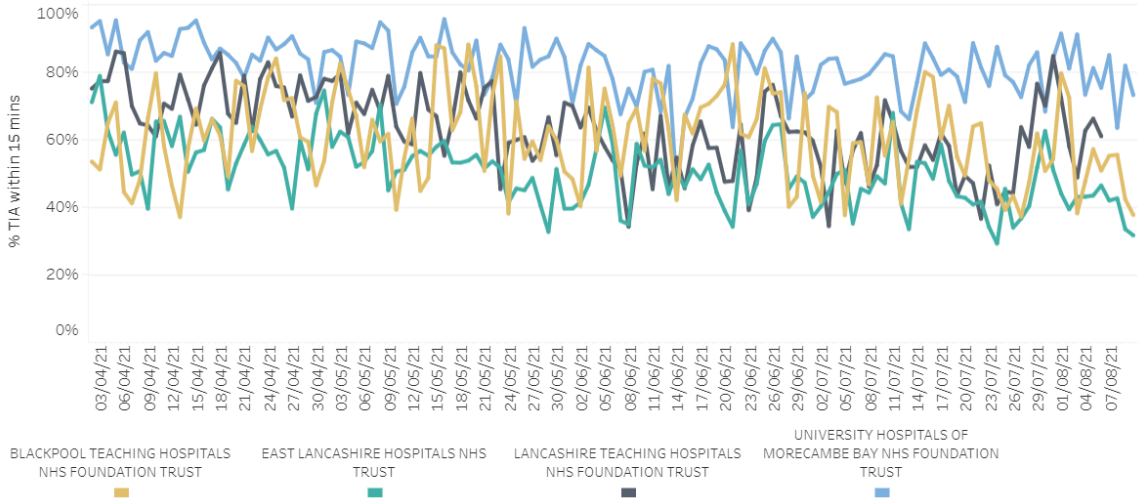

NHS 111 calls answered

The regional 111 performance indicates that NW is slightly behind the curve compared to others. NWAS are experiencing significant challenges in recruiting to its clinical assessment service.

3.4.5. Waiting times in UEC services

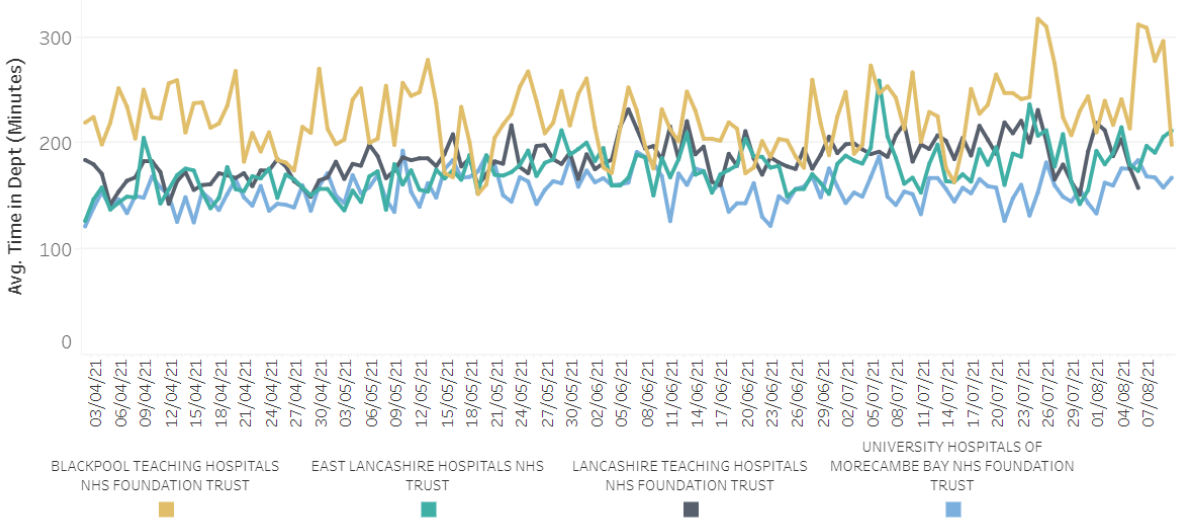
Time to Initial Clinical Assessment

Patients attending UHMB are on average assessed by a clinician earlier than the other providers although this performance is not replicated consistently at the RLI site. As a system this metric is variable across the providers ranging between 40-80% daily. Actions to support clinical assessment capacity in UEC departments identified in the Urgent Care Recovery Plans include review of medical rotas and roles, continued recruitment, and improvements to physical space.



Mean non-admitted patients

For those individuals that did not require admission, patients generally wait longer for treatment at BVH peaking at an average of waiting 316.4 minutes on 27th July 2021.

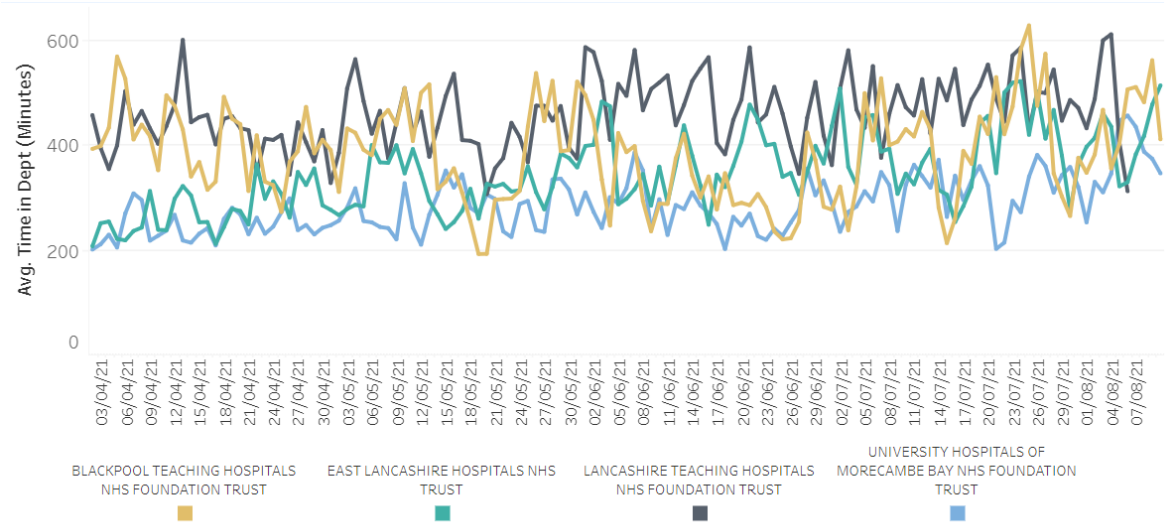



There are a number of actions identified with improvement plans to improve the wait time of those people not requiring admissions. These include:

- Explore with Primary Care the potential to increase face appointments that are directly bookable.
- Increase medical staff at peak times
- Improve rapid response for care home residents
- Set up priority services for direct referral from NHS 111 and Community Health Care Practitioners
- Increase support to Clinical assessment services and NHS 111.

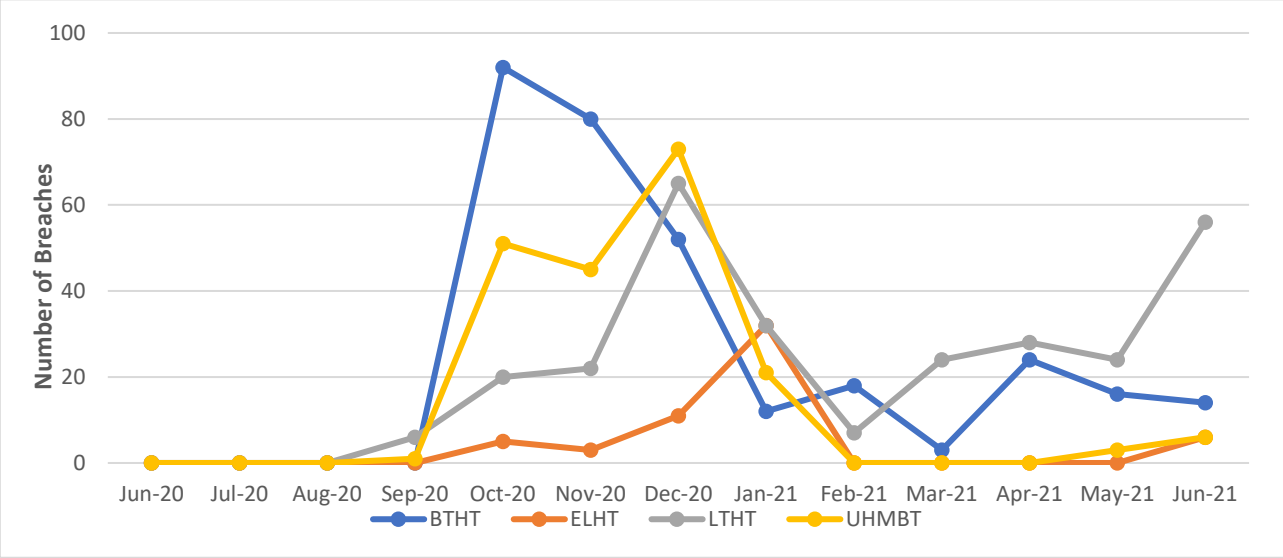
Mean admitted patients

The following chart illustrates the average time patients requiring admission to hospital are waiting for a bed with LTHT having the highest waits.



3.4.6. 12-hour Physical Health Breaches

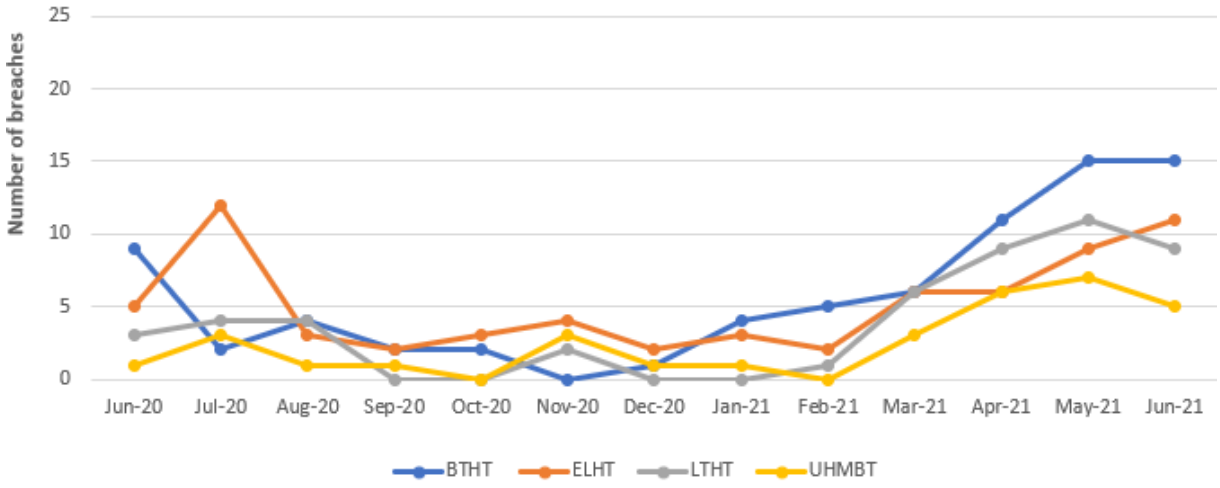
The below chart demonstrates that the number of patients waiting over 12 hours in a UEC department validated to the end on June 21. LTHT and BTH have experienced the greater challenges.




12-hour Mental Health Breaches

The below chart shows the validate mental health breaches reported up to the end of June 21.

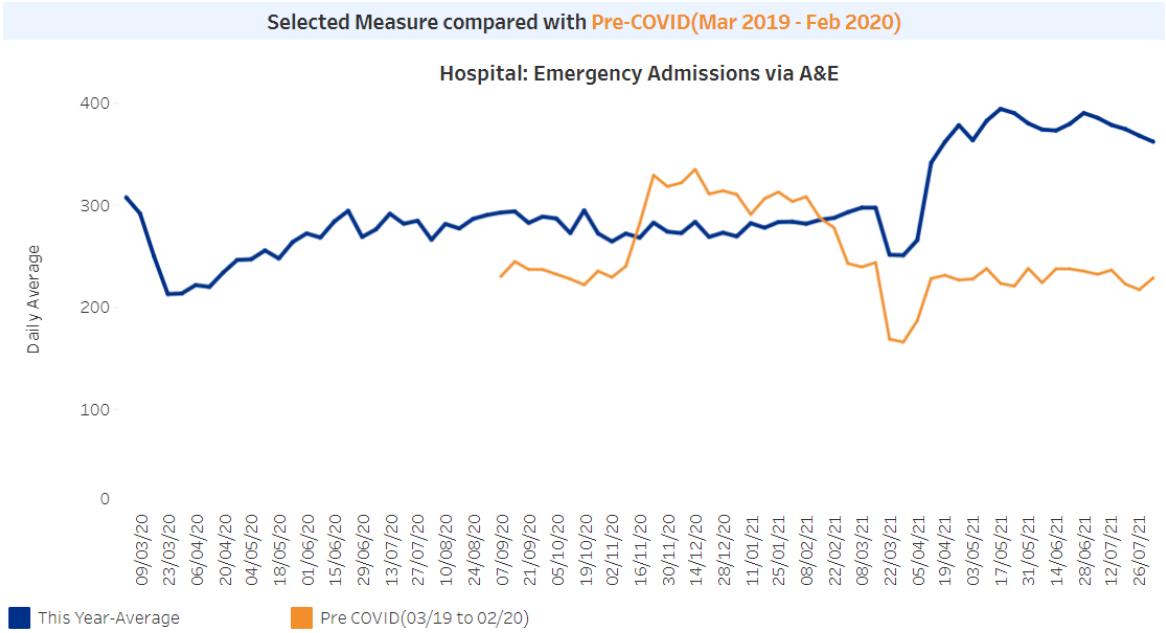
Mental Health A&E Presentations increased from 1012 in March 2021 to 1176 in April 2021 (a 16% increase) and have stayed at a similar level since. There have been 65% more presentations in A&E compared to pre-COVID rates, so there is real pressure in this service, but with improving responsiveness – 93% of referrals were seen within an hour of referral to the Liaison Team in June 2021.




All 12 hours breaches are subject to a case review and any associated harm reported to the CCG.

3.4.7. Acute Hospital Bed Flow

From the beginning of 2021 the number of emergency admissions that have come from ED has steadily increased across all acute providers with the steepest increase at ELHT during April. Emergency admissions are much higher than pre-COVID levels. For the peak week beginning 28th June 2021 this was 34.5% of all type 1 attendances.




*To note - dip seen 22/3/21 is due to missing ELHT data and is not a true dip*

The time of admission to a hospital bed and therefore exit out of ED follows a predictable trend with many transfers taking place in the late afternoon to early evening. The reason for this is related to the later time of day that hospitals achieve their discharges due to awaiting ward rounds, medicines and then transport home.

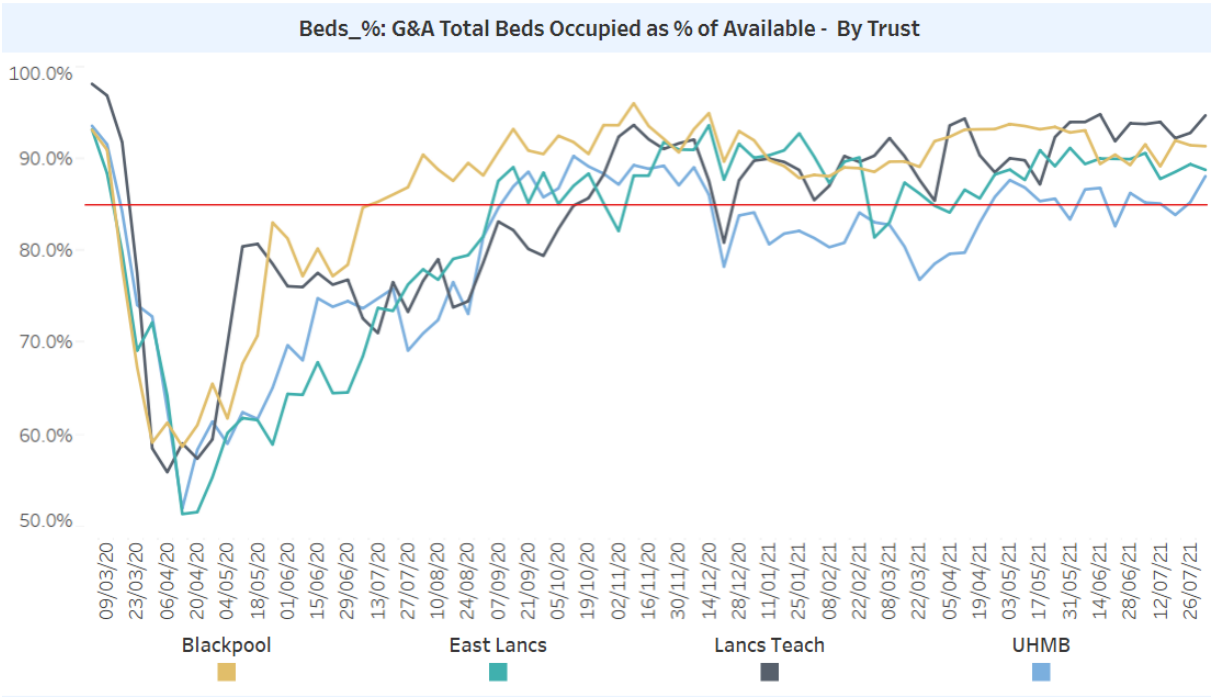
Initiatives identified with improvement plans include the implementation of frailty at the front door, increased GP access to hot clinics and achieving discharges earlier in the day (and subsequently supporting earlier hospital flow). Acute providers are focusing on getting patients home earlier, or where appropriate utilising discharge lounges.

3.4.8. Bed Occupancy

The National Audit Office has suggested that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care-acquired infections. High levels of bed occupancy may also affect patient care as directing patients to the bed most suitable for their care is less likely to be possible[3].

The below chart illustrates the General and Acute Bed occupancy levels by Trust of the acute sites with co-located Type 1 UEC departments which are regularly above 85%.

[3] Emergency admissions to hospital: managing the demand - National Audit Office (NAO) Report




3.4.9. Readmissions

Pressure in hospitals to discharge people sooner can result in a rise in re-admissions. All providers had more patients readmitted within 30 days in May 21 compared to April 21 however this reduced again in all 4 provides in June and July 21. A similar pattern followed with the 90-day readmission metric increasing in all 4 providers in May 21 compared to April 21 although a downward trajectory has not returned in June and July 21 with numbers more static. Any sustained increase in re-admission rates would trigger further exploration and action.

3.4.10. Stranded Patients

During the week of 26th July 2021 45% of acute beds were occupied by patients staying over 7 days, 23% over 14 days and 13% over 21 days. On 13th August 2021 there were 243 or 8.9% of patients in acute hospital beds that did not meet the criteria to reside. The main reason's patients remain in hospital beds fall into the below 2 pathways.

**Pathway 1** – patients waiting to return home with formal support (includes home first, reablement, nursing, therapy or supported living etc).

**Pathway 2** – patients waiting for a D2A bed in a 24-hour residential care/nursing home/community hospital/designated setting environment.

Each of the providers have focused actions to support earlier discharge of stranded patients which include the below:

- Increase provision of 7-day services
- Evaluation of community bed facilities
- Long stay patient multidisciplinary reviews with case management
- Increase Home First/Discharge to assess slots
- Long length of stay improvement project

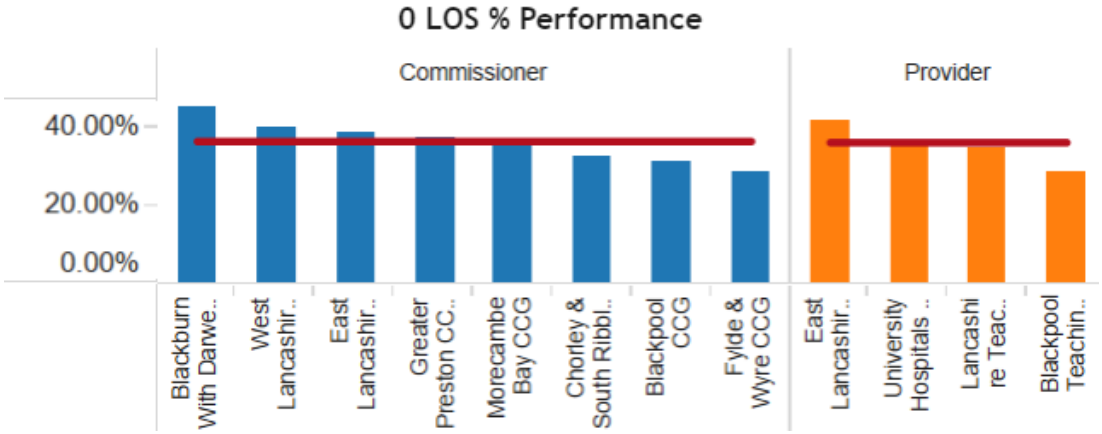
3.4.11. Same Day Emergency Care

There are significant quality and patient experience benefits associated with treating people through SDEC services, including:

- the ability for patients to be assessed, diagnosed and start treatment on the same day, improving patient experience and reducing hospital admissions
- avoiding unplanned and longer than necessary stays in hospitals, resulting in lower risk of infections and de-conditioning for patients
- financial benefits and cost savings for hospitals, and often for patients too.

The below data for the month of July 2021 shows ELHT as delivering a higher proportion of zero-day non-elective admissions and BTHT the least. A time series analysis from June 2015 to April 2021 supports that ELHT have made greater gains in this metric since October 2018. NHSE launched an SDEC strategy in April 2021 which is being approached as a programme of work across the ICS.

Zero Day LOS by Provider and CCG – July 2021




Actions identified within improvement plans to increase the use of SDEC include GP direct pathways, higher stretch targets and the development of further SDEC pathways.

3.5. Overall L&SC workforce challenges

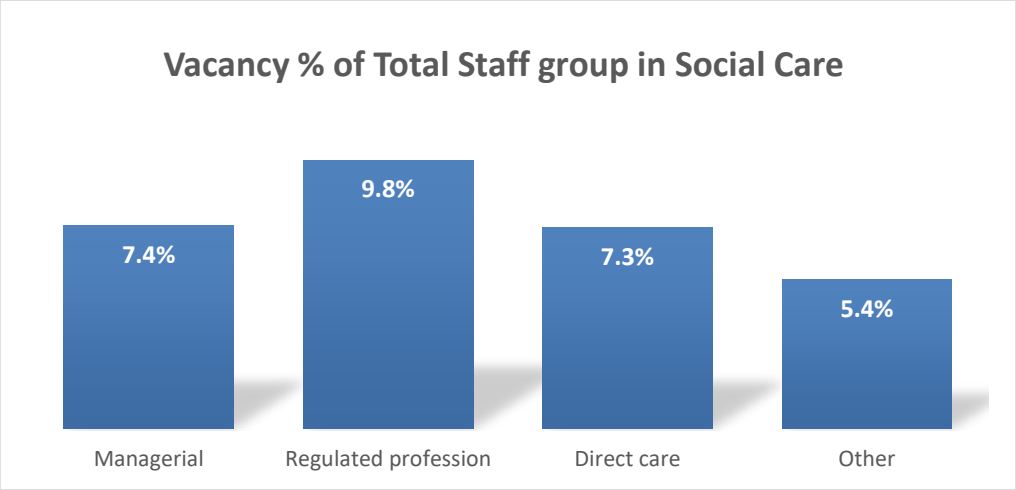
3.5.1. The number of reported vacancies across the main professional groups within L&SC has gradually reduced since August 2020. Data on Primary Care vacancies is not available at this time however Primary Care expansion on the basis of the current workforce model brings with it a number of challenges particularly around availability of qualified and experienced candidates available to work within this sector. There is an ICS programme (led by LTHT) to develop assistant practitioners to registered nurses however, international recruitment has been impacted by COVID border restrictions.

3.5.2. Within pre-hospital care NWAS continues to have a significant gap in the 111 Clinical Advisor vacancy role with a continued reliance on agency to support the maintenance of required clinical resource levels.

3.5.3. Within acute & community Mental Health services there are challenges around:

- Ability to recruit into vacancies
- Ability to recruit into new posts

3.5.4. Risks associated with direct UEC recruitment may destabilise other services impacting on Urgent Care through not optimising on admission avoidance and discharge teams. In social care as of May 2021, the vacancy rate across L&SC overall was 7.2%. By staff group, Regulated Professions had the highest vacancy rate (9.8%).




3.5.5. Specific to Emergency Care HLSC has seen an increase in ED and General Medical consultants although a high use of Locum, Honorary and Fixed Term Temporary contracts in both specialities indicates they remains a continued need to fill rotas.

3.5.6. Areas in Mental Health such as Psychiatry have experienced a reduction in Consultant numbers. This is a concern given the anticipated Mental Health demand especially in relation to the effects of the COVID-19 pandemic on the population health.

3.5.7. As part of the initial work of the People Board, an updated baseline report has been produced which highlights a number of areas of risk for the ICS in relation to workforce. While there are programmes of work taking place to address workforce retention and supply, these will not fully mitigate the potential risks facing the system.

3.5.8. <u>Feedback from the HLSC Emergency Department Workforce</u>

The main reason for staff sickness in acute provider UEC departments is related to anxiety, stress and depression (Jan-June 2021), the second is Gastrointestinal problems. In terms of staff turnover for the same period reasons such as retirement, work life balance, relocation, caring for dependents and lack of opportunities are often cited.

Full compliance with mandatory training has been difficult in terms of giving staff time to complete over the last 6 months due to the increased demand on services coupled with sickness.

The Royal College of Emergency Medicine has developed a strategy to improve the working lives of clinicians working in EDs in the UK. The key elements of this include work patterns, models of ED function, flexible careers, decades of clinical life, team working and leadership, maintaining well-being and valuing trainees.

3.6. <u>Patient Experience</u>

Vital intelligence on patient experience is collected by providers locally. This local intelligence includes feedback from Friends and Family Tests, complaints, incidents and input from the local PALS.

Friends and Family Test results are mainly positive and supportive of the Trusts; there are some concerns relating to COVID and difficulty in social distancing within busy departments. In terms are harms and serious incidents those that reach the serious incident threshold are reported to CCGs via the NHSE serios incident framework[4]. In 2020/21 serious incidents relating to diagnostics was the only common theme across all 4 providers.

From April 2022 the Serious Incident Framework currently used is planned to move to a new PSIRF[5].

3.7. Looking Ahead

3.7.1. Urgent Care Recovery Plans

HLSC AEBD have published evidence based and weekly trajectories outlining achievable performance in relation to the system UEC performance. The plans are not confined to actions within the hospital walls but include a focus of the wider urgent care system including primary care admission avoidance activities such as front door navigation and community pharmacy, and initiatives to reduce length of stay.

3.7.2. Learning from LSC Together

The Hospital and Out of Hospital cells agreed to run a system perfect week from Monday 21st June 2021 to Sunday 28th June 2021 with a focus on two clear themes of Safely and effectively reducing hospital occupancy and improving ED performance.

During the week the ICS delivered overall improved performance against the 4-hour ED target and the number of patients waiting over 12 hours and the number of ambulances held over 30 minutes decreased.

From a patient flow perspective system bed occupancy levels reduced, and discharges exceeded admissions marginally, for the week but not always on a daily basis. The NMC2R patient numbers did not decrease significantly despite more complex discharges being facilitated by community teams. Further work is required to understand this.

In terms other key learning was observed that crisis hours in community were almost exhausted on the Saturday (day 3 of the weekly allocation) while the optimum use of SDEC was during the week. The continued focus is to embed early learning (1 discharge on each ward before 10am and 2 before 12pm etc.) and continue daily ICP discharge calls. Local teams should continue other initiatives where resources are available.

Patient safety remained paramount throughout the week.

3.8. Conclusion

3.8.1. Within the section traditional performance metrics have been used alongside objectively reportable quality indicators such as the new UEC metrics and ED crowding indictors. Localised CCG knowledge and Provider workforce data have also been considered. Although not a complete pathway UEC performance metrics are a good barometer of how effective the wider health and social care system is working.

3.8.2. An overview has been provided of the complex and multi-faceted world of urgent care; the significant challenges faced. The actions required are those of all system partners and of supporting individuals themselves to assess the most appropriate service, at the right time.

[4] serious-incidnt-framwrk-upd.pdf (england.nhs.uk)
[5] NHS England » Patient Safety Incident Response Framework

## 4. Cancer – Focus Area

### 4.1. Headlines for SCC

- Recovery and restoration of services is considered the top priority ahead of long term plan ambitions for early diagnosis (see planning guidance)
- Cancer wait times have not been met consistently for 3 years+
- Covid has added to this pressure, with particular workforce issues across multiple pathways and specifically in non-surgical oncology (mutual aid in place with GM and C&M)
- All patients have been treated in order of clinical prioritisation as per national guidance
- Processes are in place for clinical review of long waiters (those waiting over 104 days)
- Trusts have continued to offer advice and support, co-ordinated through Macmillan Information Centres and by Trust teams
- Diagnostic capacity is a major issue, particularly for Endoscopy, CT and MRI
- Recovery and restoration has been steady, with referrals being above baseline since September 2020, but with gaps in some pathways such as Lung, first definitive treatments currently running just below baseline
- Cancer screening programmes are not fully recovered, with the Lancashire Bowel Cancer Screening Programme being worst performing in England
- Targeted work is needed to address inequalities and improve access for those who have been slower to come forward
- The 62 day backlog is currently reported as 241% of baseline, but it is likely to improve significantly when patients with a "no cancer" diagnosis are removed from PTL[6]
- New commissioning arrangements risk losing sight of smaller, locally commissioned services that offer vital health and wellbeing support at locality level

### 4.2. 2021/22 Oversight Framework and Metrics

| NHS Long Term Plan/People Plan headline area | 2021/22 Planning guidance deliverable | Measure name (metric) | CCG | Trust | ICS |
|---|---|---|---|---|---|
| **Restoration of elective and cancer services*** | Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services | Elective activity levels | ✓ | ✓ | ✓ |
| | | Overall size of the waiting list | ✓ | ✓ | ✓ |
| | | Patients waiting more than 52 weeks to start consultant-led treatment | ✓ | ✓ | ✓ |
| | Restore full operation of all cancer services | Cancer referral treatment levels | ✓ | ✓ | ✓ |
| | | People waiting longer than 62 days | ✓ | ✓ | ✓ |
| | | % meeting faster diagnosis standard | ✓ | ✓ | ✓ |
| | Maximise diagnostic activity focused on patients of highest clinical priority | Diagnostic activity levels | ✓ | ✓ | ✓ |
| **Improve cancer outcomes: early diagnosis and survival** | | Proportion of people who survive cancer for at least 1 year after diagnosis | ✓ | | ✓ |
| | | Proportion of cancers diagnosed at stages 1 or 2 | ✓ | | ✓ |

- These metrics are being collected through weekly activity returns to NHSE/I, and monitored through the ECRG.

[6] source weekly sitrep unpublished

- Backlogs are being tracked actively- and the aim is to restore to pre-pandemic levels by Sept/October, this is looking unlikely with current COVID related operational and workforce pressures - latest sitrep shows backlog is at 241% of baseline (additional 686 patients)
- 560 of these patients already have a “no cancer” diagnosis and will be removed from tracking

4.3. Constitutional Wait Times

- Constitutional wait times standards have not been consistently met across L&SC since 2018
- Pre-COVID, worst 62 day performance on record January 2020
- Current (May 2021) ranking against other Alliances
    - For 62 day standard 20 out of 21
    - For 2 week wait 4 out of 21
- COVID has caused pressures across all pathways, particularly in high volume specialities (breast, GI, urology)
- A clinical prioritisation process based on national guidance has been in operation throughout the pandemic so that patients are seen and treated based on clinical need
- Surgical waiting list is overseen in a weekly Escalation Committee

**Current CWT standards:**

| **Maximum two weeks from:** | **Operational Standard** |
|---|---|
| Receipt of urgent referral for suspected cancer to first outpatient attendance | 93% |
| Receipt of referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment | 93% |

| **Maximum 28 days from:** | |
|---|---|
| Receipt of two week wait referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of two week wait referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer | 75% |

| **Maximum one month (31 days) from:** | | |
|---|---|---|
| Decision to treat to first definitive treatment | | 96% |
| Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is: | surgery | 94% |
| | drug treatment | 98% |
| | radiotherapy | 94% |

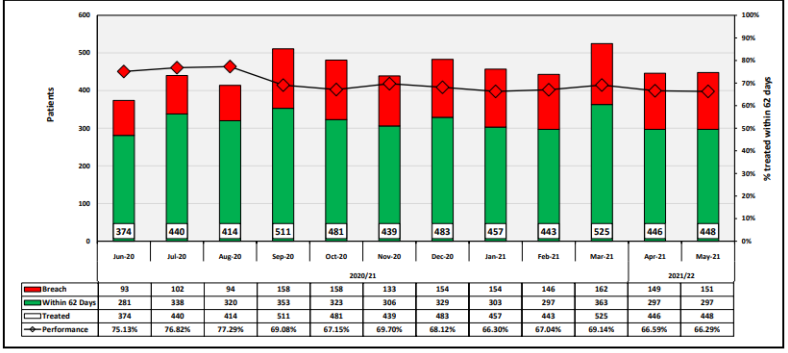
| **Maximum two months (62 days) from:** | |
|---|---|
| Urgent referral for suspected cancer to first treatment (62-day classic) | 85% |
| Urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment | 90% |

| **No separate operational standards set:** |
|---|
| Consultant upgrade of urgency of a referral to first treatment |

## 4.4. 62 Day Referral to Treatment Standard

**62 Day Classic Performance (85% Standard)**

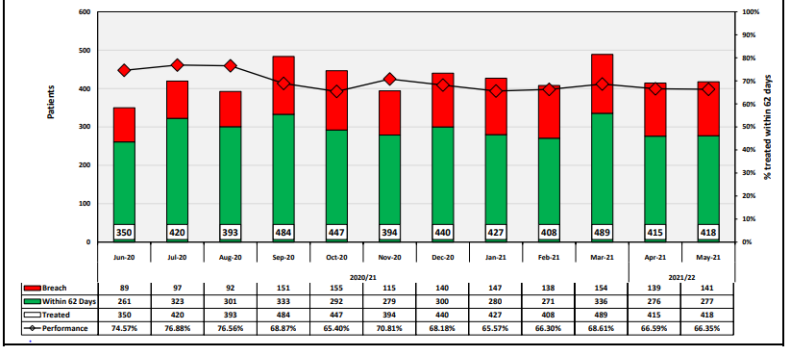
**Cancer Alliance CCGs (Jun-20 to May-21)**




| | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 93 | 102 | 94 | 158 | 158 | 133 | 154 | 154 | 146 | 162 | 149 | 151 |
| Within 62 Days | 281 | 338 | 320 | 353 | 323 | 306 | 329 | 303 | 297 | 363 | 297 | 297 |
| Treated | 374 | 440 | 414 | 511 | 481 | 439 | 483 | 457 | 443 | 525 | 446 | 448 |
| Performance | 75.13% | 76.82% | 77.29% | 69.08% | 67.15% | 69.70% | 68.12% | 66.30% | 67.04% | 69.14% | 66.59% | 66.29% |

| CCG | May-21 | | | Jun-20 to May-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BwDCCG | 36.0 | 8.0 | 77.78% | 380.0 | 92.0 | 75.79% |
| BCCG | 49.0 | 11.0 | 77.55% | 568.0 | 148.0 | 73.94% |
| CSRCCG | 54.0 | 20.0 | 62.96% | 616.0 | 201.0 | 67.37% |
| ELCCG | 71.0 | 26.0 | 63.38% | 1,025.0 | 270.0 | 73.66% |
| FWCCG | 72.0 | 19.0 | 73.61% | 808.0 | 203.0 | 74.88% |
| GPCCG | 48.0 | 15.0 | 68.75% | 547.0 | 193.0 | 64.72% |
| MBCCG | 88.0 | 41.0 | 53.41% | 1,173.0 | 450.0 | 61.64% |
| WLCCG | 30.0 | 11.0 | 63.33% | 344.0 | 97.0 | 71.80% |
| CA CCGs | 448.0 | 151.0 | 66.29% | 5,461.0 | 1,654.0 | 69.71% |

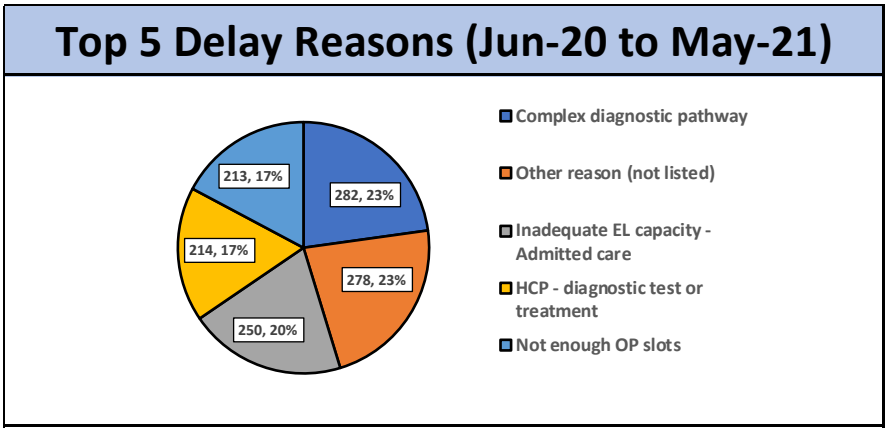
**Cancer Alliance Providers (Jun-20 to May-21)**




| | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 89 | 97 | 92 | 151 | 155 | 115 | 140 | 147 | 138 | 154 | 139 | 141 |
| Within 62 Days | 261 | 323 | 301 | 333 | 292 | 279 | 300 | 280 | 271 | 336 | 276 | 277 |
| Treated | 350 | 420 | 393 | 484 | 447 | 394 | 440 | 427 | 408 | 489 | 415 | 418 |
| Performance | 74.57% | 76.88% | 76.56% | 68.87% | 65.40% | 70.81% | 68.18% | 65.57% | 66.30% | 68.61% | 66.59% | 66.35% |

| Provider | May-21 | | | Jun-20 to May-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BTH | 106.0 | 22.0 | 79.25% | 1,225.5 | 282.5 | 76.95% |
| ELHT | 91.0 | 27.0 | 70.33% | 1,273.5 | 318.0 | 75.03% |
| LTH | 135.0 | 54.0 | 60.00% | 1,466.0 | 548.0 | 62.62% |
| UHMB | 85.5 | 37.5 | 56.14% | 1,117.0 | 406.5 | 63.61% |
| CA Providers | 417.5 | 140.5 | 66.35% | 5,082.0 | 1,555.0 | 69.40% |

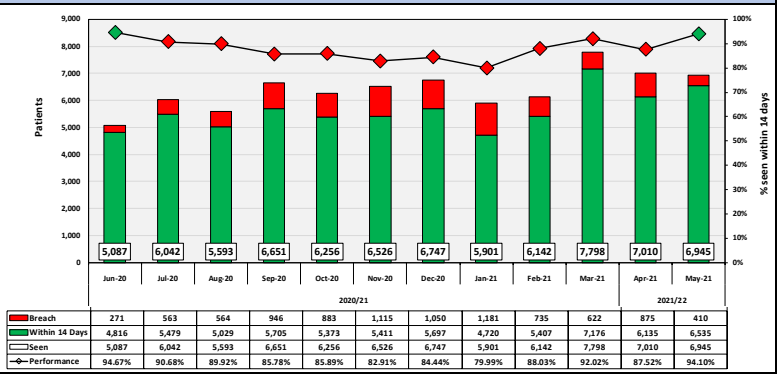
- MB CCG had the worst 62 day performance in May followed by CSR CCG
- UHMB had worst May performance followed by LTHT
- Performance unlikely to improve consistently whilst there is significant backlog to clear
- All Trusts predicting improved June 2021 position



## 4.5. 2 week wait referral to first seen standard

### 2 Week Wait Referrals (93% Standard)

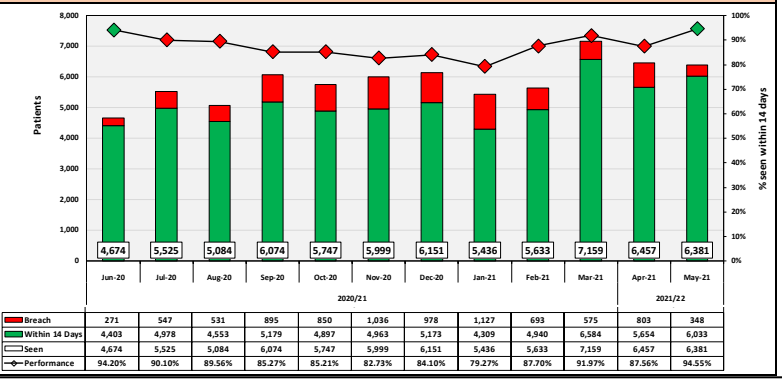
#### Cancer Alliance CCGs (Jun-20 to May-21)




| | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 271 | 563 | 564 | 946 | 883 | 1,115 | 1,050 | 1,181 | 735 | 622 | 875 | 410 |
| Within 14 Days | 4,816 | 5,479 | 5,029 | 5,705 | 5,373 | 5,411 | 5,697 | 4,720 | 5,407 | 7,176 | 6,135 | 6,535 |
| Seen | 5,087 | 6,042 | 5,593 | 6,651 | 6,256 | 6,526 | 6,747 | 5,901 | 6,142 | 7,798 | 7,010 | 6,945 |
| Performance | 94.67% | 90.68% | 89.92% | 85.78% | 85.89% | 82.91% | 84.44% | 79.99% | 88.03% | 92.02% | 87.52% | 94.10% |

| CCG | May-21 | | | Jun-20 to May-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BwDCCG | 459 | 21 | 95.42% | 5,500 | 338 | 93.85% |
| BCCG | 698 | 45 | 93.55% | 7,305 | 393 | 94.62% |
| CSRCCG | 691 | 11 | 98.41% | 8,219 | 974 | 88.15% |
| ELCCG | 1,243 | 55 | 95.58% | 14,353 | 868 | 93.95% |
| FWCCG | 938 | 83 | 91.15% | 10,166 | 739 | 92.73% |
| GPCCG | 911 | 26 | 97.15% | 10,291 | 1,218 | 88.16% |
| MBCCG | 1,474 | 112 | 92.40% | 14,964 | 4,070 | 72.80% |
| WLCCG | 531 | 57 | 89.27% | 5,900 | 615 | 89.58% |
| CA CCGs | 6,945 | 410 | 94.10% | 76,698 | 9,215 | 87.99% |

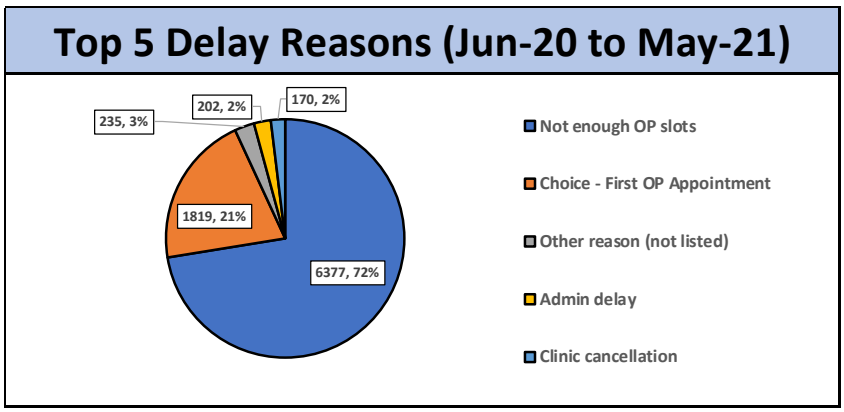
#### Cancer Alliance Providers (Jun-20 to May-21)




| | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 271 | 547 | 531 | 895 | 850 | 1,036 | 978 | 1,127 | 693 | 575 | 803 | 348 |
| Within 14 Days | 4,403 | 4,978 | 4,553 | 5,179 | 4,897 | 4,963 | 5,173 | 4,309 | 4,940 | 6,584 | 5,654 | 6,033 |
| Seen | 4,674 | 5,525 | 5,084 | 6,074 | 5,747 | 5,999 | 6,151 | 5,436 | 5,633 | 7,159 | 6,457 | 6,381 |
| Performance | 94.20% | 90.10% | 89.56% | 85.27% | 85.21% | 82.73% | 84.10% | 79.27% | 87.70% | 91.97% | 87.56% | 94.55% |

| Provider | May-21 | | | Jun-20 to May-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BTH | 1,462 | 117 | 92.00% | 15,672 | 789 | 94.97% |
| ELHT | 1,604 | 71 | 95.57% | 18,778 | 1,102 | 94.13% |
| LTH | 1,760 | 42 | 97.61% | 19,965 | 2,403 | 87.96% |
| UHMB | 1,555 | 118 | 92.41% | 15,905 | 4,360 | 72.59% |
| CA Providers | 6,381 | 348 | 94.55% | 70,320 | 8,654 | 87.69% |

- WL CCG had the worst 2WW performance in May followed by FW CCG
- BTHT had worst May performance followed by UHMB
- Performance variable and suffering because of high rates of referrals (~131% of baseline)
- Massive increase in some specialties- breast, lower GI, head and neck
- Lung still lower than baseline

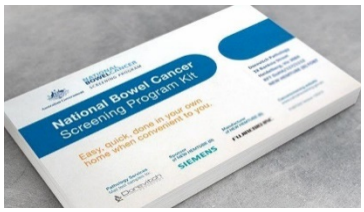


4.6. Cancer Wait Time Improvement Plan

- Focus on backlog reduction- investment in additional measures to increase diagnostic capacity and protect elective activity
- 6 point improvement plan in collaboration with NHSE/I Improvement Support Team - governance, reporting, escalation, access policies, pathway analyser, capacity and demand
- Investment in cancer team- trackers, improved systems, comprehensive training package
- Strong focus on data completeness for Faster Diagnosis Standard
- Continue to roll out Rapid Diagnostic Centre model and Optimal Timed Pathways (shown to be effective at reducing median waits for Pancreatic Pathway)
- Work with Primary care to reduce inappropriate referrals and ensure safety netting

4.7. Screening Programmes

- There is an NHSE/I NW and South Cumbria Public Health Commissioning Plan in place for 2021/22.
- The plan outlines key improvements to improve overall performance and address inequalities
- Bowel Cancer Screening in Lancashire is worst performing in England, and predicting delays in rolling out the required age extension
- The Alliance team has been giving additional support to help negotiate additional lists at Trusts and develop workforce
- There are gaps in the numbers of screen detected cancers for both Breast and Colorectal over the course of 2020
- There is a detailed Improvement Plan held by NHSE




4.8. Quality Frameworks for Cancer

- Cancer is subject to the Quality Surveillance Programme which measures compliance against NICE Improving Outcomes Guidance
- Annual self assessment was not mandated in 2020, but the 4 acute providers chose to undertake this as an internal exercise
- Although the results are not published they will be used to inform the work plans of the tumour specific Clinical Reference Groups which are overseen by the Alliance Clinical Director
- There are 6 National (HQIP) Cancer audits and although these are also not mandated they are routinely contributed to.
- Any issues identified will also be incorporated into CRG workplans
- Urology and Breast Services have new GIRFT data packs, action plans will be developed by each unit

Quality Surveillance Programme
Now incorporating SSQD

4.9. Clinical Engagement

- The Cancer Alliance has maintained all Cancer Clinical Reference Groups
- The groups are administrated via a funded agreement with the Rosemere Education Hub and are complimented by an annual programme of education and development opportunities, some linked with HEE funding
- Each CRG has a Clinical Chair, and all providers are included in the membership
- Chairs and Leads also meet regularly with the Alliance Clinical Chair
    - Standard agenda items include:
    - Quality of Care
    - Safety
    - Performance- working as a "system"
    - Pathways
    - Guidelines
    - Workforce

4.10. Patient Experience Measures

- The National Cancer Patient Experience Survey was "opt in" for 2020 and all 4 Trusts chose to participate- report will be Autumn 2021
- Last published report (Sept 2019) overall rating of care in L&SC was 8.9/10
- There have been 2 National Patient Experience Collaborative Projects ongoing through 2020 at BTHT and ELHT - very well received and nominated for recognition
- The Alliance continues to work with charities (Macmillan and CRUK) to develop our patient experience work stream
- Focused work on inequalities started with first workshop held in July
- Cancer Quality of Life first National report expected soon

| CCG Code | CCG Name | Number of responses | Case mix adjusted CCG scored percentage |
|---|---|---|---|
| 00Q | NHS Blackburn with Darwen CCG | 203 | 8.89 |
| 00R | NHS Blackpool CCG | 220 | 8.73 |
| 00X | NHS Chorley and South Ribble CCG | 244 | 8.91 |
| 01A | NHS East Lancashire CCG | 623 | 8.85 |
| 01E | NHS Greater Preston CCG | 191 | 8.86 |
| 01K | NHS Morecambe Bay CCG | 695 | 8.92 |
| 02G | NHS West Lancashire CCG | 114 | 9.00 |
| 02M | NHS Fylde and Wyre CCG | 438 | 8.78 |

4.11. Health, Wellbeing, Information and Support

- A review of availability and accessibility of Health and Wellbeing Information and Support for people affected by cancer was undertaken in 2021
- The report aims to address gaps in provision of the LTP aim that by 2021, where appropriate every person with cancer will have access to personalised care, including needs assessment, a care plan, and health wellbeing information support
- 9 types of HWBIS need were identified and there were gaps identified across all domains
- There is a lack of locally accessible prehab/rehab provision, variation in smoking cessation services, and a significant requirement for alternative methods of support during the pandemic (e.g. online or by telephone)
- The Alliance will work to articulate the full directory of services that are needed at locality level to support people affected by cancer to live well, and that smaller locally commissioned services are not lost

1. Signs and symptoms of recurrent or progressive disease
2. Health promotion
3. Pre-treatment interventions
4. Confidence and skills to self-manage
5. Psychological impact of cancer and its treatment
6. Complementary therapies
7. Consequences of treatment
8. Financial, benefits and housing advice
9. Work support / vocational rehabilitation


4.12. Harms

- There has been an increase in the number of patients waiting over 104 days for diagnosis and/or treatment as a result of COVID
- A review of 6 months data (434 patients) demonstrated that there are robust processes in place to clinically review long waiters
- The review found that:
    - Over 70% of breaches were unavoidable
    - Most 104 day breaches were in urology (34%) and many of these patients did have anti-cancer treatment on board which did not “stop the clock”
    - 15 cases of “low harm” reported mainly due to psychological distress
    - A NW Policy has since been agreed to ensure consistency in management of 104 day waiters
    - The review will be repeated at 6 monthly intervals

| | |
|---|---|
| Avoidable | 15.63% |
| Not Avoidable | 70.42% |
| Unknown | 13.96% |
| **Grand Total** | **100.00%** |

4.13. Transformation Programme

- The Cancer Alliance, as the ICS body responsible for cancer, participates in a planning and assurance process that is overseen by the Regional NHSE/I Medical Director's team, and by the National Cancer Programme Team.
- Objectives taken from the 20/21 planning guidance are described in more detail in a planning template, and are split into 6 main areas:
  1. Recovery and operational performance
  2. Earlier and faster diagnosis
  3. Personalised Care
  4. Innovation
  5. Treatment
  6. Workforce
- There are multiple projects that sit under these headings, and some key overarching and enabling work streams such as the continued collaboration with elective care, diagnostics, third sector partners, and population health. All programmes are designed with the central principles set out below in mind:


4.14. Key Risks and Issues

| Issue | Description | Mitigation |
|---|---|---|
| Ongoing Covid related pressures leading to reduced capacity to deliver fully restored services | Current bed occupation and covid cases in hospital impacting on elective programme with some isolated cases of cancer surgery being cancelled | Weekly oversight of Cancer Surgery Prioritisation lists, and all measures taken to avoid cancellation, mutual aid process in place as required |
| Chronic workforce shortages further compounded by self-isolation requirements with particular impact in non-surgical oncology and diagnostics | Unable to offer treatment to some cancer groups for radiotherapy such as gynae | Mutual aid in place with GM and C&M, joint appointments made with the Christie whilst longer term solutions worked on through Radiotherapy ODN |
| Lack of diagnostic capacity | LSC has lower ratio of diagnostic capacity compared to other NW regions for key imaging and endoscopy modalities | Working with Diagnostics programme re: roll out of CDHs, and large investment in endoscopy workforce schemes. Capital bid successful for endoscopy during 2020- £6.9m |

4.15. Performance

| | | | Q2 | | | Q3 | | | Q4 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-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% | 94.2% | 85.1% | 92.0% | |
| | 14 Day Target (Breast) | 93.0% | 94.0% | 98.6% | 96.1% | 97.1% | 95.1% | 95.3% | 94.4% | 98.1% | 64.9% | 40.5% | 49.6% | |
| | 62 Day Target | 85.0% | 82.7% | 89.0% | 76.7% | 75.4% | 78.6% | 70.0% | 72.9% | 68.8% | 73.1% | 80.3% | 79.3% | |
| Lancashire Teaching Hospitals | 14 Day Target | 93.0% | 89.1% | 95.7% | 96.0% | 87.6% | 80.5% | 74.8% | 72.0% | 85.2% | 92.6% | 92.3% | 97.6% | |
| | 14 Day Target (Breast) | 93.0% | 41.9% | 87.1% | 100.0% | 82.8% | 30.9% | 2.3% | 7.1% | 38.2% | 58.5% | 57.3% | 95.7% | |
| | 62 Day Target | 85.0% | 75.3% | 70.2% | 67.3% | 55.8% | 54.6% | 64.4% | 57.4% | 53.0% | 64.5% | 59.2% | 60.0% | |
| East Lancashire Hospitals | 14 Day Target | 93.0% | 91.8% | 90.7% | 93.0% | 95.0% | 95.0% | 95.7% | 94.2% | 97.1% | 96.6% | 89.2% | 95.6% | |
| | 14 Day Target (Breast) | 93.0% | 93.3% | 95.7% | 95.9% | 96.5% | 94.3% | 88.1% | 96.0% | 99.3% | 97.2% | 84.0% | 88.0% | |
| | 62 Day Target | 85.0% | 78.0% | 80.5% | 70.5% | 72.1% | 82.6% | 72.9% | 69.0% | 79.0% | 74.6% | 70.6% | 70.3% | |
| Morecambe Bay Hospitals | 14 Day Target | 93.0% | 81.8% | 69.9% | 51.3% | 59.1% | 59.3% | 68.2% | 56.5% | 72.2% | 83.8% | 81.9% | 92.4% | |
| | 14 Day Target (Breast) | 93.0% | 33.3% | 20.0% | 0.0% | 4.7% | 0.0% | 4.0% | 1.6% | 4.2% | 21.9% | 20.3% | 87.0% | |
| | 62 Day Target | 85.0% | 70.5% | 66.9% | 60.0% | 60.1% | 68.3% | 67.6% | 66.3% | 69.1% | 58.5% | 56.0% | 56.1% | |

4.15.1. The table above shows that in May 2021 L&SC ICS performance against the cancer waiting times targets has been challenging; performance is in line with April's position for all trusts. Although the Cancer waiting times targets remain NHS constitutional targets, and will continue to be monitored monthly, the Cancer Alliance have been advised that NHSE and NHSI will be monitoring cancer alliances specifically against restoration aims until Autumn 2021.

4.15.2. There are a number of challenges that are impacting upon performance across all trusts. Self-isolation and sickness related to COVID-19 are placing significant pressure on the system. Endoscopy capacity and the high demand in the lower GI pathway contribute to 18% of all breaches of the 62 day standard, second only to Urology at 30%. There are significant capacity issues within MRI and CT and backlogs within both areas. Oncology workforce pressures are extending pathways for patients.

4.15.3. These issues are being addressed via targeted investment, particularly in relation to endoscopy. RDC programmes in upper and lower GI and prostate are being delivered in 21-22. Following the covid pandemic the alliance is revisiting optimal timed pathways to improve outcomes for patients. Risks associated with long waiting cancer patients are manged by Trust specific deep dives and audits of the 104 day waiting lists.

4.15.4. L&SC Cancer Alliance are ranked 1st out of the 21 Cancer Alliances in England in terms of restoration of urgent cancer referral numbers; however treatment volumes are not matching the referral numbers which can be seen in the performance figures. The table below shows the level of restoration in May 21/22 compared to May 2019/20 for referrals and 1st treatments at providers in L&SC.

| Trust | Referrals | 1st Treatments |
|---|---|---|
| BTHT | 125% | 93% |
| ELHT | 101% | 72% |
| LTHT | 113% | 101% |
| UHMB | 126% | 81% |
| CA | 115% | 89% |

4.15.5. The table below compares L&SC's May 2021 performance against NW Alliances and the England average performance; this includes monitoring against the faster diagnosis standard. Performance against the faster diagnosis standard has improved recently in

readiness for it to be a national standard in Q3. Trusts have been working on completeness of records and three out of the four trusts have hit the threshold of 80%.

| | 2ww 1st seen standards | | FDS | 31 day treatment standards | | | | 62 day referral to treatment standards | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Urgent suspected cancer | Breast symptomatic | Faster Diagnosis Standard | 1s treatment | Subsequent surgery | Subsequent drugs | Subsequent radiotherapy | Urgent GP suspected cancer | Urgent Screening | Consultant upgrade |
| **BTHT** | 92.0% | 49.6% | 72.0% | 98.9% | 100.0% | 100.0% | 95.5% | 79.2% | 33.3% | 91.2% |
| **ELHT** | 95.6% | 88.0% | 83.1% | 94.1% | 98.9% | N/A | 90.3% | 70.3% | 75.0% | 87.2% |
| **LTHT** | 97.6% | 95.7% | 79.9% | 87.8% | 99.1% | 99.5% | 78.7% | 60.0% | 66.7% | 88.6% |
| **UHMB** | 92.4% | 87.0% | 86.6% | 97.8% | 100.0% | N/A | 100.0% | 56.1% | 67.5% | 90.5% |
| **CA** | 94.1% | 80.9% | 80.1% | 94.2% | 99.4% | 99.1% | 86.6% | 66.3% | 68.5% | 89.3% |
| **NW** | 91.8% | 76.4% | 77.0% | 95.5% | 90.9% | 99.5% | 99.3% | 73.2% | 77.9% | 85.1% |
| **England** | 87.5% | 67.9% | 74.3% | 95.1% | 88.5% | 99.1% | 97.1% | 73.0% | 74.5% | 83.6% |
| **Standard** | **93%** | **93%** | **75%** | **96%** | **98%** | **94%** | **94%** | **85%** | **90%** | **N/A** |

4.15.6. L&SC Cancer Alliance has also been ranked against the 21 Cancer Alliances in England as follows for the Cancer waiting time targets:

| Standard | Cancer Alliance Ranking |
|---|---|
| 2WW | 4/21 |
| Breast Symptomatic | 8/21 |
| FDS | 2/21 |
| 1st Treatment | 17/21 |
| 62 Day referral to treatment | 20/21 |

4.15.7. Faster Diagnostic Standard

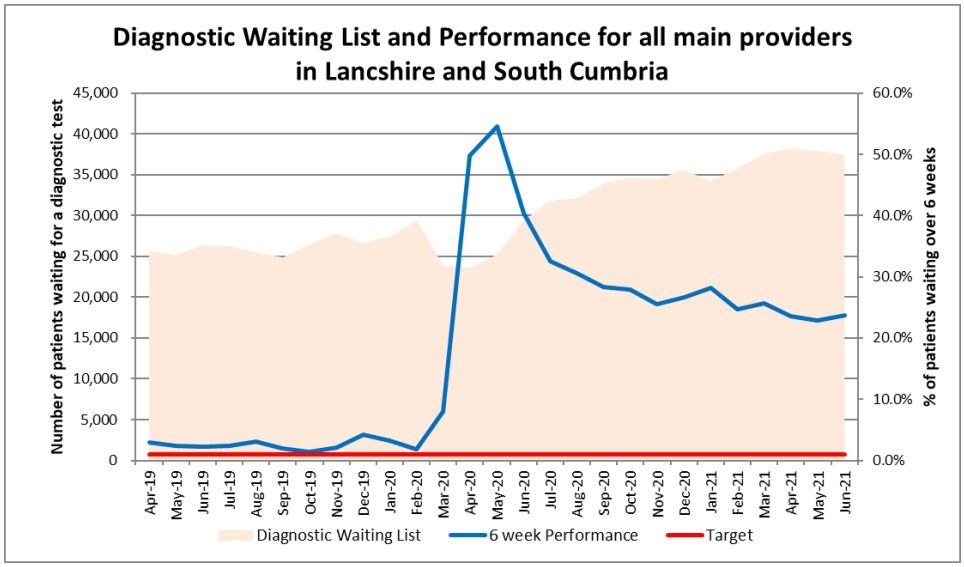
Ahead of FDS becoming a standard in Q3 set at 75% the alliance has been working with Trusts to improve performance. We are currently ranked second of 21 alliances for this measure. However, there is further improvements in the completeness of patient records required which may impact performance in the short-term. The table below highlights performance by pathway and Trust.

| **Pathway** | **BTHT** | **ELHT** | **LTHT** | **UHMB** | **CA** |
|---|---|---|---|---|---|
| Breast | 42.9% | 94.7% | 93.3% | 75.0% | 74.6% |
| Gynaecological | 0.0% | 83.3% | | 0.0% | 66.7% |
| Haematological (Excluding Acute Leukaemia) | 50.0% | 100.0% | 50.0% | 66.7% | 53.3% |
| Head & Neck | 100.0% | 57.1% | 66.7% | 66.7% | 68.4% |
| Hepatobiliary | 0.0% | 100.0% | | | 50.0% |
| Lower Gastrointestinal | 50.0% | 62.5% | 0.0% | 42.9% | 31.4% |
| Lung | 16.7% | 100.0% | 12.5% | 36.4% | 40.6% |
| Not_Recorded | 73.0% | 83.8% | 81.6% | 88.1% | 81.3% |
| Other (not listed) | | | 0.0% | | 0.0% |
| Pancreatic | 0.0% | | | 100.0% | 66.7% |
| Prostate | 54.5% | 42.9% | 9.1% | 35.7% | 32.3% |
| Sarcoma | | | 0.0% | | 0.0% |
| Skin | 96.6% | 33.3% | 100.0% | 100.0% | 87.8% |

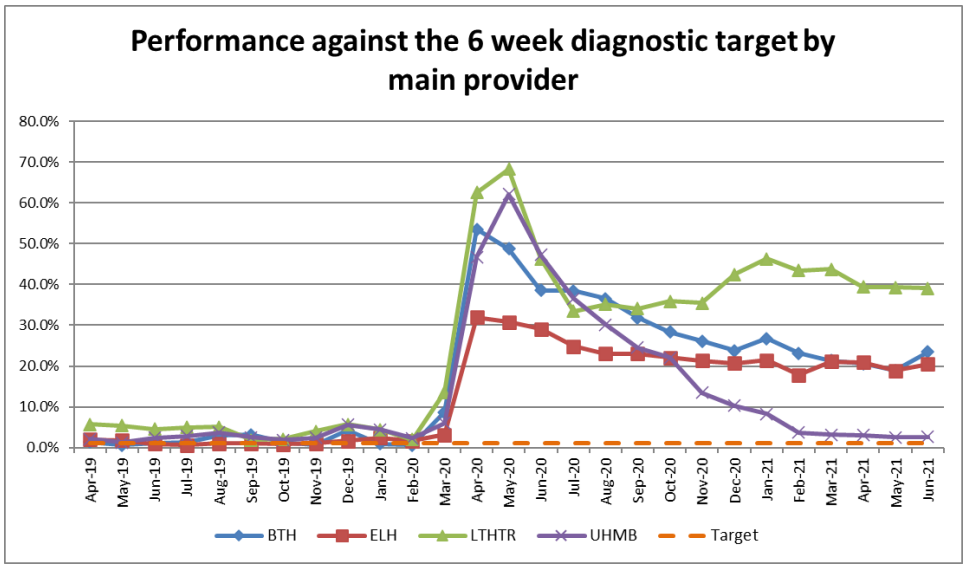
| | | | | | |
|---|---|---|---|---|---|
| Testicular | 100.0% | | 100.0% | 100.0% | 100.0% |
| Thyroid | | 0.0% | | 50.0% | 33.3% |
| Upper Gastrointestinal | | 100.0% | 100.0% | 85.7% | 100.0% |
| Urological (Excluding Testicular and Prostate) | 20.0% | 100.0% | 100.0% | 100.0% | 71.4% |
| **Total** | **72.0%** | **83.1%** | **79.9%** | **86.6%** | **80.1%** |

## 5. Diagnostics

5.1. The information for June 2021 shows a further fall in the number of patients on a waiting list for diagnostic services. This is the second consecutive month of falling waiting list numbers for diagnostics. The fall in the list was due to significant falls at ELHT and BTHT, which offset the increase in the list at LTHT and UHMB. Performance deteriorated in June 2021 to 23.7% at L&SC level, after improving performance since January 2021.




5.2. The performance for the individual main providers shows that UMHB remains the best performing against this indicator with performance for June 2021 being 2.7%, a slight worsening on the previous month at 2.5%. BTHT and ELHT have also both seen a worsening in their performance on the previous month. LTHT remains the outlier with performance at 39.1%, a slight improvement on the previous month.



5.3. A further breakdown of diagnostic activity shows that the performance remains more problematic in Endoscopy than Non Endoscopy pathways.

5.4. There is a mixed picture when the activity is split between Endoscopy and Non Endoscopy, with ELHT showing a worsening in performance in Endoscopy, LTHT and UHMB showing an improvement and BTHT showing a static performance position. All trusts with the exception of LTHT have seen a worsening position in Non Endoscopy performance (LTHT remained static).

| | % of patients waiting over 6 weeks (Jun 2021) | | |
|---|---|---|---|
| Provider | Endoscopy | Non Endoscopy | All Diagnostic Tests |
| BTHT | 42% ↔ | 15% ↑ | 24% ↑ |
| ELHT | 36% ↑ | 18% ↑ | 20% ↑ |
| LTHT | 60% ↓ | 37% ↔ | 39% ↔ |
| UHMB | 4% ↓ | 3% ↑ | 3% ↑ |

5.5. A breakdown at procedure level shows that there are significant numbers of patients waiting over 6 weeks in Non Endoscopy procedures, even though performance for that split is significantly better than in Endoscopy. The information shows that for June 21 the number waiting over 6 weeks for a diagnostic procedure was 8,901. The table below shows the numbers waiting over 6 weeks for the top 7 procedures.

| Procedure | Number waiting > 6 wks | Endoscopy/Non Endoscopy | Comment |
|---|---|---|---|
| Echocardiography | 3,141 | Non Endoscopy | Mainly ELH and LTHTR |
| MRI | 2,008 | Non Endoscopy | Majority at LTHTR |
| Gastroscopy | 850 | Endoscopy | At ELH, BTH and LTHTR, UMHB has small numbers |
| Colonoscopy | 658 | Endoscopy | At ELH, BTH and LTHTR, UMHB has small numbers |
| Peripheral Neurophysiology | 656 | Non Endoscopy | All but 13 at LTHTR |
| Non Obstetric Ultrasound | 412 | Non Endoscopy | Mainly at LTHTR with some at UMHB |
| Flexi Sigmoidoscopy | 372 | Endoscopy | At ELH, BTH and LTHTR, UMHB has 1 |

5.6. The plans for the recovery of the diagnostic waiting list are continuing to be developed and monitored through the ECRG.

5.7. The plans for Community Diagnostic Hubs are developing with work now looking at looking at developments in year 2 and beyond. The ICS steering group has asked CCGs to look at work developed in MB CCG to understand the demands and delivery of Community Diagnostic Hubs going forward.

5.8. The ECRG continues to manage performance against historic activity baselines for endoscopy and diagnostic imaging.

5.9. In Central Endoscopy they are reporting that due to the IPC measures which now must be in place, capacity across the service remains reduced. To increase its core capacity and reduce the need for downtime between aerosol generating procedures during June 2021, the service trailed ID Now/LIAT testing for patients attending upper GI sessions at its RPH unit which allows rapid testing for Coronavirus. From August, the service will resume with testing on the Wednesday PM UGI session at RPH, this will be rolled out to Chorley District Hospital, once pathology is in a position to support it. The service has been impacted by increased staff sickness levels and self isolation. The service is currently actively recruiting to both nursing and administrative roles. Longer term this will enable the service to move to 7 day working /

3 session days, but in the short term will enable the service to return to and maintain its pre-Covid session schedule.

5.10. Works on recovery area at Chorley District Hospital which began in March 2021 and which impacted on our available capacity is now complete.

5.11. External works on the RPH unit has begun, with the extensions for the recovery area and new decontamination room currently under construction. Currently there is no impact on the running of the unit. Current project timescales indicate that the recovery area will need to close for a period of approximately 5 weeks from week commencing 4 October 2021.

5.12. Pennine are reporting the areas with the highest number of breaches are Echocardiography, endoscopy, audiology, and MRI. LTHT is reporting they are unaware of any harms because of the waits at this moment in time. LTHT have implemented several different initiatives:

- Echocardiography - the teams are working 7 days which includes evenings and Waiting List Initiatives are also being utilised. An extra locum echocardiographers has been recruited from the beginning of June 2021. The Trust has also purchased an extra echocardiogram machine, which is currently in use.

- Audiology - have recruited a locum for paediatric audiology starting in July 2021. The administrative team continue to maintain regime of calling all parents to check intention to attend.

- MRI - Additional independent sector activity is continuing in June, July, and August 2021 to support delivery of the activity. LTHT has extended this provision from 15 days per month in July and August 2021 to 31 days. Most of the vacant positions have now been appointed to, but the Trust are awaiting start dates for the new team members. A review has commenced to consider capacity and demand across CT & MRI (to be rolled out to other areas in the future). This will also consider the booking processes followed for maximum usage of available capacity. LTHT are hopeful that the enhanced payment for Trust staff for additional workload will increase capacity in July and August 2021 however it is recognising that this is a peak holiday period. ELHT is reporting that they have confirmation on funding related to the Community Diagnostic Hub developments across L&SC. The early adopter funding bid was successful, and the Trust is finalising the details around a 3-month contract offering MRI scanning at Rossendale Primary Care Centre.

5.13. Work on increasing endoscopy capacity is also key to improving flow through some cancer pathways and will positively impact cancer performance, especially in Colorectal and Urology.

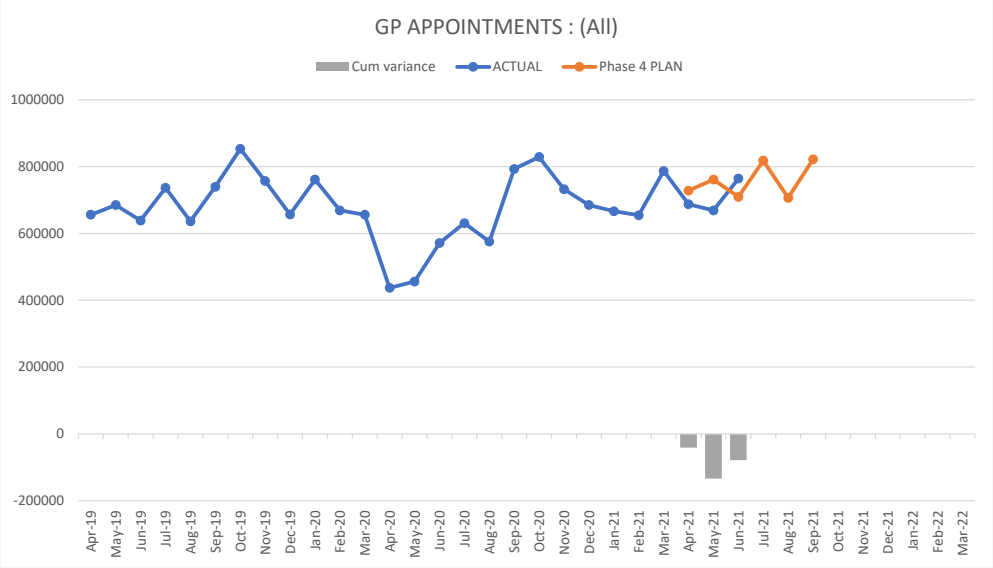
5.14. With regards to the quality of the services delivered, across the ICS there have been five incidents reported across the ICS in relation to missed incidental findings and not following pathways. There have been 4 StEIS reports closed with actions in place none related to waiting times.

## 6. Elective Care

### 6.1. Demand

6.1.1. Appointment demand and activity within GP practices has returned to pre-COVID levels (Chart 1). This is anticipated to be maintained and potentially increase as patient confidence grows following the removal of restrictions.

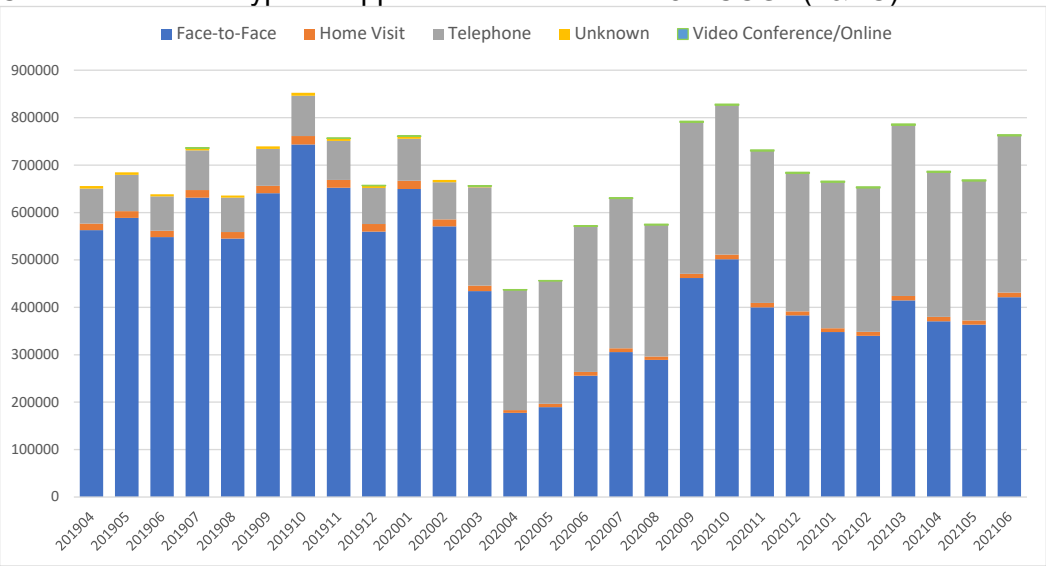
6.1.2. Chart 1 – GP Appointment trends and 2021 H1 plan




6.1.3. Although total appointments have moved back to pre-COVID levels the 'type' of appointment has changed with reductions in face-to-face appointments and increases in telephone and video appointments.

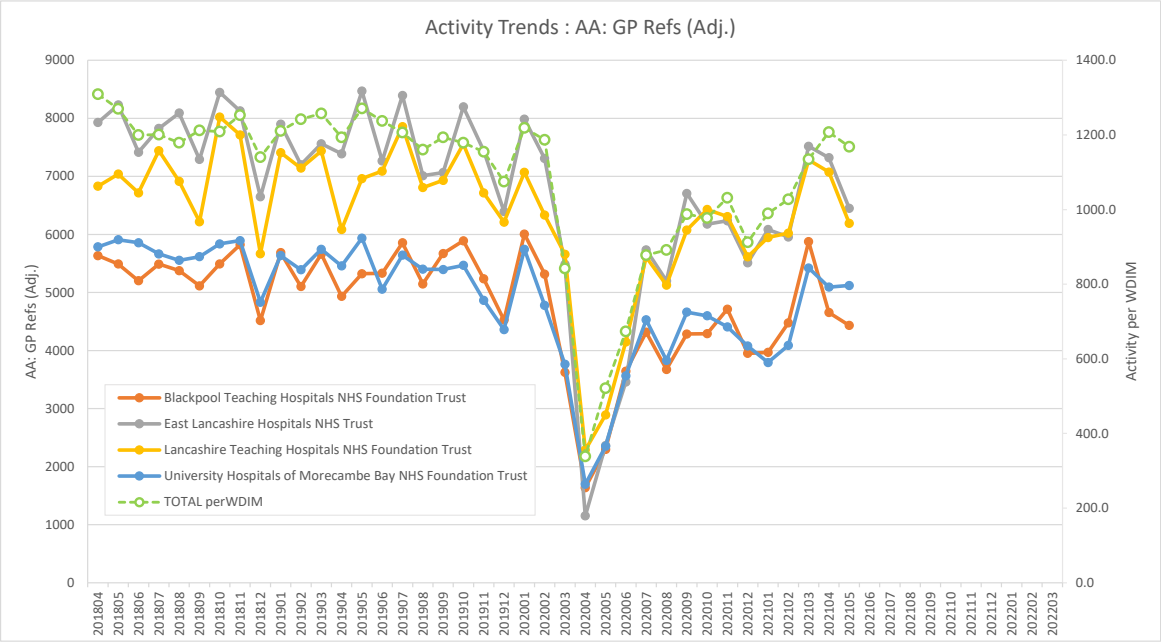
| Period | % Face to Face Appointments | % Telephone Appointments |
|---|---|---|
| April-June 2019 | 85.9% | 11.3% |
| April-June 2021 | 54.5% | 43.9% |

6.1.4. Chart 2 – Shift in 'Type' of appointment over time – 8 x CCGs (L&SC)



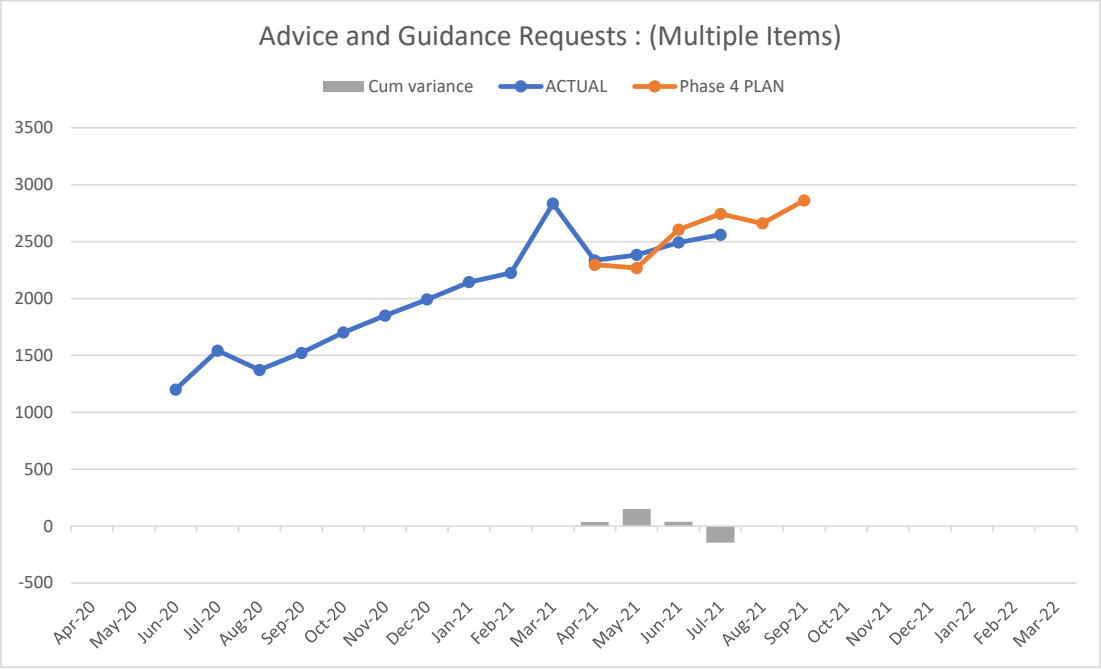
6.1.5. As noted in previous reports, the patterns of demand to our elective services changed significantly as result of COVID-19. Chart 2 below shows GP referrals to the four main ICS acute hospitals, this illustrates the decline and recovery of referrals. GP referrals have continued to recover back towards historic levels with the Apr-June 21 activity across the 4 x L&SC providers (adjusted for working days in the month) was 94.6% of the GP referral activity in Apr-June 19.

6.1.6. Chart 3 – GP referrals into the 4 main acute hospitals across L&SC




6.1.7. One approach being utilised across L&SC to support management of demand into the acute system has been the implementation of Advice and Guidance (based on the Morecambe Bay system [Except West Lancs which uses consultant connect]). The use of this system has been steadily increasing, and the final phase 4 plans are anticipating that this will continue [Chart 4].

6.1.8. Chart 4 – Advice and Guidance requests and Final Phase 4 Plan



6.1.9. 90.0% of all Advice and Guidance requests in Apr-Jul 21 were responded to within 2 days while referrals to outpatients were effectively halved (Table 1)

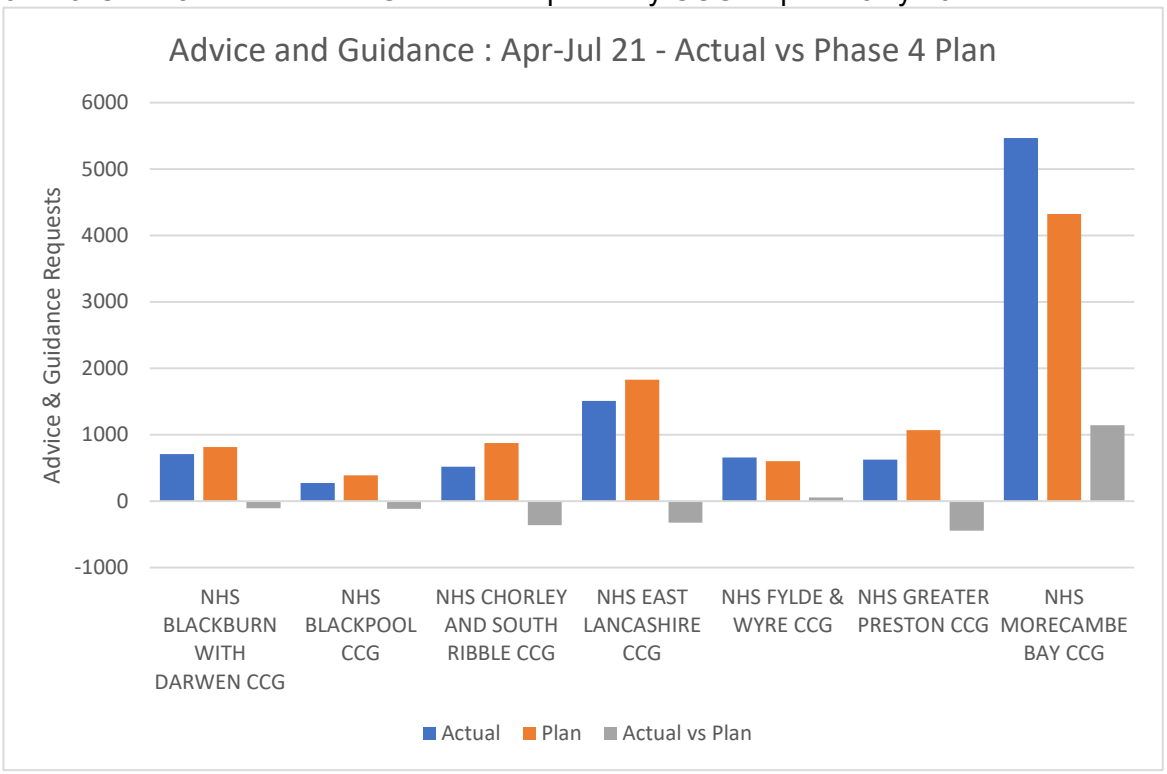
6.1.10. Table 1 – Pre and Post- Advice and Guidance outcomes Apr-Jul 2021

| Treatment Plan [Apr-Jul 21] | BEFORE | AFTER A&G | MOVEMENT | % SHIFT |
|---|---|---|---|---|
| (blank) | 2631 | 2407 | -224 | -8.5% |
| Admit | 845 | 790 | -55 | -6.5% |
| Carry out further investigations | 433 | 825 | 392 | 90.5% |
| Forced Closure | | 224 | 224 | |
| Manage patient's care myself | 524 | 2440 | 1916 | 365.6% |
| Other | 564 | 829 | 265 | 47.0% |
| Radiology test sanctioned by radiologist | | 319 | 319 | |
| Refer to outpatients | 3391 | 1718 | -1673 | -49.3% |
| Seek advice from another source | 1429 | 265 | -1164 | -81.5% |
| **TOTAL** | **9817** | **9817** | **0** | **0.0%** |

6.1.11. The volume of advice and guidance requests reported in July is lower than the recently submitted plan levels (updated in the final phase 4 submission) and there are variations in volumes and patterns of utilisation across CCGs. Morecambe Bay CCG (early adopter) accounts for over half of all advice and guidance requests and is also over plan. If MB CCG is excluded then the combined position across all other CCGs for this year to date is well below plan.

6.1.12. In addition, further direction from NHSE/I has outlined that systems should aim for a "…minimum adoption level of 15% (A&G) by the end of September 2021" and should have "…plans for increased use of these approaches to service regardless of their current level, given the importance for creating capacity and supporting recovery. " (NHSE/I 3rd July 2021)

6.1.13. Chart 5 – Advice and Guidance requests by CCG : April to July 2021



6.1.14. Actual A&G vs Phase 4 plan by CCG [April – July 2021]

| CCG Name | Actual | Plan | Actual vs Plan | % Variance |
|---|---|---|---|---|
| NHS BLACKBURN WITH DARWEN CCG | 709 | 816 | -107 | -13.1% |
| NHS BLACKPOOL CCG | 275 | 390 | -115 | -29.5% |
| NHS CHORLEY AND SOUTH RIBBLE CCG | 519 | 876 | -357 | -40.8% |
| NHS EAST LANCASHIRE CCG | 1510 | 1832 | -322 | -17.6% |
| NHS FYLDE & WYRE CCG | 658 | 603 | 55 | 9.1% |
| NHS GREATER PRESTON CCG | 628 | 1071 | -443 | -41.4% |
| NHS MORECAMBE BAY CCG | 5469 | 4325 | 1144 | 26.5% |
| **TOTAL** | **9768** | **9913** | **-145** | **-1.5%** |
| | | | | |
| Total Excluding Mbay | 4299 | 5588 | -1289 | -23.1% |

6.1.15. Radiology, Dermatology, Cardiology and Clinical Haematology are the 4 specialties that receive the greatest number of Advice and Guidance requests (40% of all A&G requests in Apr-Jul 21). 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.

**Recommendation**: Take action to promote and maximise the use of Advice and Guidance across the ICS

6.2. Activity

6.2.1. The national planning letter received on the 25th of March 2021 set 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[7] reported in 2019-20 with a five-percentage point increase in delivery in subsequent months to 85% from July 2021. Additional monies are available via the Elective Recovery Fund for performance above these thresholds.

6.2.2. However, the thresholds have been reviewed taking account of progress to date and "as a result the thresholds for earning ERF are being adjusted to 95% of 2019/20 activity levels from 1st July 2021." (NHSE/I 9th July 2021). The financial impact is currently being assessed and will result in a reduction of income. This could jeopardize Providers ability to deliver additional activity, which by enlarge can only be carried out at premium costs.

6.2.3. The final Phase 4 planning submission covering the first half of 2021-22 was submitted in early June and is planning to deliver the following levels of recovery across the 4 x providers and across the 8 x CCGs for total elective activity (Daycase and Elective). 120% recovery has also been planned for outpatients.

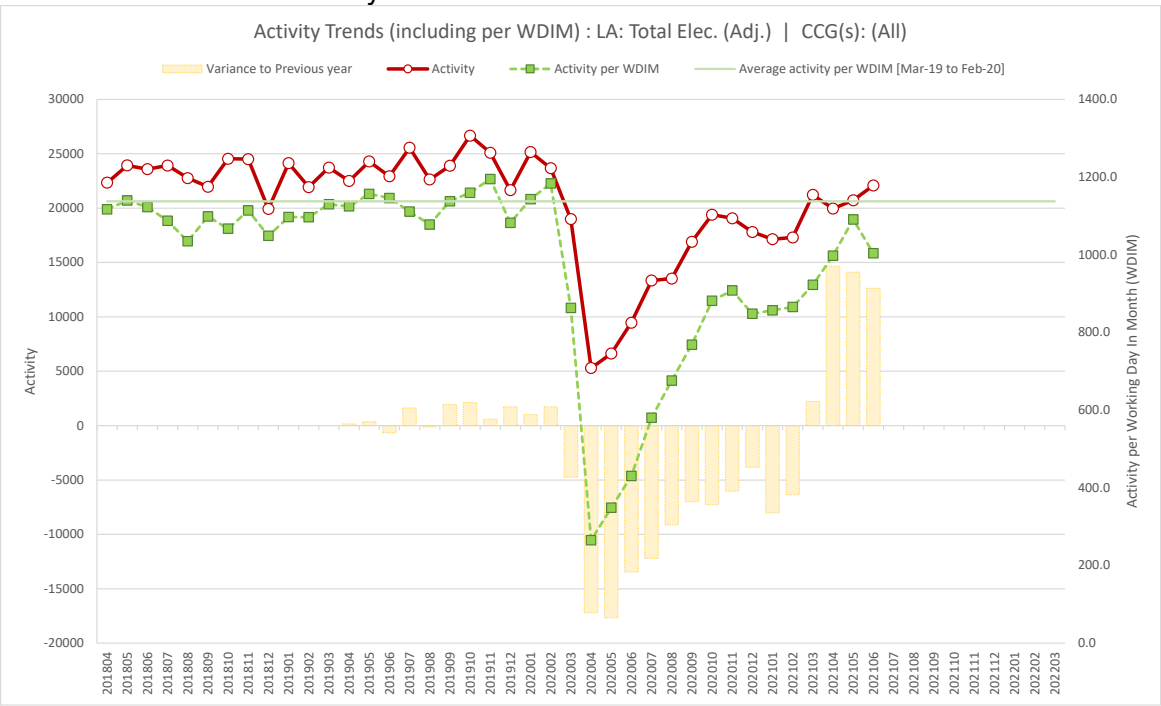
| | TOTAL ELECTIVE [4 x L&SC Providers] | | | | | |
|---|---|---|---|---|---|---|
| | April | May | June | July | August | September |
| 2019-20 | 18803 | 20480 | 19153 | 21404 | 19063 | 19661 |
| 2021-22 | 17122 | 17146 | 19791 | 24571 | 22879 | 24721 |
| % of 'baseline' | **91.1%** | **83.7%** | **103.3%** | **114.8%** | **120.0%** | **125.7%** |
| | **TOTAL ELECTIVE [L&SC CCGs - All Providers]** | | | | | |
| | April | May | June | July | August | September |
| 2019-20 | 22467 | 24290 | 22937 | 25526 | 22630 | 23919 |
| 2021-22 | 20500 | 20329 | 23687 | 29013 | 26923 | 29617 |
| % of 'baseline' | **91.2%** | **83.7%** | **103.3%** | **113.7%** | **119.0%** | **123.8%** |

[7] A sub-set of total activity

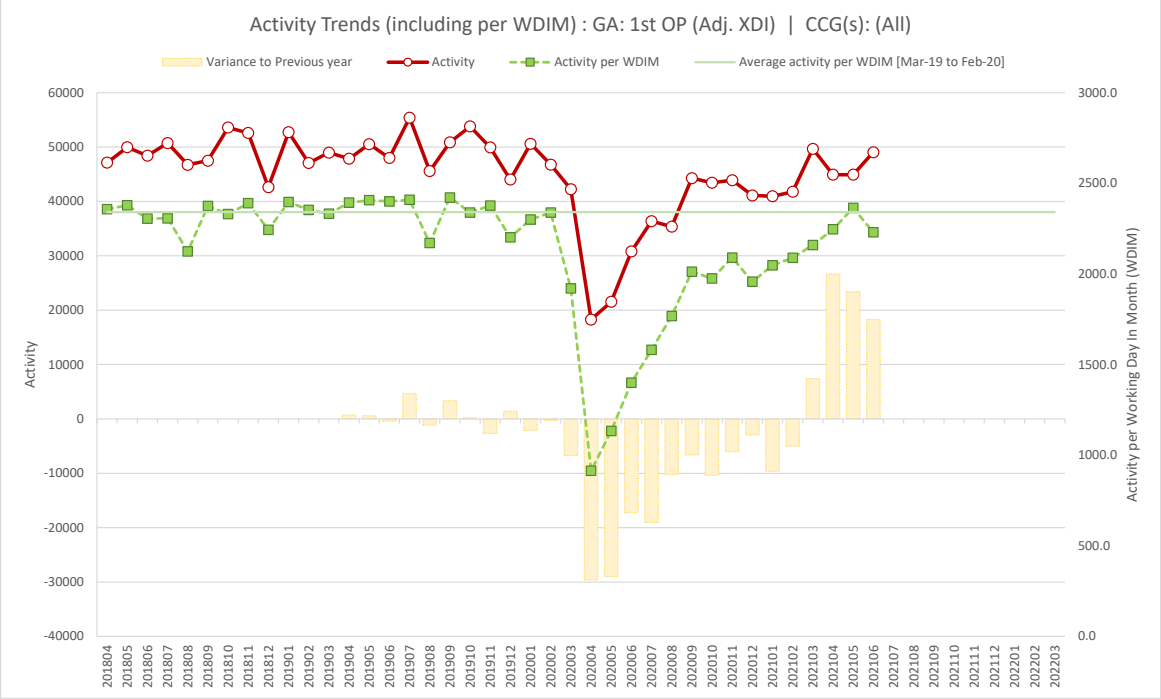
6.2.4. Activity trends based on the national dataset for CCGs (across all providers) showed a reduction in the level of recovery in June 2021.

| Activity Type | June 2019 (Activity per WDIM) | June 2021 (Activity per WDIM) | June 21 Indicative Recovery % |
|---|---|---|---|
| Total Elective (EL+DC) | 1146.2 | 1003.8 | 87.6% |
| First Outpatients | 2400.2 | 2229.7 | 92.9% |
| Follow-Up Outpatients | 4653.6 | 4538.4 | 97.5% |

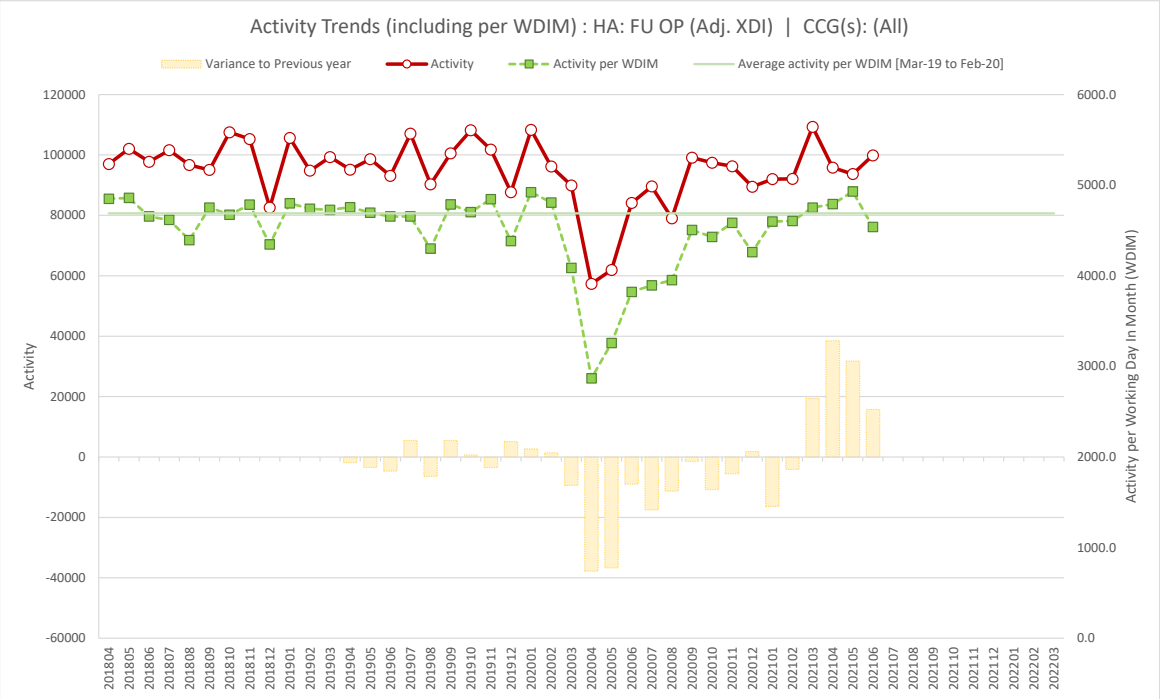
6.2.5. Chart – Total Elective Activity Trends – L&SC CCGs




6.2.6. Chart – Total First Outpatient Activity Trends – L&SC CCGs



6.2.7. Chart – Total Follow-Up Outpatient Activity Trends – L&SC CCGs




6.2.8. Weekly Activity Return information has been reviewed across the NW, and for the rolling 4 weeks to 1st August 2021, the total elective recovery position (elective ordinary and daycases) was strongest in L&SC. There is some variation at provider level underneath this L&SC position. [note that this is only based on a single week this year compared with the same period historically]

6.2.9. Recovery – Elective activity and daycases – ICS Level

| | Daycases | | | | | | Ordinary Electives | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 Week Average (Final data) | | | Latest Week (Provisional) | | | 4 Week Average (Final data) | | | Latest Week (Provisional) | | |
| STP | Same weeks in 2019/20 | 4 Weeks Ending: 01 Aug 2021 | as a % of 2019/20 | Same week 19/20 | Week Ending: 08 Aug 2021 | as a % of 2019/20 | Same weeks in 2019/20 | 4 Weeks Ending: 01 Aug 2021 | as a % of 2019/20 | Same week 19/20 | Week Ending: 08 Aug 2021 | as a % of 2019/20 |
| Cheshire and Merseyside STP | 7,298 | 5,603 | 77% | 7,072 | 5,290 | 75% | 1,115 | 1,008 | 90% | 1,053 | 967 | 92% |
| Greater Manchester Health and Social Care Partnership (STP) | 7,613 | 6,515 | 86% | 7,123 | 6,483 | 91% | 1,451 | 1,173 | 81% | 1,348 | 1,214 | 90% |
| Healthier Lancashire and South Cumbria STP | 4,058 | 3,603 | 89% | 3,949 | 3,365 | 85% | 615 | 577 | 94% | 657 | 546 | 83% |
| **North West** | **18,968** | **15,720** | **83%** | **18,144** | **15,138** | **83%** | **3,180** | **2,757** | **87%** | **3,058** | **2,727** | **89%** |

6.2.10. Recovery – Elective activity and daycases (w/e 8th August 2021) – Provider Level

| Name | Historic Weekly Activity | Current Weekly Activity (raw values) | Variance | % activity restored (raw values) |
|---|---|---|---|---|
| L&SC | 4,606 | 3,911 | 695 | 84.9 % |
| Blackpool Teaching | 1,164 | 1,034 | 130 | 88.8 % |
| East Lancashire | 1,222 | 1,073 | 149 | 87.8 % |
| Lancashire Teaching | 1,303 | 973 | 330 | 74.7 % |
| Morecambe Bay | 917 | 831 | 86 | 90.6 % |

6.2.11. In terms of outpatient activity (first and follow-up), both GM Health and Social Care Partnership STP and C&M STP are continuing to report higher levels of recovery than HLSC STP.

6.2.12. Recovery – Outpatient (First and Follow-up) – ICS Level

| | First Outpatients | | | | | | Follow-Up Outpatients | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 4 Week Average (Final data) | | | Latest Week (Provisional) | | | 4 Week Average (Final data) | | | Latest Week (Provisional) | | |
| STP | Same weeks in 2019/20 | 4 Weeks Ending: 01 Aug 2021 | as a % of 2019/20 | Same week 19/20 | Week Ending: 08 Aug 2021 | as a % of 2019/20 | Same weeks in 2019/20 | 4 Weeks Ending: 01 Aug 2021 | as a % of 2019/20 | Same week 19/20 | Week Ending: 08 Aug 2021 | as a % of 2019/20 |
| Cheshire and Merseyside STP | 21,019 | 20,151 | 96% | 19,501 | 20,543 | 105% | 50,127 | 51,832 | 103% | 48,039 | 49,280 | 103% |
| Greater Manchester Health and Social Care Partnership (STP) | 21,591 | 25,247 | 117% | 20,441 | 23,440 | 115% | 52,314 | 54,676 | 105% | 49,695 | 51,318 | 103% |
| Healthier Lancashire and South Cumbria STP | 10,265 | 9,489 | 92% | 9,239 | 8,867 | 96% | 20,829 | 19,435 | 93% | 19,114 | 17,889 | 94% |
| **North West** | **52,875** | **54,886** | **104%** | **49,181** | **52,850** | **107%** | **123,269** | **125,943** | **102%** | **116,848** | **118,487** | **101%** |

6.2.13. Early indication weekly activity has been used by the ECRG to highlight the position in July 2021 against the Core, Core+ and Accelerator targets. The pace of restoration is different between the individual providers within the ICS as shown in the table below. Core targets are being met with Electives, Daycases and First Outpatient attendances based on the rolling 4 weeks to 1st August 2021. However, no Core+ or Accelerator targets are being delivered and the actual level of recovery has actually been showing signs of reducing.

6.2.14.

| | July | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Data Source: | Weekly Activity Return (excludes CCG IS) | | | | | | | | | | | | | | |
| Point of Delivery | LSC Rolling 4 wk av. | | | | | Restoration Target | | | % Diff vs Latest 4 wk av. | | | Provider Rolling 4wk av. 01/08 | | | |
| | 04-Jul | 11-Jul | 18-Jul | 25-Jul | 01-Aug | Core | Core+ | Accel | Core | Core+ | Accel | BTH | ELHT | LTH | UHMB |
| OEL | 94% | 95% | 97% | 95% | 94% | 89% | 104% | 120% | 5% | -10% | -26% | 97% | 99% | 86% | 96% |
| DC | 92% | 92% | 92% | 89% | 89% | 85% | 101% | 120% | 4% | -12% | -31% | 96% | 87% | 83% | 90% |
| OPFA | 95% | 96% | 97% | 94% | 92% | 90% | 100% | 120% | 2% | -8% | -28% | 87% | 102% | 83% | 94% |
| OPFUP | 97% | 96% | 96% | 93% | 93% | 94% | 100% | 120% | -1% | -7% | -27% | 88% | 97% | 89% | 102% |
| **Total** | **96%** | **96%** | **96%** | **93%** | **93%** | **92%** | **100%** | **120%** | **1%** | **-7%** | **-27%** | **89%** | **98%** | **87%** | **97%** |

6.2.15. The ECRG 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<br>• Establishing surgical hubs<br>• Co-ordinated waiting list (inc. IS) & protocol to determine system wide priorities<br>• Oversight clinical validation of waiting lists<br>• Managed system view of EBIs & implementation of clinical policies<br>• System wide surgical prioritisation committee |
| Outpatients | • Increased use of Patient Initiated Follow Ups (PIFUs)<br>• Increased use of Advice and Guidance<br>• Increased volume of Virtual Consultations<br>• Clinical pathway redesign: MSK & dermatology to reduce attendances |
| Diagnostic Imaging | • Securing additional imaging capacity<br>• Establishing Provider Collaborative Diagnostics Imaging Network<br>• Implementing Community Diagnostic Hubs |
| Diagnostics Endoscopy | • Establishing Endoscopy Hub and manage at system level Mobile scanner utilisation rates<br>• Workforce capacity, staffing models & skills |

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

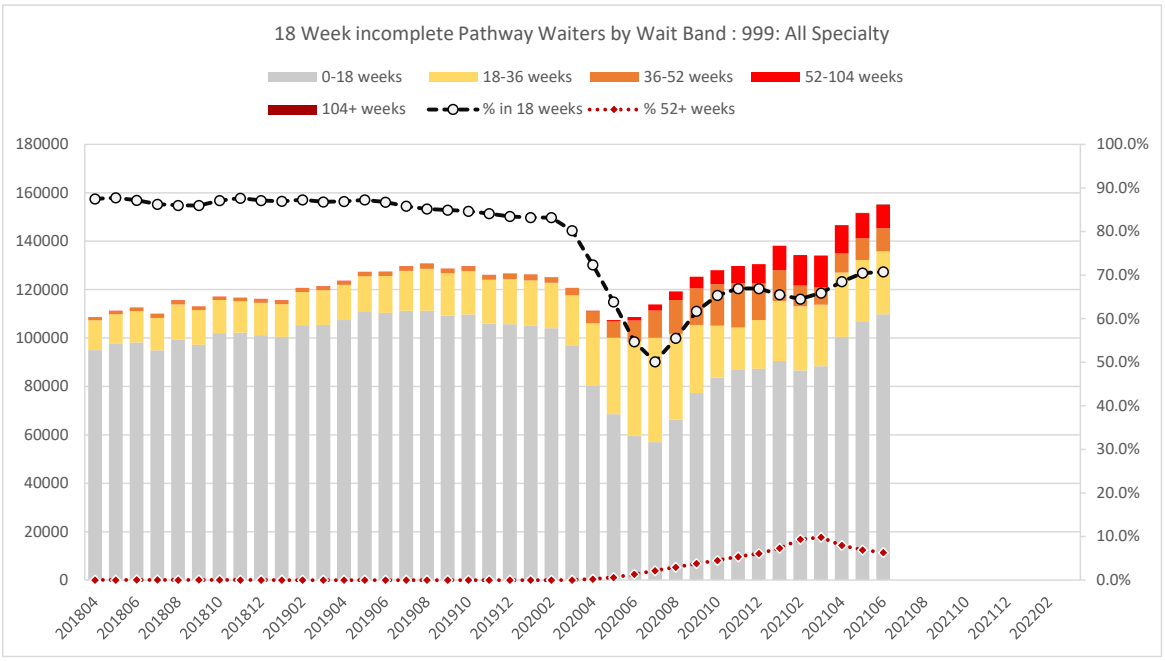
6.3. <u>18 Weeks Referral to Treatment Target / Incomplete Pathways / 52+ Week Waiters</u>

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%)

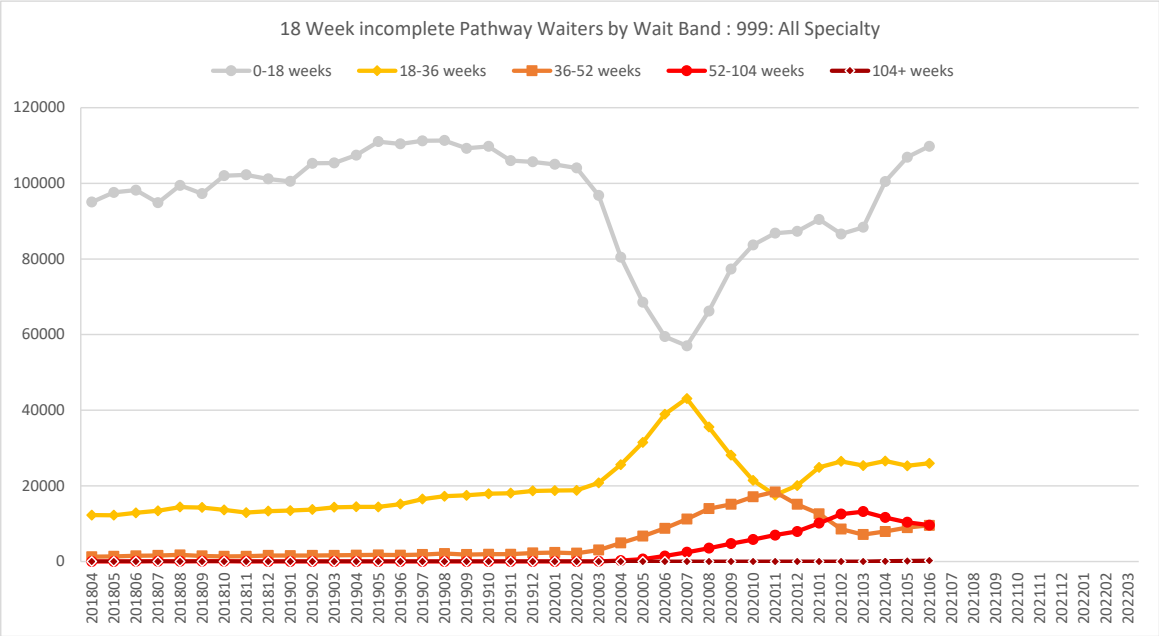
6.3.2. The chart below shows the ICS performance (aggregated for the 8 x CCGs) against these 3 measures. Prior to the COVID pandemic, the total number of patients waiting to start treatment had stabilised and was showing signs that it was starting to reduce.

6.3.3.




6.3.4. In February 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%). As of June 2021 the total number of patients waiting to start treatment has increased to 155,201, performance against the 18-week standard was 70.7%, and there were 9,854 over 52-week waiters (6.3%) of which 223 had been waiting in excess of 104 days.

6.3.5.




6.3.6. The number of over 52 week waiters has continued to slowly decrease in June 2021. However, the 36-52 week cohort is showing an increase for the fourth consecutive month. The 0-18 band has continued to grow.

6.3.7. National 18 week returns have now been extended to include data beyond just the 52+ week category in recognition of the lengthening waiting lists across the country. Within the June 2021 return, 223 patients across L&SC had been waiting in excess of 104 weeks (2 years). 60% of these 104+ week waiters are reported to be waiting at LTHT. 36% of the 104+ week waiters are under the General Surgery specialty (across multiple providers) with 14.3% waiting Plastic Surgery at LTHT.

6.3.8. Table – 104+ week waiters by provider and specialty (June 2021)

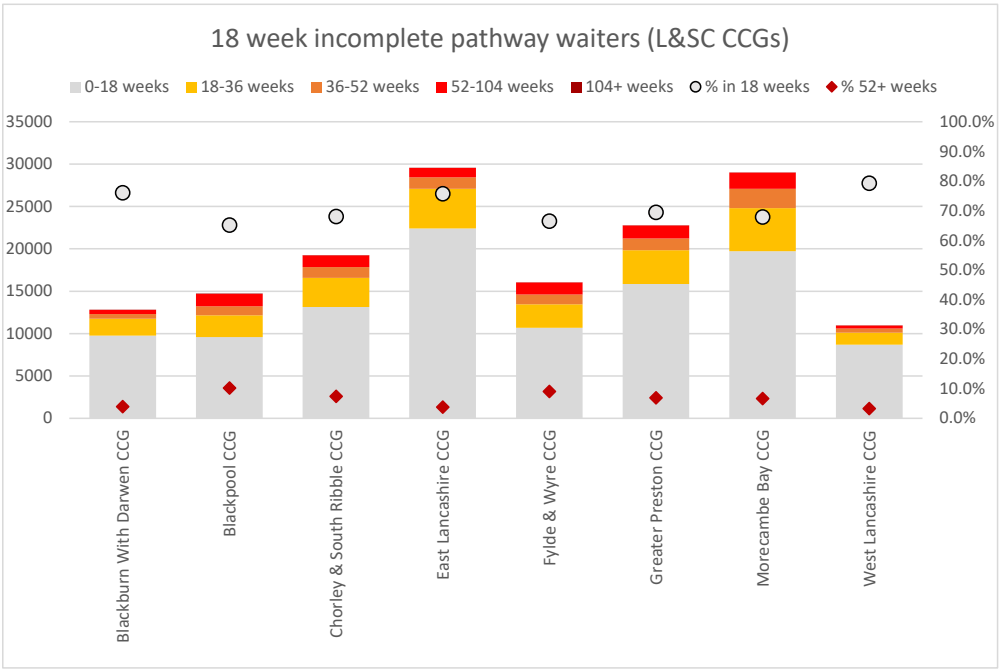
| PROVIDER | LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | SPIRE FYLDE COAST HOSPITAL | CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST | EAST LANCASHIRE HOSPITALS NHS TRUST | ALL OTHER | TOTAL | % TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| 100: GENERAL SURGERY | 41 | 25 | 5 | 2 | 5 | 1 | 1 | 80 | 35.9% |
| 101: UROLOGY | 12 | 4 | 0 | 0 | 0 | 0 | 1 | 17 | 7.6% |
| 110: TRAUMA & ORTHOPAEDICS | 8 | 9 | 0 | 9 | 0 | 0 | 2 | 28 | 12.6% |
| 120: ENT | 15 | 1 | 3 | 0 | 0 | 1 | 1 | 21 | 9.4% |
| 130: OPHTHALMOLOGY | 8 | 0 | 1 | 0 | 0 | 1 | 1 | 11 | 4.9% |
| 160: PLASTIC SURGERY | 32 | 0 | 0 | 0 | 0 | 0 | 0 | 32 | 14.3% |
| 400: NEUROLOGY | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 3.6% |
| 502: GYNAECOLOGY | 1 | 0 | 5 | 4 | 0 | 0 | 0 | 10 | 4.5% |
| X05: All other TREATMENT FUNCTIONS in the Surgical group nc | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0.4% |
| X04: All other TREATMENT FUNCTIONS in the Paediatric group | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 4 | 1.8% |
| X02: All other TREATMENT FUNCTIONS in the Medical Services | 9 | 0 | 1 | 0 | 0 | 0 | 1 | 11 | 4.9% |
| **Grand Total** | **134** | **39** | **20** | **15** | **5** | **3** | **7** | **223** | **100.0%** |
| % TOTAL | 60.1% | 17.5% | 9.0% | 6.7% | 2.2% | 1.3% | 3.1% | **100.0%** | 0.4% |

6.3.9. The following table and chat show the variation in numbers of patients waiting to start treatment and the % waiting 18 weeks and 52+ weeks at the end of June 2021. There is significant variation between CCGs which will be linked to differences in the position of their main providers and specialties. In terms of the volumes of longer waiter patients then there appears to be the greatest pressure in the Fylde Coast where over 9% of patients are waiting 52+ weeks.

6.3.10. Table - Waiting list variation between CCGs (June 2021)

| PROVIDER | 0-18 weeks | 18-36 weeks | 36-52 weeks | 52-104 weeks | 104+ weeks | TOTAL | % in 18 weeks | % 52+ weeks |
|---|---|---|---|---|---|---|---|---|
| Blackburn With Darwen CCG | 9744 | 2014 | 541 | 495 | 12 | 12806 | 76.1% | 4.0% |
| Blackpool CCG | 9588 | 2575 | 1054 | 1456 | 42 | 14715 | 65.2% | 10.2% |
| Chorley & South Ribble CCG | 13123 | 3445 | 1280 | 1396 | 31 | 19275 | 68.1% | 7.4% |
| East Lancashire CCG | 22417 | 4666 | 1370 | 1102 | 23 | 29578 | 75.8% | 3.8% |
| Fylde & Wyre CCG | 10677 | 2767 | 1167 | 1410 | 39 | 16060 | 66.5% | 9.0% |
| Greater Preston CCG | 15846 | 3983 | 1399 | 1524 | 48 | 22800 | 69.5% | 6.9% |
| Morecambe Bay CCG | 19718 | 5105 | 2281 | 1895 | 27 | 29026 | 67.9% | 6.6% |
| West Lancashire CCG | 8675 | 1426 | 486 | 353 | 1 | 10941 | 79.3% | 3.2% |
| **Grand Total** | **109788** | **25981** | **9578** | **9631** | **223** | **155201** | **70.7%** | **6.3%** |

6.3.11.




6.3.12. 72.9% of all over 52-week waiters for the CCGs are at the four main providers in the ICS, with 42.4% at LTHT (See Appendix 1). Four specialties account for 61.8% of all long waiters (as at the end of June 2021):

| Specialty | June 2021 | % Total 52+ week waiters |
|---|---|---|
| Trauma & Orthopaedics | 2,226 | 22.6% |
| General Surgery | 1,867 | 18.9% |
| ENT | 1,174 | 11.9% |
| Ophthalmology | 822 | 8.3% |
| **Top 4** | **6,089** | **61.8%** |

6.3.13. When a provider view is taken across the 4 x L&SC providers (Appendix 2) then Oral Surgery is reported to have the greatest number of 52+ week waiters (2,022) with 84.1% of these waiting at LTHT. Oral surgery is commissioned by NHS England and as such these waiters currently appear in provider totals, but not CCG figures. The current intention is for Integrated Care Boards to "be able to take on delegated responsibility for dental (primary, secondary and community)" from April 2022 and have "taken on delegated responsibility for dental (primary, secondary and community) "by April 2023. [PAR817-NHS-England-and-NHS-Improvements-direct-commissioning-functions.pdf]

6.3.14. For patients waiting over 52 and 104 weeks processes are in place at each provider across Lancashire and South Cumbria to identify any harm as a result of the long waits; to date no harms have been identified however there needs to be an acknowledgement that harms may start to emerge when patients are actually brought in for treatment. National guidance was released in June 2021 to all CCGs and NHS Trusts by NHS E/I - 'How To' guide: A clinical

harm review (CHR) process. The document provides guidance to NHS organisations on how to establish a clinical harm review process which requires senior clinical involvement and oversight; all CCG quality teams are working closely with provider colleagues to agree the implementation of this guidance. Additionally, thematic reviews have been requested in consideration of the new guidance and links to the principles of the Patient Safety Incident Response Framework (PSIRF) that is currently being piloted nationally.

6.3.15. All Trusts continue to undertake the national clinical prioritisation programme, treating patients in clinical priority order; patients are all made aware of how they can escalate any concerns or report deterioration in their condition to enable re-assessment either through an information leaflet or by being given a telephone number. Should any potential harms be reported through from Primary Care, quality colleagues would escalate to the relevant provider. All quality teams are fully aware that the current position in respect of long waits is a key line of interest and continually seek opportunities to check and triangulate information to confirm whether potential harm may be arising which is not being reported. This is done through regular communication with provider colleagues, collation of soft intelligence, complaints/PALS enquiries and at quality review meetings.

## 7. Nosocomial Infections

7.1. Introduction

7.1.1. This report provides an overview of Nosocomial infection presence within the L&SC ICS. The COVID-19 pandemic continues to present significant challenges within the community and hospital.

7.1.2. As of 19th August 2021, the positive COVID-19 tests in the community indicate a very small increase from the previous 7 days (+0.6%), however Chorley shows a 23.8% increase at 303 per 100,000 of the population and Barrow-in-Furness increasing by 29.9% to 381 per 100,000.

7.1.3. Positive tests in those aged > 60 have continued to increase since the beginning of the week rising from 612 to 658 yesterday, with an even spread of growth across the 4 ICPs.

7.1.4. Blackpool continues to have the highest rate at ICP level, at 375 per 100,000 population compared to 291 across Lancashire & South Cumbria, equivalent to a 5% increase since 16th August 2021.

7.1.5. There are currently 127 COVID-19 positive patients being managed across L&SC hospitals at close of play 18th August 2021, a 11% decrease on 7 days ago.

7.1.6. LTHT have experienced the biggest reduction having peaked at 47 patients on 15th August down to 36. The Trust has reported no nosocomial outbreaks during the month of July and August to date. In order to reduce nosocomial transmissions and outbreaks LTHT have introduced daily lateral flow testing in inpatient areas which has been successful in identifying asymptomatic carriage which is the biggest risk at this time. Given the success of this and the increase in community incidence, the decision was made on 12 July to broaden this to include all patient facing staff. Following on from the outbreak learning further steps have been introduced which has resulted in patients undergoing a PCR test in ED if they are going on to be admitted. This aims to identify early asymptomatic carriage that can lead to earlier isolation of patients. In addition to this staff in outbreak areas have now moved to wearing enhanced PPE to minimise the risk associated with the more transmissible Delta variant.

7.1.7. ELHT currently have 25 COVID-19 patients. No nosocomial outbreaks have been reported for the Trust this month. UHMB currently have 38 COVID-19 patients. BTHT currently have 26 COVID-19 patients.

7.2. Workforce

7.2.1. The number of staff isolating due to being identified as a contact of COVID-19 is significant and increasing as community incidence increases. This is impacting on all care settings across the system.

7.2.2. The Government on 19th July 2021 published guidance in relation to the self- isolation approach for frontline staff, with NHSE releasing subsequent letter on 'Updated PHE guidance on NHS staff and student self-isolation and return to work following COVID-19 contact' on 12th August 2021.

7.3. Acute Trusts

All trusts are reviewing the national guidance with consideration of how this will be operationalised at a local level including SOP and risk assessment to evidence decision of outcome to ensure both staff and patient safety is not compromised. Decisions must be made at senior level.

7.4. Primary Care

7.4.1. A draft risk assessment 'COVID-19: Exemption from contact isolation for fully vaccinated health and social care staff in exceptional circumstances' for practices has been developed by the ICS. This has been shared with the ICP's and is currently under review. The aim is to ensure that this will provide the necessary assurance that the practice has carried out a full assessment and explored all options.

7.4.2. Regulated Care continues to report both outbreak (2 or more COVID-19 positive cases) and incidents (less than 2 suspected cases awaiting results) across the sector. Multi-agency support to care homes continues with specialist advise and input from colleagues from health, local authority, infection, prevention and control.

7.4.3. The end of incident and outbreaks dates will now be counted as 14 days, this is a reduction from the previous 28 days. Recovery testing will commence on day 14.

7.4.4. As with the acute sector Regulated Care are experiencing staffing issues due to staff being notified as a contact. The sector is following the latest Government Guidance 'COVID-19: management of staff and exposed patients and residents in health and social care settings'. Risk assessments are being undertaken for staff in isolation in order to return to work

7.4.5. Issues previously relating to delays in receiving test result has now resolved.

7.4.6. Review of trends and themes of those homes in outbreaks has highlighted the majority of staff with a positive result were asymptomatic and fully vaccinated. Residents who were positive have been experiencing mild symptoms (headaches, aching limbs, gastroenteritis like symptoms, light headed/dizzy) which is a shift in presentation from the previous respiratory and flu like symptoms. This intelligence continues to be collated and reported back to PHE.

7.4.7. Work continues to ensure that vaccinations status for both staff and residents is in line with SAGE requirements.

7.4.8. Phase 3 planning of the COVID-19 vaccination (COVID Booster) is underway with all ICPs having to submit their plans to the ICS by 28th July. Each ICP is inviting expressions of interest from their PCNs. In addition, community pharmacy have been asked for their EOI and this is being led by and coordinated by NHSE/I. The aim is to have access to vaccination via hospital, PCN, mass vaccination sites and community pharmacy with this being ready to commence by September and will run till December.

7.4.9. Vaccine uptake amongst pregnant women is an area of focus with CCGs working with their communication team to develop key messaging to promote uptake and dispel concerns around harm.

7.5. <u>COVID-19 Nosocomial Deaths</u>

7.5.1. In response to the guidance LTHT and ELHT have developed an agreed framework for reviewing COVID-19 Nosocomial Deaths that captures all the information required in relation to a modified Structured Judgement Review that builds “Overall Care” and “End of Life Care” sections and IPC Key Lines of Enquiry.

7.5.2. The Guidance advises that the focus should be on Hospital-Onset Definite Healthcare-Associated that is those patients defined as having a positive specimen date 15 or more days after hospital admission.

7.5.3. LTHT have submitted a report from the initial reviews and findings from the HODHA cases to the Trusts Safety & Quality Committee. A number of key learning points have been identified with recommendations for improvement actions.

7.5.4. ELHT is currently undertaking their review and a report is expected in September following review by Trust Board. ELHT completed an initial IPC thematic review which they used a basis for this work which was shared with the CCG in place of a rapid review. The report set out some early findings following audits in relation to:

- Hand hygiene
- PPE
- Social distancing
- Environment

With associated actions required.

Updates have been requested from BTHT and UHMB.

**8. Individual Patient Activity and Continuing Healthcare**

8.1. The core IPA/CHC service is still experiencing increased levels of activity since exiting the COVID-19 Scheme 1 & 2 work with all Deferred Assessments having been completed supporting with the D2A pathway across some CCGs, this now has a reduced 28 day timeframe in line with update National guidance to 30th September 2021. MLCSU is required to monitor and report on breaches. This has had an impact on the service’s ability to handle incoming non discharge referrals and essential review activity and is reported to the ICS SRO/Leadership Team weekly.

8.2. The project to address the legacy Incomplete Referrals (ICR) is almost completed, following completion of the COVID 19 Deferred Assessments with a small number (4) remaining cases which are complex in nature and are being jointly managed with LA colleagues. These cases are now progressing to an independent review stage. Since week commencing 19th July 2021 the weekly Assurance Reports submitted and calls held with NHSE/I CHC Regional Team colleagues have been stood down to fortnightly submissions and update calls and still

involve the ICS IPA Programme's senior responsible officer and commissioning lead to give assurance on the delivery of the project.

8.3. A trajectory of new assessment cases to be completed within 28 days for the Quality Premium up to year end was submitted to NHSE/I for the LSC CCGs and monthly assurance meetings with NHSE are being planned.

## 9. Safeguarding

9.1. Items to be escalated to SCC:

Safeguarding Professionals continue to work with colleagues and wider partners to support sourcing and or commissioning placements for individuals requiring complex care and or in view of package breakdown. Minimising adverse impact to individuals is central to the strategy meetings. Safeguarding is aware of the significant activity, escalation processes and responses being planned locally, at ICS and region. This note is to inform SCC of the increasing level of resource input and commitment from Safeguarding teams.

9.2. Emerging items to be aware of that may require future escalation or may become a significant risk:

9.2.1. There is a gap in service provision for undertaking Looked After Children Initial Health Assessments for 16 - 17 year olds since 1 August 2021 for Central Lancashire. The CCG is working with the Trust to reach a solution. No other ICP area is impacted.

9.2.2. Due to changes within the commissioning of the CSU there is a demand being put on to CCG Safeguarding Designate Professionals to manage Court of Protection application process for complex individuals not in receipt of CHC who require a CoP application to be made. This impact is currently being reported on and will be escalated as appropriate dependant on findings.

9.3. Current area of focus:

9.3.1. Domestic Abuse

The health response to the Domestic Abuse Act is being formulated through a series of focussed discussions with PH, Providers and Commissioners. The aim is for Health collectively to be able to describe how we will contribute to the DA Partnership and support to break the cycle of Domestic Abuse. Representatives from the National Violence Reduction team and Domestic Abuse DHSC joined the first session. We aim to have a draft proposal for discussion at SCC in October.

Health continues to be a key contributing partner into the Violence Reduction Unit, main areas of focus are the expansion of Emergency Department Navigators and the development of a vision and pledge to move to Trauma Informed Care Model for L&SC. A number of joint bids have been submitted with confirmation of success from Home Office to support Trauma Informed Training. Data, analytical and academic evaluation continues as this is a key contributor in our ability to access additional funding.

9.3.2. Key Performance Indicators (KPI) Development

We have in draft a number of potential ICS level KPIs to facilitate assurance and continued improvement. Two of these will be further developed over the next month. It is recognised in developing these that they need to be of measurable value and demonstrate how effectively we are achieving key outcomes.

9.4. Successes:

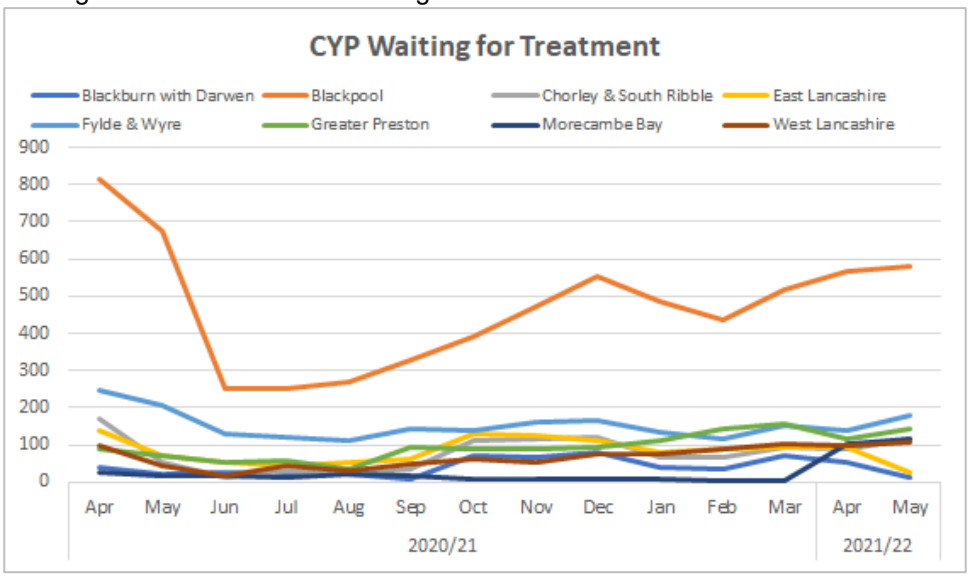
9.4.1. The ICS SG system held its first System Learning Event utilising an appreciative enquiry approach to learning. The session acknowledged complexity and its multiple interfacing factors, the need for mind-set change that we can't 'learn and blame', traps to avoid i.e. language bias and counterfactuals. A self-neglect case study was shared and mapped against best evidence practice, the aim to note any short comings. The session illustrated what good looks like and noted positive multiple agency connectivity and commitment to respond to the needs of the individual and family.

9.4.2. The L&SC ICS have been successful in being awarded £200,000 funding via the Targeted Funding Projects; this was a joint submission with Population Health aimed at supporting the uptake of preventative Population Health Programmes underpinned by Trauma Informed Practice in deprived areas. This is key for the Morecambe Bay footprint as it extends the Population Health Programme and expansion of the Trauma Informed Practice into South Cumbria. Planning meetings are being convened with key partners within the system to firm up the proposal.

## 10. Children and Adolescent Mental Health Services (CAMHS)

10.1. Waiting Lists

Waiting Times - No. of CYPs waiting for treatment




10.1.1. May 2021 Position

- Overall, there has been a 3% increase in the number of CYPs waiting for treatment at Providers BTH, ELCAS and LSCFT, from 1,151 (April'21) to 1,183 (May'21). We are now receiving further data from ADHD North West and Barnardo's (My Time), therefore, increasing the total number of CYPs waiting for treatment to 1,284 (May'21). ADHD have no CYPs waiting for treatment.

- **BTHT** have seen an increase in the number of CYPs waiting for treatment compared to the previous month, from 682 (Apr'21) to 712 (May'21). The increase in caseloads can be attributed to the complexity of cases across CAMHS, CASHER and Youtherapy, causing young people to stay on caseloads longer, and a good DNA rate resulting in more attendances and fewer discharges due to non-attendance.

- **ELHT** have not submitted data for May'21, therefore cannot provide an accurate comparison on the previous month.

- **LSCFT** have seen an increase in the number of CYPs waiting for treatment compared to the previous month, from 360 (Apr'21) to 471 (May'21).

10.1.2. Quality - The COVID-19 pandemic and associated social restrictions were expected to impact particularly on young people's mental health and emotional wellbeing. We are seeing above-typical referrals into CAMHS and this is impacting on increasing numbers of young people on waiting lists for the service. There have been no harms reported, however, there is an increase in complex cases and children going into crisis. A dedicated complex children's case manager is working within the Team to support looked after children working closely with Local Authorities. There has also been an increase in CYP with SEND, especially ASD. Mental Health in Schools Teams have been in schools, picking up a lot of the early intervention cases, school summer holidays will impact on this intervention.

Families who have CYP with SEND have found it difficult since COVID, service provision has been increased for Action ASD and ADHD NW to respond to this demand. Commissioners are working with parent carer forums and they all state that families are struggling. Support is being provided to families around anxiety, self-harm and depression. There is also the L&SC Healthy Young Minds website that provides information for families. The Local Authorities also have local offers that families can access help from.

There has not been any increase in the number of complaints received by the service. The main theme from complaints, continues to be around appointments and these have been resolved.

10.1.3. Action – a CYP transformation programme is in development to support the delivery of sustainable services across the system.

10.2. Access

% of CYP accessing treatment by NHS funded community services (at least two contacts) - Latest Prevalence Position May '20 – Apr '21

| | May'20 -Apr'21 National Data (All Providers) | | |
|---|---|---|---|
| | 12 Month National Rolling Position | Prevalence | % Achieved |
| Blackburn with Darwen CCG | 1,725 | 3,871 | 45% |
| Blackpool CCG | 1,735 | 2,952 | 59% |
| Chorley & South Ribble CCG | 1,580 | 3,227 | 49% |
| East Lancashire CCG | 3,360 | 8,115 | 41% |
| Fylde & Wyre CCG | 1,800 | 2,702 | 67% |
| Greater Preston CCG | 1,605 | 3,975 | 40% |
| Morecambe Bay CCG/Bay | 2,915 | 6,084 | 48% |
| West Lancashire CCG/WCP | 1,190 | 2,040 | 58% |
| Lancashire & South Cumbria Total | 15,910 | 32,966 | 48% |

| | | | |
|---|---|---|---|
| Central Lancashire | 3,185 | 7,202 | 44% |
| Fylde Coast | 3,535 | 5,654 | 63% |
| Pennine Lancashire | 5,085 | 11,986 | 42% |

The 12-month rolling position (May 2020 – April 2021) demonstrates L&SC is achieving a 48% target overall which continues to exceed the National target set for 2020/21 of 35% by 13%, suggestion has been made that we will move away from a percentage target to whole numbers, however, we await planning publication in the autumn.

10.3. Eating Disorders

CYP Eating Disorders Month 2 position

| CCG | Number of New Referrals | Number of New Referrals - Female | Number of New Referrals - Male | Number of Routine Referrals Received | Number of Urgent Referrals Received |
|---|---|---|---|---|---|
| Blackburn with Darwen | 4 | 3 | 1 | 4 | 0 |
| Blackpool | 8 | 7 | 1 | 6 | 2 |
| Chorley & South Ribble | 10 | 9 | 1 | 9 | 1 |
| East Lancashire | 14 | 12 | 2 | 14 | 0 |
| Fylde & Wyre | 7 | 7 | 0 | 5 | 2 |
| Greater Preston | 14 | 11 | 3 | 14 | 0 |
| Morecambe Bay | 9 | 7 | 2 | 4 | 5 |
| West Lancashire | 3 | 3 | 0 | 3 | 0 |
| **Total** | **69** | **59** | **10** | **59** | **10** |

10.3.1. Local monthly data published by LSCFT is showing for the L&SC area a total of 69 new referrals from patients aged under 19 for the ED service, of which, 10 were an urgent requirement and 59 were a routine requirement. The target of 95% of patients to start treatment within 1 week for urgent cases was not met overall for the L&SC area, however, 100% was achieved for patients within Blackpool, Chorley & South Ribble, Greater Preston and West Lancashire CCGs. Blackburn with Darwen (50%), East Lancashire (64%), Fylde & Wyre (0%) and Morecambe Bay (50%), due primarily to team capacity.

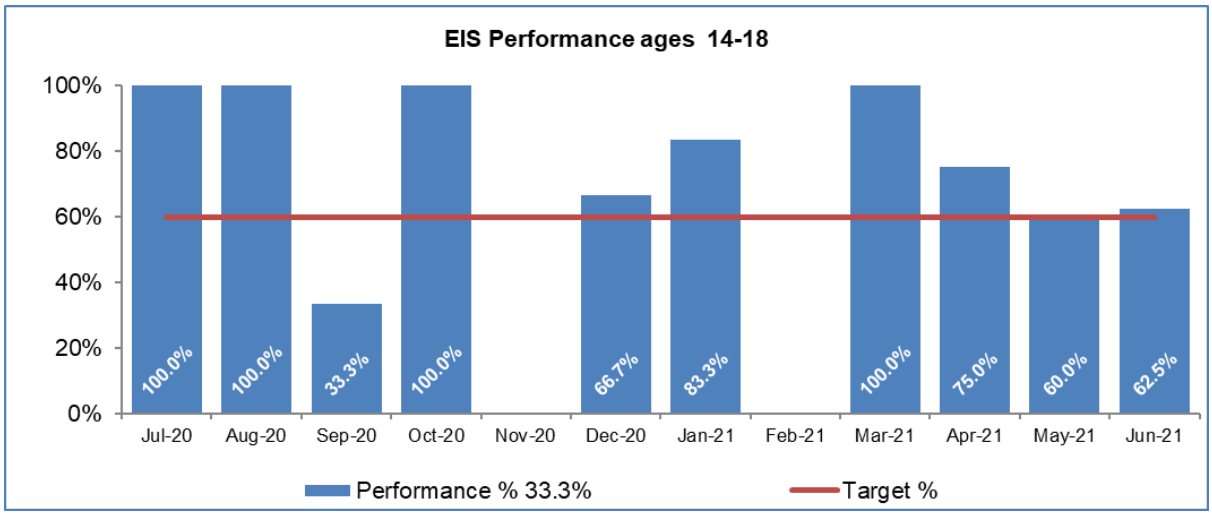
10.3.2. 5x routine case patients started treatment in May ’21 of which only the East Lancashire patient was seen within 4 weeks. The increased demand is having a direct impact on the team’s ability to see routine cases.

10.3.3. Quality – Demand and number of referrals have increased, with post lockdown demand higher than in similar periods in the previous years. A number of complaints have been received relating to Eating Disorders and where there are patient concerns that meet StEIS criteria, these have been reported on StEIS for full Root Cause Analysis. Delays in routine service users being seen has impacted on the number of service users presenting as urgent or requiring specialist services. There is a national shortage of specialist beds which has led to a greater number of admissions to Lancashire Teaching Hospitals for support whilst beds become available. LSCFT have commenced recruitment to additional posts and locum posts to increase capacity.

10.3.4. Action - LSCFT are currently developing a plan to support delivery of the CYP ED demand. A capacity and demand review is underway, including Adult ED and investment has been allocated in the recent planning process to support the required developments. Issues have been added to the Pennine Lancashire CCGs risk register as host commissioner for the service to allow clear oversight.

10.4. Early Intervention to Psychosis (CYP)

% of people who started treatment within 2 weeks of referral

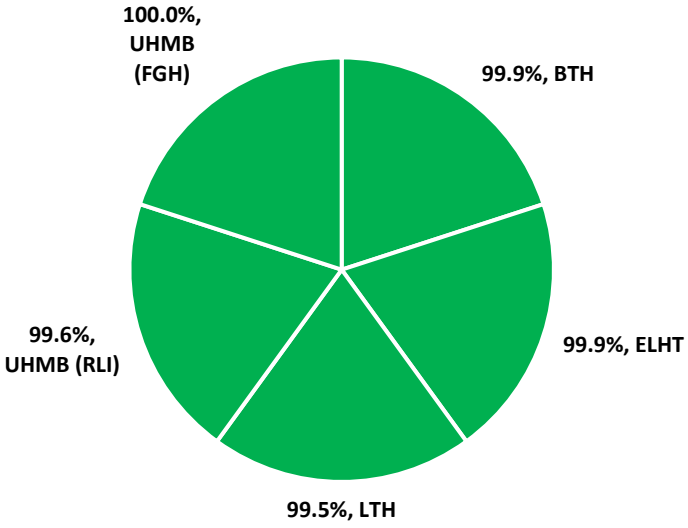



10.4.1. Performance – The teams achieved 75% in April 2021 which is 15% above the National target of 60%. 100% was not achieved this month due to one complex patient.

## 11. Adult Mental Health

11.1. Urgent Care

Mental Health A&E 4-hour Compliance in Q1

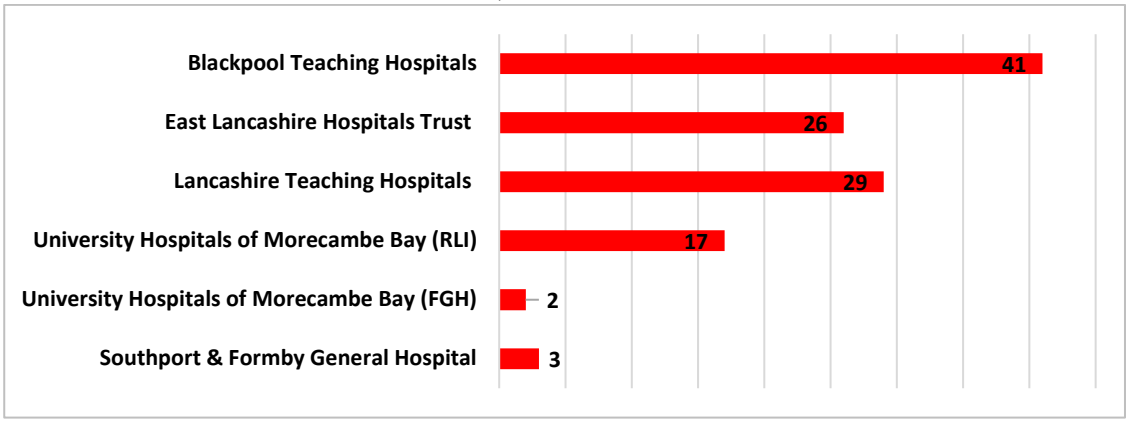



*National Target – 95%*
*Local Target – 95%*

11.1.1. Performance - All Trusts have met the 4-hour compliance target in Q1. With significantly high levels of demand for MHLT in A&E and on the wards the maintenance of performance is encouraging regarding sustainability.

11.1.2. Quality – The teams in A&E continue to monitor patient experience through the Friends and Family Test. There have been no new themes or trends reported. The 'Together Week' has assisted with decongesting hospitals and the associated Emergency Department crowding risk. In Pennine Lancashire the John Hewitt Suite is being utilised to provide a low stimulus therapeutic environment for low risk service users.

Mental Health A&E 12-hour breaches in Q1




*National Target – 0*
*Local Target – 0*

11.1.3. Performance - The total number of 12-hour breaches in Q4 were 118 which is a considerable increase from 39 in Q4. The total number of patients seen by MHLTs increased in Q1 by 49% compared to Q4. The urgent care pathway and demand in A&Es was high in Q1 and A&E performance dropped. Bed availability was the key reason for the breaches in A&E 12-hour performance.

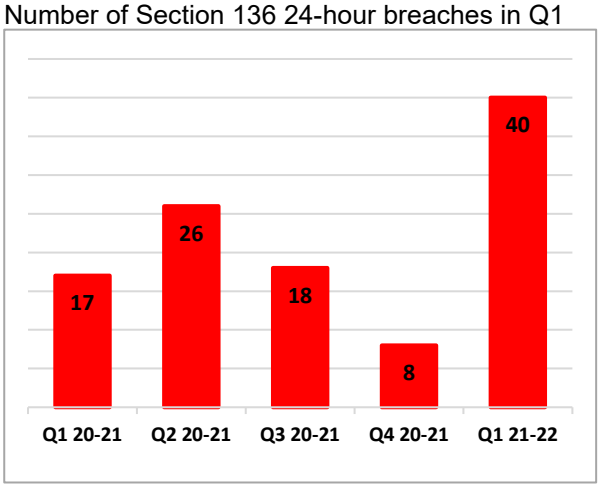
11.1.4. Quality – The teams have seen an increase in activity and acuity which has been partly attributed to the easing of lockdown restrictions. Monitoring of long waits and patient experience in A&E continues. The themes from the analysis of the breeches within the ED demonstrate that the main issues relate to the availability of mental health beds across the system. Risk assessments are undertaken for patients to determine whether a move to an acute bed would be better than staying in ED. In Pennine Lancashire the John Hewitt Suite is being utilised for lower-level risk patients to provide a therapeutic environment. There have been 0x 12 hour breaches reported for patients who have been transferred to this suite and in a large number of cases patients are able to be discharged home with community support rather than require admission. A number of patients have been placed out of area due to capacity constraints within L&SC. No harm has been reported as a result of any of these breaches.

11.1.5. To support service users with Learning Disabilities and Autism, there has been closer liaison with Mental Health Teams to improve the use of the Transforming Care Dynamic Support database to ensure those with a diagnosis of autism at risk of admission to a mental health bed are identified and interventions such as Community Care and Treatment Reviews are used to avoid admission.

11.1.6. Action – A review of the crisis and liaison services across the system is underway to ensure that provision offers full coverage and the right services. A recent review by NICHE identified a significant gap in the required in patient capacity and a plan is in place to deliver expansion in capacity over the next two years within LSCFT. Work continues within LSCFT looking at admissions, discharges and flow using right to reside principles, implementation of the safer bundle including red to green principles and participation in the perfect week.

## 11.2. Mental Health Detentions

Number of Section 136 24-hour breaches in Q1

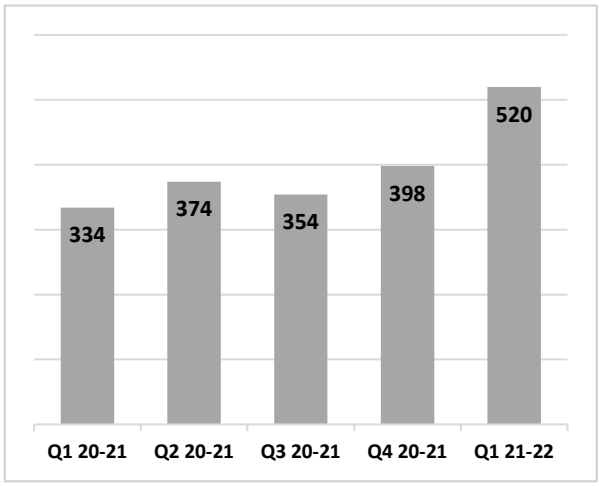



11.2.1. Performance - There were 40x 136 breaches in Q4, this is a significant increase from Q4 and the highest total figure since last year.

11.2.2. Quality – The Police have been working on training staff about appropriate lengths for S136 detentions. This is looking like it has a positive effect due to the reduction in S136 breaches.

*National Target – 0*
*Local Target – 0*

Number of Section 136 Detentions in Q1

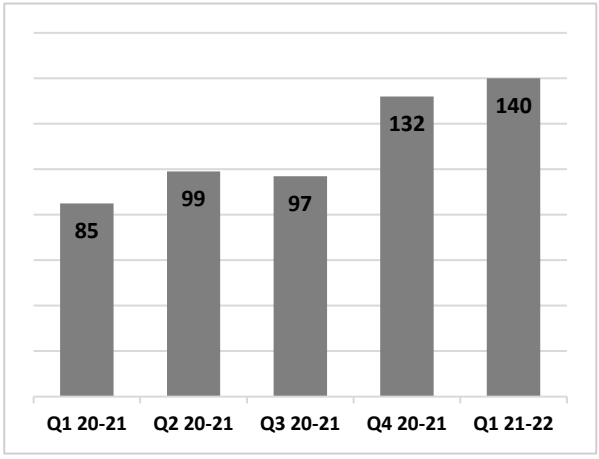



*National Target – N/A*
*Local Target – N/A*

11.2.3. Performance - There were 520 section 136 detentions in Q1 which is an increase from Q4. Work is continuing to take place with the Police regarding appropriate section 136 detentions.

11.2.4. Quality - 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 Q1

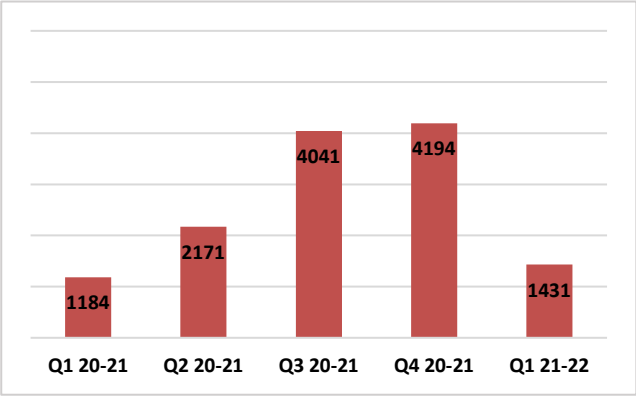



11.2.5. Performance - The number of detentions under the mental health act in Q1 was 140. This is a slight increase in comparison to Q4.

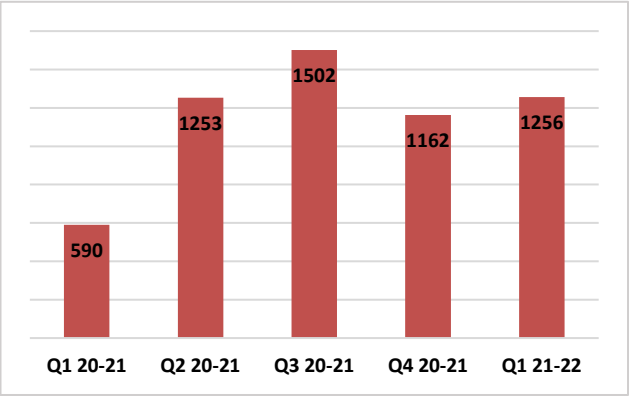
*National Target – N/A*
*Local Target – N/A*

11.3. Out of Area Placements

Number of AMH Acute Inappropriate OAP OBDs




Number of AMH PICU Inappropriate OAP OBDs




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

11.3.1. Performance - LSCFT have remained reliant on independent sector beds (reported as 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, along with 26 Learning Disability beds and range of Rehabilitation (High Dependency, Long-Term Complex Care, Moving On) beds. Furthermore, 37 acute functional and PICU beds across adult and older adult wards have been closed to enable Covid-secure Wards and enable ward refurbishment. The current bed deficit is commensurate with the number of Inappropriate Out of Area Placements in the latter half of 2020/21.

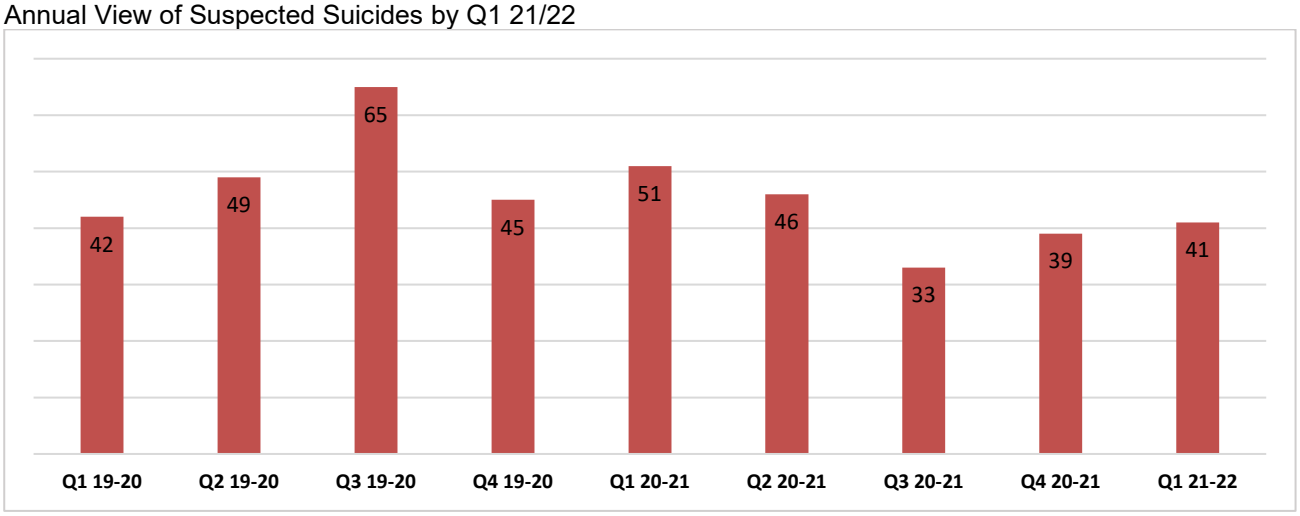
11.3.2. There is a plan in place to develop the required bed capacity. In the meantime, LSCFT have contracted an additional 67 beds from independent sector providers, which meet the NHSE Principle of Continuity. While outside of the borders of Lancashire, these hospitals are as accessible as L&SC bedstock and provide continuity of care and governance. The Principle of Continuity means that these beds have not be reported as inappropriate OAPs from April 2021 onwards, and are considered as part of the planned L&SC bedstock.

11.3.3. Quality - Acuity of patients was again noted in Q1 through regular flow calls each day.

11.3.4. Action – Work is ongoing to review of the crisis and liaison services across the system to ensure that provision offers full coverage and the right services. Building on the review by NICHE, which identified a significant gap in the required inpatient capacity, a plan is in place to deliver expansion in capacity over the next two years within LSCFT. Work continues within LSCFT looking at admissions, discharges and flow, with implementation and expansion underway of using right to reside principles, and the safer bundle (including red to green principles.

## 11.4. Suicide Prevention

Annual View of Suspected Suicides by Q1 21/22



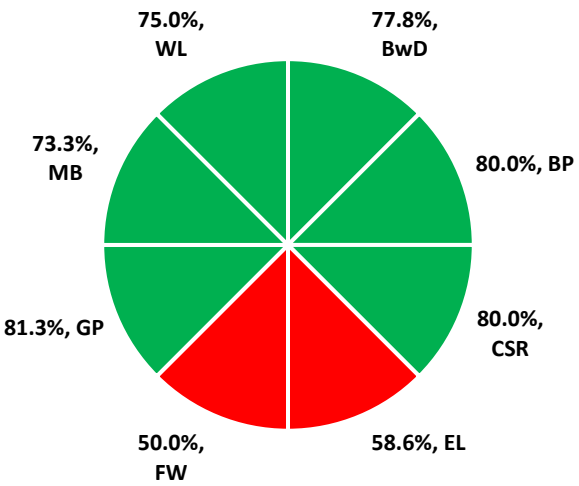

*National Target – 10% reduction on previous year*
*Local Target – TBD*

11.4.1. Performance - There was a slight increase of suspected suicides in Q1.

11.4.2. Quality – Work continues to take place with families of those who have taken their own life. Cluster analysis is taking place to identify any hot spot areas and engage with local services where appropriate.

## 11.5. Early Intervention to Psychosis

% with a first episode of psychosis who start treatment in early intervention in psychosis services within two weeks of referral Q1 - All ages

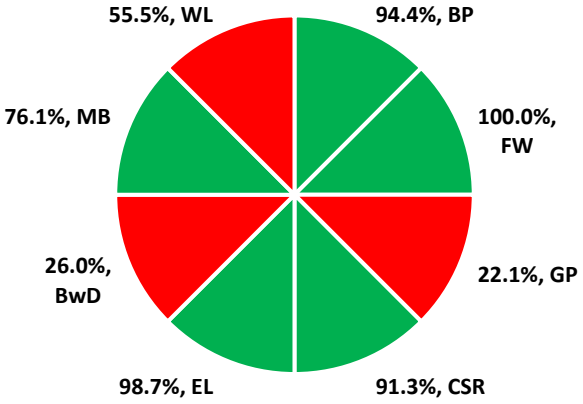



11.5.1. Performance - The EIP target was met by all but 2 CCG areas in Q1. The IPS team is fully integrated with the EIP team and is exceeding employment targets, Further funding is in place for the IPS teams.

11.5.2. Quality – The team has a robust complaints process with no issues to report in Q4. The teams are liaising with patients and families to improve areas of the service where appropriate. No harm has been reported as a result of delays and there have been 0x serious incidents reported for EIP.

11.6. Older Adult (MAS)

Memory Assessment Services Seen within 6-weeks Q1




*National Target – N/A*
*Local Target – 70%*

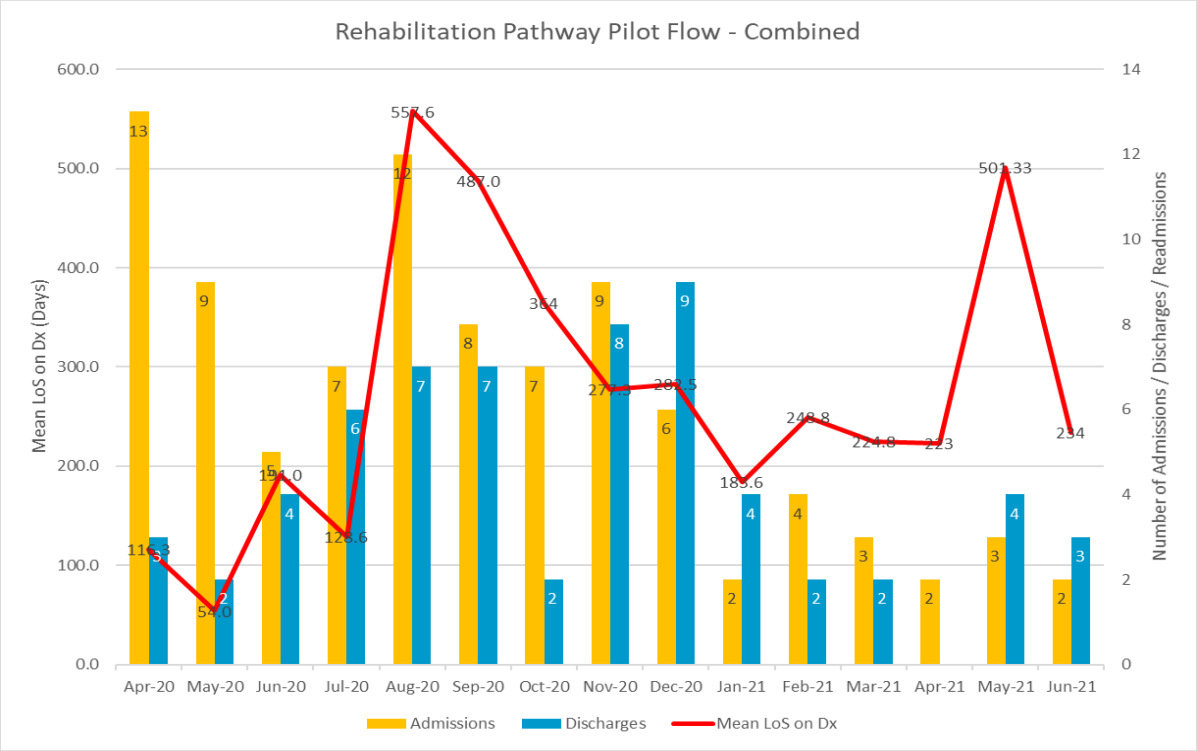
11.6.1. Performance - Service remains impacted by acute trust suspension of diagnostic testing. Recovery trajectories developed but Network looking to develop detail to a greater degree. Further social restrictions have impacted in Q1. 72.1% of people were seen within the 6-week time frame across Lancashire in Q1 overall which is a decrease from 77.3% in Q4. The service achieved target in month 1, 2 and 3. 633 people were on the MAS waiting list as of 30th June 2021 across Lancashire The average wait across Lancashire was 4.7 weeks in June 2021.

11.6.2. Quality – The position for service users being seen within 6 week's has been impacted in Greater Preston and Chorley South Ribble by staffing pressures whereby the Team was down by 2x Band 6, with 1x on Secondment (staff member returned in June 2021) and 1x staff member was required to cover titration clinics, due to annual leave. The longest wait has remained static at 16 weeks. Initial assessments are now prioritised as clinic appointments, with Attend Anywhere utilised as a second option due to increased DNA. There is clinic availability in satellite clinics at Fulwood, Euxton, Penwortham and Longridge Hospital. In addition, the service is now seeing patients back in Charnley Fold as medic face-to-face OPA to assist with the diagnostic waiting times. The service is also re-starting its One Stop Clinics on Friday mornings from 2nd July 2021. A high number of referrals across the service were returned to GPs as incomplete or inappropriate (21.67% - April 2021), which impacts negatively on patient pathways. At point of triage the rejection data is now being captured to allow focussed discussions with referrers; once this has been collated for themes this will be fed back to commissioners. There has been no harm reported as a result of delays and 0x incidents reported on StEIS. There has also been a slight increase in Attend Anywhere DNA's from care homes resulting in assessments having to be re-arranged.

11.6.3. Action - A Recovery plan is in place which includes the return of the WTE band 6. All appointments are being offered face-to-face and only by digital platform at request to reduce DNA numbers. More face-to-face assessments are now being offered due to Charnley Fold being open to Service Users, however clinical space is limited due to social distancing rules. Historic home visit appointments are subject to review and subsequent home visits will be undertaken in accordance with the home visiting policy. A licence for the Text message reminder has now been obtained and operationalised from 7th July 2021, which will reduce DNAs. Clinical assessment capacity and utilisation is being monitored closely and a recovery trajectory initiated 7th July 2021. Capacity and demand deep dive was undertaken at the beginning of August 2021. One-stop Clinic commenced 9th July 2021 which will improve wait times.

## 11.7. Rehab

Rehabilitation Pathway Pilot Flow – Combined

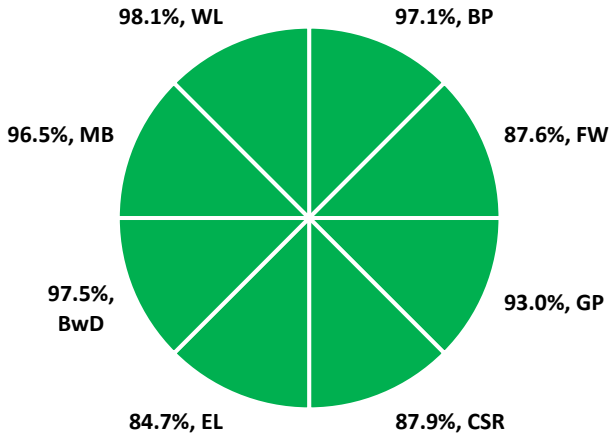



11.7.1. Performance – Admissions and discharges have remained lower across Q1 2021/22, as compared to the first six months of the pilot. High numbers of admissions and discharges were seen in the first half of 2020/21 as the new independent sector beds came into use (see April/May 2020) and the Skylark Unit opened (see July/August 2020). As regular patient reviews commenced, the newly established LSCFT Rehab Flow Team was also able to discharge a number of long length of stay cases between August and October 2020, which can be seen in the spike in the mean length of stay on discharge on the chart (left), also temporarily supporting flow through the rehab beds. It is therefore understood that the reduction in Q4 2020/21 and Q1 2021/22 is likely to be a reflection of flow returning to expected levels. It is also possible that the Winter 2020/21 Discharge Schemes, such as additional Discharge to Assess capacity, may have also had an impact by diverting some referrals from the Rehab Pilot Pathway. The peak in Mean LoS of discharge that can be seen in May 2021, is skewed by a single patient that was discharged from Newton House with a length of stay of 1,369 days (3 years and 9 months).

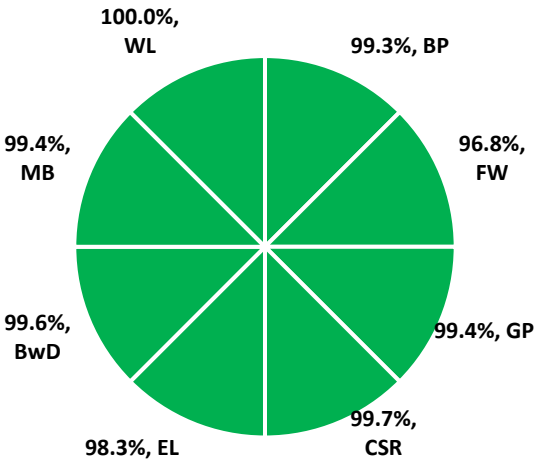
11.7.2. Quality – Routine quarterly quality monitoring is overseen by LSCFT as part of the lead contractor arrangements. A Quality Assurance summary report is shared with stakeholders on a quarterly basis.

11.8. IAPT

% of people receiving a first appointment within 6 weeks of referral Q4 (Q1 data not yet available)




% of people receiving a first appointment within 18 weeks of referral Q4 (Q1 data not yet available)



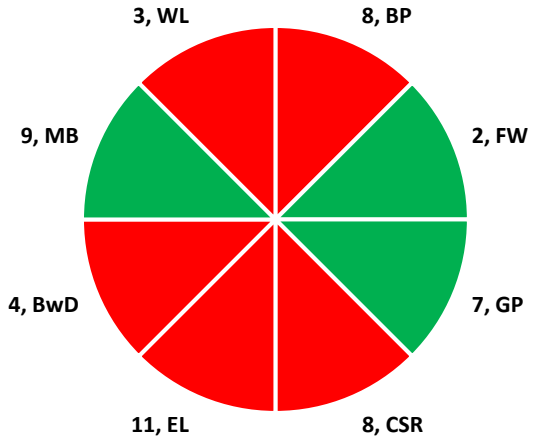

11.8.1. Performance – 6-week RTT achieved consistently at 95.2% in Q4 18-week RTT achieved consistently at 99.7% in Q4.

11.8.2. Quality – Where patients are awaiting therapies, processes are in place to manage patient safety with patients at 6 weeks sent a letter apologising for the wait with information on what to do if their mental health deteriorates. At 10 weeks a Clinician will attempt to make contact to discuss welfare. There have been no serious incidents / complaints / soft intelligence raised as a result of delays, these areas are being closely monitored for any impact.

11.8.3. Action - Prevalence levels were only met by West Lancashire CCG in April 2021, with all other CCG's under target. There continues to be a shortfall in the number of referrals required to meet target. The Trust have a communications and social media plan which includes increasing GP communication via CCG Communications Teams; social media output and targeting underrepresented groups. This aims to raise awareness of the service and allow better access for self-referral for vulnerable groups. Targeted work is also taking place for Long Term Conditions and there has been a greater number of referrals received for this cohort of patients as at M01.

## 12. Learning Disabilities and Autism Q1

Number of Patients Against Trajectory – Q1




*National Target – N/A*
*Local Target – Q1 21-22 end trajectory of 50*

12.1.1. Performance - Position at the end of Q1 is 52 against our Q1 trajectory of 50 (+2). All CCG in-patients have been reviewed as part of a deep dive by the regional team during April to understand the barriers to discharge. An aligned Health and Social Care Discharge team has been established across LSC and both a health and social care professional identified to co-ordinate the discharges into the community.

During Q1 there has been 22 CCG admissions and 0 secure admissions (14 admissions and 8 readmissions) and 13 CCG discharges and 6 secure.

12.1.2. Admissions

- 3 people transferred from secure into a CCG funded bed OOA as part of planned discharge pathway
- 2 people have been discharged from LSCFT (and readmitted)
- Of the 8 people admitted into an LSCFT bed 3 are male, 5 female
- 6 have a diagnosis of autism, 1 learning disability and 1 learning disability and autism)
- 1 person has been admitted to an OOA bed

Admissions mirror the increasing demand in the population as a whole for inpatient mental health care during the Covid pandemic and we would not expect people with a Learning Disability or, in particular, ASC to be less vulnerable to Covid-related stresses

12.1.3. Readmissions (6 people)

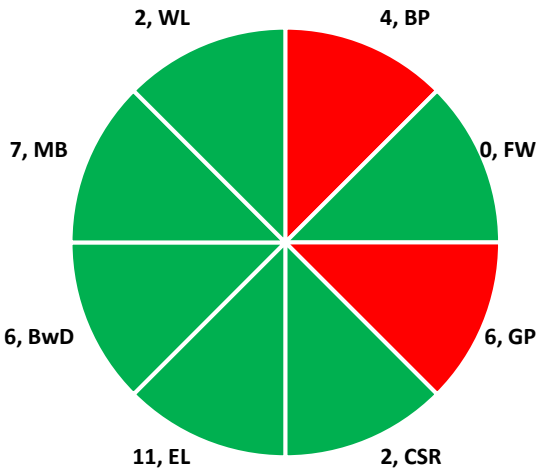
- 3 people have been discharged
- 4 admitted into an LSCFT bed (4 female)
- All 4 have a diagnosis of autism
- 1 person has been admitted to an OOA bed

12.1.4. Actions

- All patients who are readmitted are having a Root Cause Analysis (RCA) completed by 19.07.21
- Outcome and actions from RCA discussed at Inpatient Solutions Forum and monitor monthly
- Engage with ICS Mental Health/Learning Disability and Autism Director of Nursing to consider impact review of the readmissions and consider patient/carer views

## 12.2. Secure Inpatient

Number of Patients Against Trajectory – Q1
Position at the end of Q1 was 38 which exceeded the trajectory.




*National Target – N/A*
*Local Target – Q1 < 42*

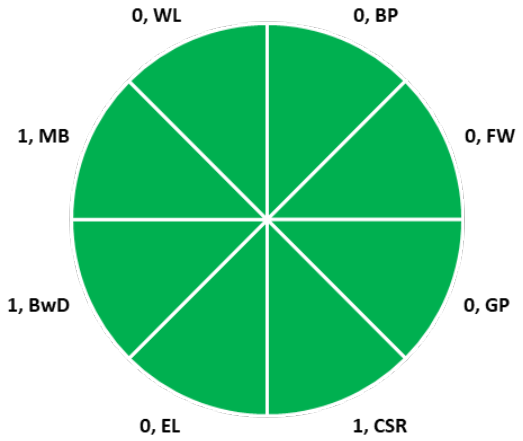
### 12.2.1. Performance

Position at the end of Q1 is 38 against our Q1 trajectory of 42 (-4). All secure in-patients are being reviewed as part of a deep dive by the regional team during June to understand the barriers to discharge. An aligned Health and Social Care Discharge team has been established across LSC and both a health and social care professional identified to co-ordinate the discharges into the community

12.2.2. During Q1 there hasn't been any admissions, but 6 discharges have taken place: 3 people have stepped down into a CCG bed and 3 people discharged into the community.

## 12.3. Children and Young People Tier 4 Beds

Number of Patients Against Trajectory – Q1




*National Target – N/A*
*Local Target – Q1 < 6*

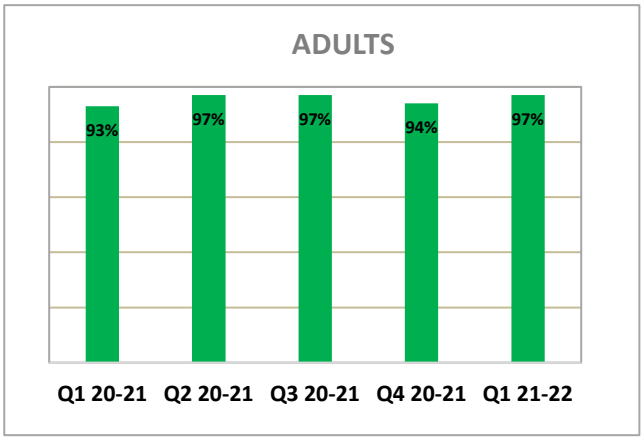
### 12.3.1. Performance

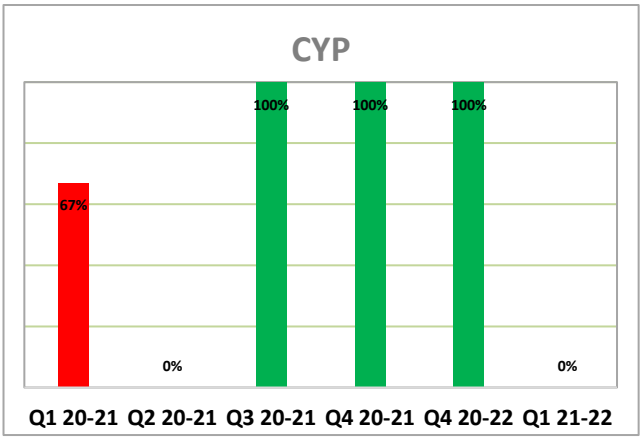
Position at the end of Q1 is 2 children and young people are in a hospital bed against our trajectory at the end of Q1 as 6 (-4). During Q1 there has been 1 admission and 2 discharges.

12.4. Care (Education) and Treatment Reviews

Performance

Trajectory is 75%. 100% compliance for both adults and CYP both for pre-admission and post admission reviews; 92% and 97% for non-secure and secure repeat reviews during Q4.




## Regional Position - Care (Education) Treatment Reviews

April 21

| CTR Metric | NORTH % compl | NORTH WEST % compl | C&M % compl | GM % compl | Lancs & SC % compl | NORTH EAST % compl | NCNE % compl | Humber % compl | NYorks % compl | SYorks % compl | WYorks % compl | Expected performance by March 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Under 18's: Pre or post admission CTRs (with pre admission CTR within 28 days or post admission CTR (if no pre-) within 14 days of admission)** | | | | | | | | | | | | |
| Latest position (admissions Jan 21 - Mar 21) | 71% | 64% | 71% | 50% | NA | 77% | 86% | 100% | 100% | 50% | 0% | 90% |
| | 17 of 24 | 7 of 11 | 5 of 7 | 2 of 4 | 0 of 0 | 10 of 13 | 6 of 7 | 2 of 2 | 1 of 1 | 1 of 2 | 0 of 1 | |
| **Under 18's: Repeat CTRs (of those U18 inpatients with total LOS more than 3 months, % with most recent CTR within 3 months)** | | | | | | | | | | | | |
| Latest position (inpatients as at 30 Apr 21) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | NA | 100% | 100% | 75% |
| | 26 of 26 | 15 of 15 | 8 of 8 | 5 of 5 | 2 of 2 | 11 of 11 | 3 of 3 | 2 of 2 | 0 of 0 | 2 of 2 | 4 of 4 | |
| **Adults: Pre or post admission CTRs (pre admission CTR within 28 days or post admission CTR (if no pre-) within 28 days of admission)** | | | | | | | | | | | | |
| Latest position (admissions Jan 21 - Mar 21) | 73% | 59% | 100% | 33% | 88% | 83% | 92% | 100% | 100% | NA | 69% | 75% |
| | 38 of 52 | 13 of 22 | 2 of 2 | 4 of 12 | 7 of 8 | 25 of 30 | 11 of 12 | 2 of 2 | 3 of 3 | 0 of 0 | 9 of 13 | |
| **Adults: Repeat CTRs (non-secure) (of those adult inpatients in non-secure with LOS in current setting more than 6 months, % with most recent CTR within 6 months)** | | | | | | | | | | | | |
| Latest position (inpatients as at 30 Apr 21) | 73% | 62% | 37% | 50% | 89% | 83% | 78% | 91% | 100% | 85% | 79% | 75% |
| | 141 of 193 | 56 of 90 | 10 of 27 | 13 of 26 | 33 of 37 | 81 of 98 | 25 of 32 | 10 of 11 | 8 of 8 | 11 of 13 | 27 of 34 | |
| **Adults: Repeat CTRs (secure) (of those adult inpatients in secure settings with LOS in current setting more than 12 months, % with most recent CTR within 12 months)** | | | | | | | | | | | | |
| Latest position (inpatients as at 30 Apr 21) | 97% | 96% | 100% | 92% | 97% | 98% | 100% | 100% | 100% | 82% | 95% | 75% |
| | 223 of 230 | 91 of 95 | 24 of 24 | 35 of 38 | 32 of 33 | 132 of 135 | 75 of 75 | 17 of 17 | 13 of 13 | 9 of 11 | 18 of 19 | |

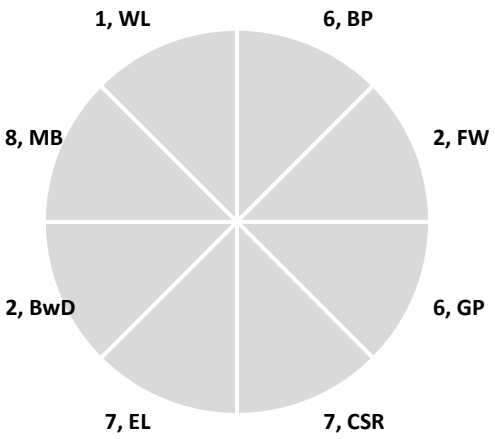
Please Note: This information is derived from the latest AT data. It is an aid to improve data quality and it should not be used for performance management as it is subject to retrospective changes.

## 2 CTRs completed outside of the timeframe

- Provider asked to postpone the CTR to allow potential community providers to carry out assessments prior to the CTR. The CTR was held 18 days outside of the timeframe.
- The CTR was delayed as unfortunately the person's mum passed away and therefore the CTR was cancelled and re-arranged 12 days outside of the timeframe.
- The CTR was booked within timeframe, however person was unwell after testing positive for Covid-19, provider advised there had been an outbreak on the ward and a number of the staff were not in work, resulting in low staffing levels, and asked for the CTR to be postponed taking it 10 days outside of the timeframe.
- Delay in confirming diagnosis (meets Transforming Care), offered provider several dates within timeframe, agreed date 9 days outside of timeframe.
- Admitted to assessment ward, date agreed within timeframe, patient transferred to a treatment ward and CTR was re-arranged, delay in agreeing date with new ward due to RC's secretary being on annual leave and no one on ward able to offer RC's availability. CTR date agreed 13 days outside of timeframe.

12.5. Quality Oversight Visits

8-week Quality Oversight Visits for all CCG Inpatients:




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

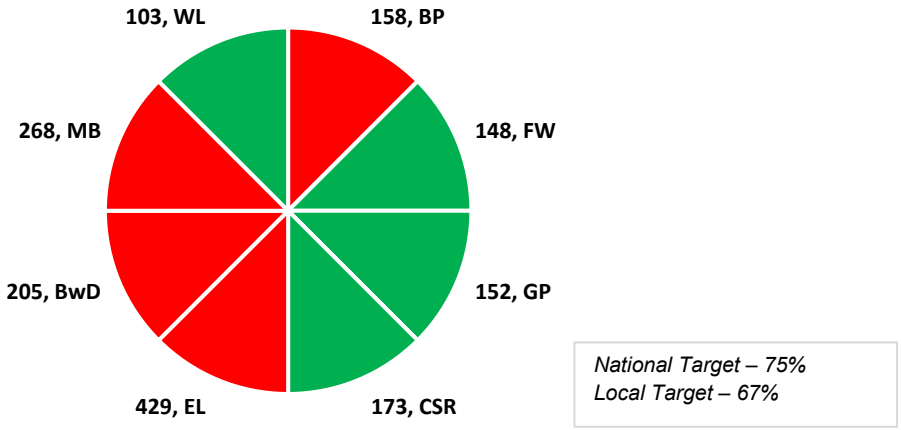
12.5.1. Performance

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.

## 12.6. Annual Health Checks

75% of people on a GP learning disability register to have had an annual health check (by 2023/24)

**Q4 Data**




- L&SC exceeded the trajectory of 67% of people with a learning disability having a health check completed. LSC achieved 68% with 50% of CCGs surpassing this trajectory.
- L&SC ambition for 2021-22 is to achieve 70%

Trajectory of 67% for 20-21. The data shown below is for 20/21

Definitions:

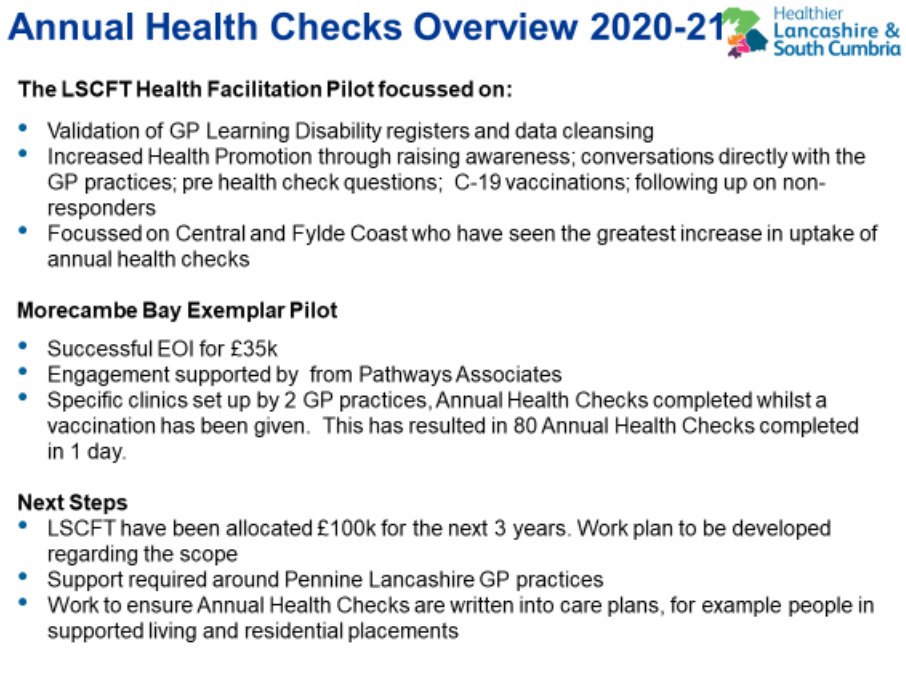
PCN002 Cumulative count of patients aged 14 and over on the learning disability register, up to and including reporting period end date.

PCN003 The number of patients aged 14 and over on the learning disability register who received a learning disability health check, up to and including reporting period end date

PCN004 Cumulative count of patients aged 14 and over on the learning disability register who have chosen not to receive a learning disability (LD) health check, up to and including reporting period end date.

| CCG | Region | PCN002: Register size (age 14+) | PCN003: Completed health check | PCN004: Health check declined | % completed health checks (14+) | % completed health checks (14+) excluding declines |
|---|---|---|---|---|---|---|
| NHS BLACKBURN WITH DARWEN CCG | NORTH WEST | 834 | 464 | 7 | 56% | 56% |
| NHS BLACKPOOL CCG | NORTH WEST | 814 | 530 | 17 | 65% | 66% |
| NHS CHORLEY AND SOUTH RIBBLE CCG | NORTH WEST | 1116 | 860 | 15 | 77% | 78% |
| NHS EAST LANCASHIRE CCG | NORTH WEST | 1863 | 1024 | 9 | 55% | 55% |
| NHS GREATER PRESTON CCG | NORTH WEST | 1135 | 754 | 55 | 66% | 70% |
| NHS MORECAMBE BAY CCG | NORTH WEST | 1748 | 1090 | 37 | 62% | 64% |
| NHS WEST LANCASHIRE CCG | NORTH WEST | 541 | 482 | 7 | 89% | 90% |
| NHS FYLDE AND WYRE CCG | NORTH WEST | 737 | 549 | 28 | 74% | 77% |
| LSC | | 8788 | 5753 | 175 | 68% | 70% |

This data shows an increase in performance against 19-20. 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**
**Director of Quality and Chief Nurse from Pennine Lancashire CCGs**

## Glossary

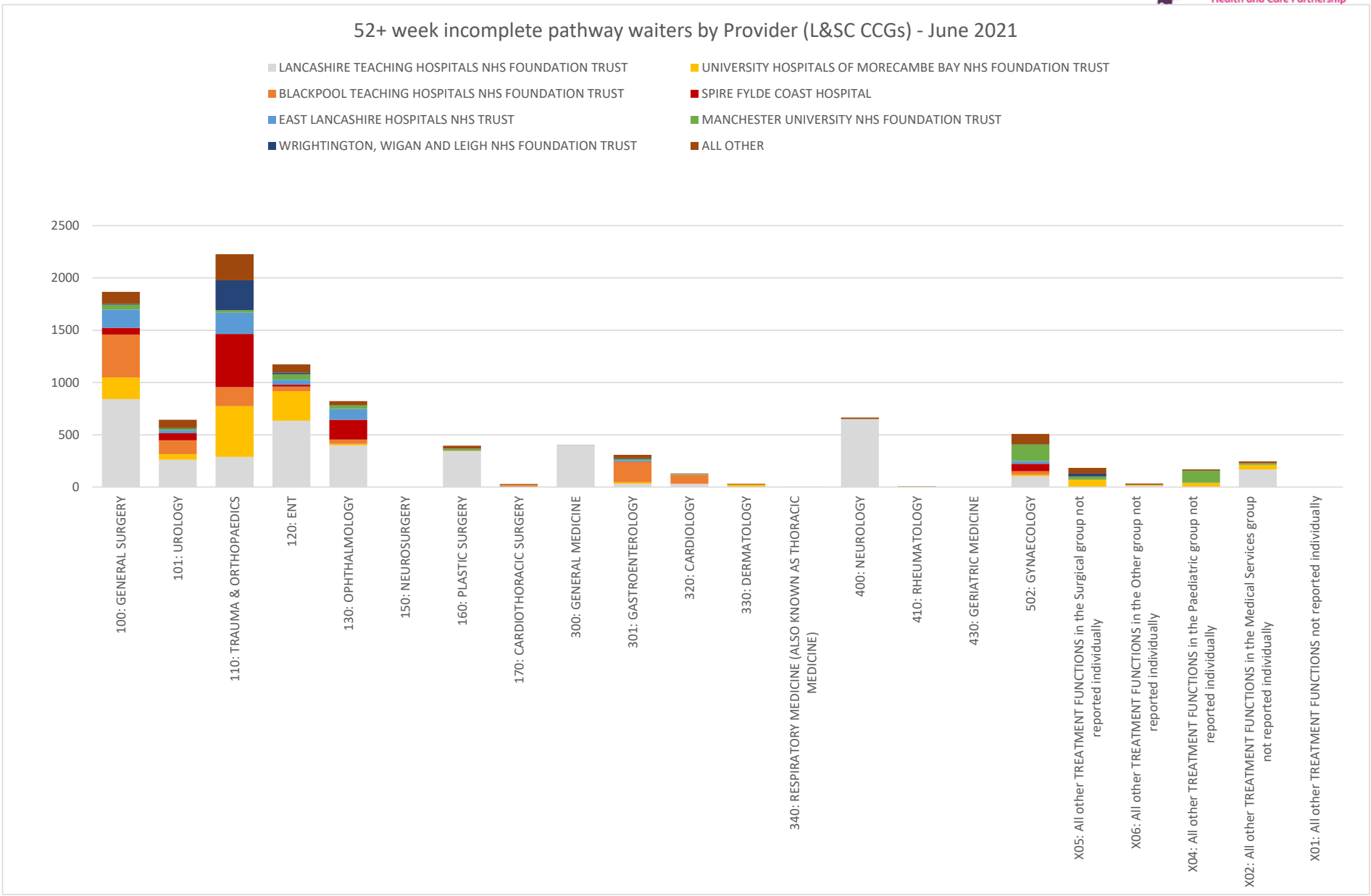
| | | | |
|---|---|---|---|
| A&E | Accident & Emergency | LCC | Lancashire County Council |
| AEDB | A&E Delivery Boards | LeDeR | Learning Disabilities Mortality Review |
| AHP | Allied Health Professional | LPS | Liberty Protection Safeguards |
| AMHP | Approved Mental Health Professional | LSABs | Local Safeguarding Adults Boards |
| ASD | Autism Spectrum Disorder | LSCFT | Lancashire South Cumbria Foundation Trust |
| B CCG | Blackpool Clinical Commissioning Group | LTC | Long Term Condition |
| BGH | Burnley General Hospital | LTHT | Lancashire Teaching Hospital Trust |
| BI | Business Intelligence | MAS | Memory Assessment Service |
| BTHT | Blackpool Teaching Hospitals Trust | MB CCG | Morecambe Bay Clinical Commissioning Group |
| BVH | Blackpool Victoria Hospital | MDT | Multidisciplinary Team |
| BwD | Blackburn with Darwen | MH | Mental Health |
| C&M | Cheshire and Mersey | MHLT | Mental Health Liaison Team |
| CASHER | Child and adolescent support and help enhanced response team | MLCSU | Midlands and Lancashire Commissioning Support Unit |
| CAMHS | Children and Adolescent Mental Health Service | MRI | Magnetic Resonance Imaging |
| CBT | Cognitive Behavioural Therapy | MRSA | Methicillin-resistant Staphylococcus aureus |
| CC | Complications and Comorbidities | MSA | Mixed Sex Accommodation |
| CCG | Clinical Commissioning Group | MSK | Musculoskeletal |
| CHC | Continuing Health Care | NEC | Not Elsewhere Classified |
| CHR | Clinical harm review | NELSD | Non-elective same day |
| CI | Consultant Initiated | NELST | Non-elective short stay |
| CoP | Court of Protection | NHSE | National Health Service England |
| CPA | Care Programme Approach | NHSI | National Health Service Improvement |
| CPN | Contract Performance Notice | NICE | National Institute for Health and Care Excellence |
| CQUIN | Commissioning for Quality and Innovation | NMC2R | did not meet the criteria to reside |
| CRG | Clinical Reference Group | NQB | National Quality Board |
| CSR | Chorley and South Ribble | NW | North West |
| CT | Computerized Tomography scan | NWAS | North West Ambulance Service |
| CTR | Care and Treatment Review | OAP | Out of Area Placement |
| CYP | Children and Young People | OPEL | Operational Pressures Escalation Levels |
| D2A | Discharge to assess | OPFA | Outpatient First Attendances |
| DA | Domestic Abuse | OPFUP | Outpatient Follow Up |
| DC | Day Case | OPPROC | Outpatients Procedures |
| DES | Direct Enhanced Services | PALS | Patient Advice and Liaison Service |
| DH&SC | Department of Health and Social Care | PCN | Primary Care Network |
| DNA | Did not attend | PCR | Polymerase chain reaction |
| DPH | Director of Public Health | PDSA | Plan Do Study Act |
| DToC | Delayed transfer of care | PHE | Public Health England |
| ECDS | Emergency Care Dataset | PICU | Psychiatric Intensive Care Unit |
| ECRG | Elective Care Recovery Group | PLCV | Procedures of Limited Clinical Value |
| ED | Emergency Department | PPE | Personal Protective Equipment |
| EDi | Eating Disorders | PSIRF | Patient Safety Incident Response Framework |
| EIP | Early Intervention Psychosis | Q&P | Quality and Performance |

| | | | |
|---|---|---|---|
| EL | East Lancashire | QI | Quality Improvement |
| ELCAS | East Lancashire Child and Adolescent Services | QIPP | Quality for Innovation, Productivity and Prevention |
| ELHT | East Lancashire Hospitals Trust | QOF | Quality Outcomes Framework |
| EMS+ | Escalation Management System Plus | RAP | Recovery Action Plan |
| EMSA | Eliminate Mixed Sex Accommodation | RAT | Rapid Assessment and Treatment |
| ENT | Ear Nose Throat | RBH | Royal Blackburn Hospital |
| ERF | Elective Recovery Fund | RCA | Root Cause Analysis |
| F&W | Fylde and Wyre | REAP | Resource Escalation Action Plan |
| FDS | Faster Diagnostic Standard – is a new policy in which patients should have cancer ruled out or diagnosed within 28 days of referral | RESTORE2 | Recognising Early Soft Signs, Take Observations, Respond, Escalate |
| FFT | Friends and Family Test | RLI | Royal Lancaster Hospital |
| FGH | Furness General Hospital | RPH | Royal Preston Hospital |
| FOI | Freedom of Information | RTT | Referral to Treatment |
| G&A | General and Acute | S136 | Section 136 |
| GIRFT | Getting It Right First Time | SAGE | Scientific Advisory Group for Emergencies |
| GP | Greater Preston | SBAR | System Background Assessment and Recommendation |
| GM | Greater Manchester | SCC | Strategic Commissioning Committee |
| HCAI - CDIFF | Health Care Associated Infections - Clostridium Difficile | SDEC | Same Day Emergency Care |
| HEE | Health Education England | SLAM | Service Level Agreement Monitoring |
| HFC | Harm Free Care | StEIS | Strategic Executive Information System |
| HLSC | Healthier Lancashire and South Cumbria | STF | Sustainability and Transformation Fund |
| HODHA | Hospital-Onset Definite Healthcare-Associated | SUDC | Sudden Unexpected Death Childhood |
| HSMR | Hospital Standardised Mortality rate | SUI | Serious Untoward Incident |
| HWBIS | Health, Wellbeing, Information and Support | SUS | Secondary Uses Service |
| IAPT | Improving Access to Psychological Therapies | TARN | Trauma Audit & Research Network |
| ICP | Integrated Care Partnership | TCI | To Come In |
| ICS | Integrated Care System | Type 1 A&E | The NHSE definition of a Type 1 A&E department is a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. The performance measure is the total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge. |
| IPA | Individual Patient Activity | UCC | Urgent Care Centre |
| IPC | Infection Prevention and Control | UEC | Urgent and Emergency Care |
| IPS | Individual Placement and Support | UHMB | University Hospitals of Morecambe Bay |
| IUCS | Integrated Urgent Care Service | US | Ultrasound |
| IV | Intravenous | VCFSE | Voluntary, Community, Faith and Social Enterprise Sector |
| KPI | Key Performance Indicator | VSA | Value Stream Analysis |
| L&SC | Lancashire and South Cumbria | WL | West Lancashire |
| LA | Local Authority | WLIs | Waiting List Initiatives |
| LAC | Looked After Children | YTD | Year to date |
| LAMP | Loop-mediated Isothermal Amplification | | |

# Appendix 1: Over 52 week waiters for L&SC CCGs split by Specialty and Provider (June 2021)

Lancashire and South Cumbria Health and Care Partnership

| PROVIDER | LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | SPIRE FYLDE COAST HOSPITAL | EAST LANCASHIRE HOSPITALS NHS TRUST | MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST | ALL OTHER | TOTAL | % TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| 100: GENERAL SURGERY | 842 | 207 | 410 | 64 | 175 | 46 | 9 | 114 | 1867 | 18.9% |
| 101: UROLOGY | 263 | 52 | 133 | 68 | 27 | 17 | 6 | 77 | 643 | 6.5% |
| 110: TRAUMA & ORTHOPAEDICS | 289 | 484 | 183 | 507 | 204 | 23 | 287 | 249 | 2226 | 22.6% |
| 120: ENT | 634 | 282 | 45 | 17 | 49 | 52 | 15 | 80 | 1174 | 11.9% |
| 130: OPHTHALMOLOGY | 399 | 15 | 40 | 190 | 103 | 32 | 4 | 39 | 822 | 8.3% |
| 150: NEUROSURGERY | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| 160: PLASTIC SURGERY | 346 | 0 | 2 | 0 | 0 | 19 | 0 | 29 | 396 | 4.0% |
| 170: CARDIOTHORACIC SURGERY | 0 | 0 | 22 | 0 | 0 | 2 | 0 | 7 | 31 | 0.3% |
| 300: GENERAL MEDICINE | 401 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 402 | 4.1% |
| 301: GASTROENTEROLOGY | 33 | 14 | 191 | 5 | 12 | 13 | 7 | 33 | 308 | 3.1% |
| 320: CARDIOLOGY | 32 | 0 | 86 | 0 | 0 | 7 | 1 | 5 | 131 | 1.3% |
| 330: DERMATOLOGY | 1 | 23 | 2 | 0 | 0 | 0 | 0 | 7 | 33 | 0.3% |
| 340: RESPIRATORY MEDICINE (ALSO KNOWN AS THORACIC MEDICINE) | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 1 | 3 | 0.0% |
| 400: NEUROLOGY | 651 | 0 | 0 | 0 | 0 | 0 | 0 | 14 | 665 | 6.7% |
| 410: RHEUMATOLOGY | 0 | 5 | 1 | 0 | 0 | 1 | 0 | 1 | 8 | 0.1% |
| 430: GERIATRIC MEDICINE | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0.0% |
| 502: GYNAECOLOGY | 103 | 15 | 33 | 73 | 26 | 158 | 1 | 99 | 508 | 5.2% |
| X05: All other TREATMENT FUNCTIONS in the Surgical group not reported individually | 0 | 69 | 2 | 0 | 0 | 31 | 26 | 56 | 184 | 1.9% |
| X06: All other TREATMENT FUNCTIONS in the Other group not reported individually | 12 | 8 | 0 | 0 | 0 | 2 | 0 | 12 | 34 | 0.3% |
| X04: All other TREATMENT FUNCTIONS in the Paediatric group not reported individually | 0 | 39 | 2 | 0 | 0 | 116 | 0 | 13 | 170 | 1.7% |
| X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported individually | 167 | 47 | 0 | 0 | 1 | 13 | 0 | 19 | 247 | 2.5% |
| X01: All other TREATMENT FUNCTIONS not reported individually | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **Grand Total** | **4175** | **1261** | **1152** | **924** | **598** | **532** | **356** | **856** | **9854** | **100.0%** |
| % TOTAL | 42.4% | 12.8% | 11.7% | 9.4% | 6.1% | 5.4% | 3.6% | 8.7% | **100.0%** | |


52+ week incomplete pathway waiters by Provider (L&SC CCGs) - June 2021
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
SPIRE FYLDE COAST HOSPITAL
EAST LANCASHIRE HOSPITALS NHS TRUST
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
ALL OTHER
2500
2000
1500
1000
500
0
100: GENERAL SURGERY
101: UROLOGY
110: TRAUMA & ORTHOPAEDICS
120: ENT
130: OPHTHALMOLOGY
150: NEUROSURGERY
160: PLASTIC SURGERY
170: CARDIOTHORACIC SURGERY
300: GENERAL MEDICINE
301: GASTROENTEROLOGY
320: CARDIOLOGY
330: DERMATOLOGY
340: RESPIRATORY MEDICINE (ALSO KNOWN AS THORACIC MEDICINE)
400: NEUROLOGY
410: RHEUMATOLOGY
430: GERIATRIC MEDICINE
502: GYNAECOLOGY
X05: All other TREATMENT FUNCTIONS in the Surgical group not reported individually
X06: All other TREATMENT FUNCTIONS in the Other group not reported individually
X04: All other TREATMENT FUNCTIONS in the Paediatric group not reported individually
X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported individually
X01: All other TREATMENT FUNCTIONS not reported individually

## Appendix 2: Over 52 week waiters for L&SC Providers split by Specialty (June 2021)

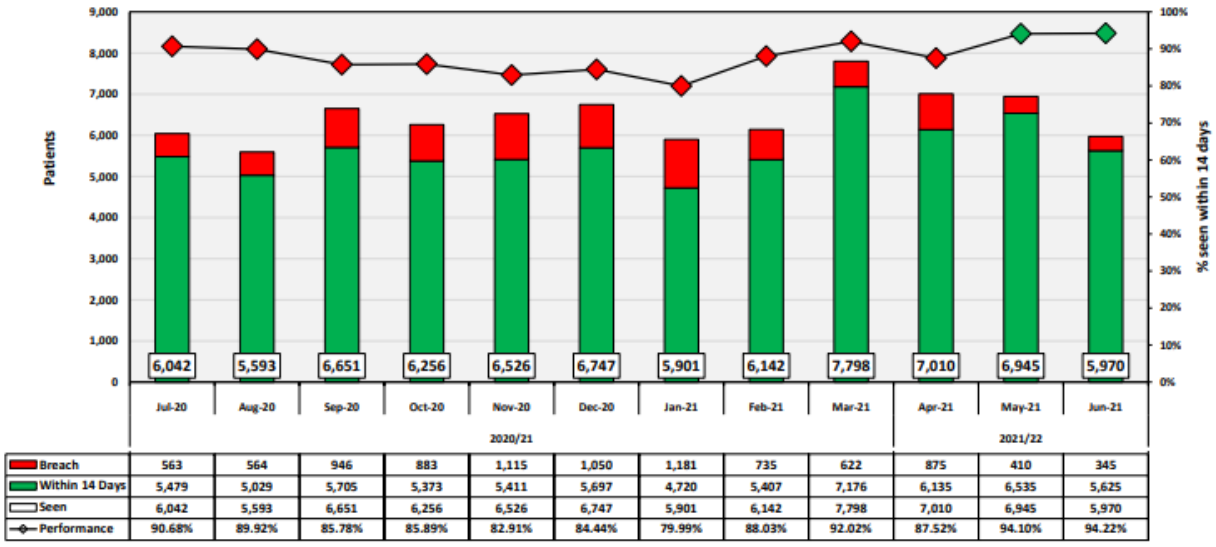
| Treatment Function | LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | EAST LANCASHIRE HOSPITALS NHS TRUST | TOTAL | % TOTAL |
|---|---|---|---|---|---|---|
| Oral Surgery Service | 1701 | 52 | 21 | 248 | 2022 | 20.3% |
| General Surgery Service | 903 | 216 | 416 | 178 | 1713 | 17.2% |
| Trauma and Orthopaedic Service | 322 | 504 | 187 | 207 | 1220 | 12.2% |
| Ear Nose and Throat Service | 660 | 291 | 45 | 49 | 1045 | 10.5% |
| Neurology Service | 666 | 0 | 0 | 0 | 666 | 6.7% |
| Ophthalmology Service | 408 | 16 | 40 | 103 | 567 | 5.7% |
| Urology Service | 277 | 56 | 137 | 28 | 498 | 5.0% |
| Neurosurgical Service | 461 | 0 | 0 | 0 | 461 | 4.6% |
| General Internal Medicine Service | 417 | 0 | 0 | 0 | 417 | 4.2% |
| Plastic Surgery Service | 365 | 0 | 2 | 0 | 367 | 3.7% |
| Gastroenterology Service | 33 | 15 | 193 | 12 | 253 | 2.5% |
| Other - Medical Services | 185 | 47 | 0 | 1 | 233 | 2.3% |
| Gynaecology Service | 112 | 17 | 33 | 27 | 189 | 1.9% |
| Cardiology Service | 34 | 0 | 96 | 0 | 130 | 1.3% |
| Other - Surgical Services | 0 | 79 | 2 | 0 | 81 | 0.8% |
| Other - Paediatric Services | 0 | 39 | 2 | 0 | 41 | 0.4% |
| Dermatology Service | 1 | 23 | 2 | 0 | 26 | 0.3% |
| Cardiothoracic Surgery Service | 0 | 0 | 22 | 0 | 22 | 0.2% |
| Other - Other Services | 14 | 8 | 0 | 0 | 22 | 0.2% |
| Rheumatology Service | 0 | 5 | 1 | 0 | 6 | 0.1% |
| Elderly Medicine Service | 2 | 0 | 0 | 0 | 2 | 0.0% |
| Respiratory Medicine Service | 0 | 1 | 0 | 1 | 2 | 0.0% |
| Other - Mental Health Services | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **TOTAL** | **6561** | **1369** | **1199** | **854** | **9983** | **100.0%** |
| % TOTAL | 65.7% | 13.7% | 12.0% | 8.6% | 100.0% | |

| | |
|---|---|
| Very High (>1000) | 1000 |
| High (>500) | 500 |
| Elevated (>100) | 100 |
| Track (<100) | |

# % 2 Weeks Cancer – Urgent GP Referral – June 21

## 2 Week Wait Referrals (93% Standard)

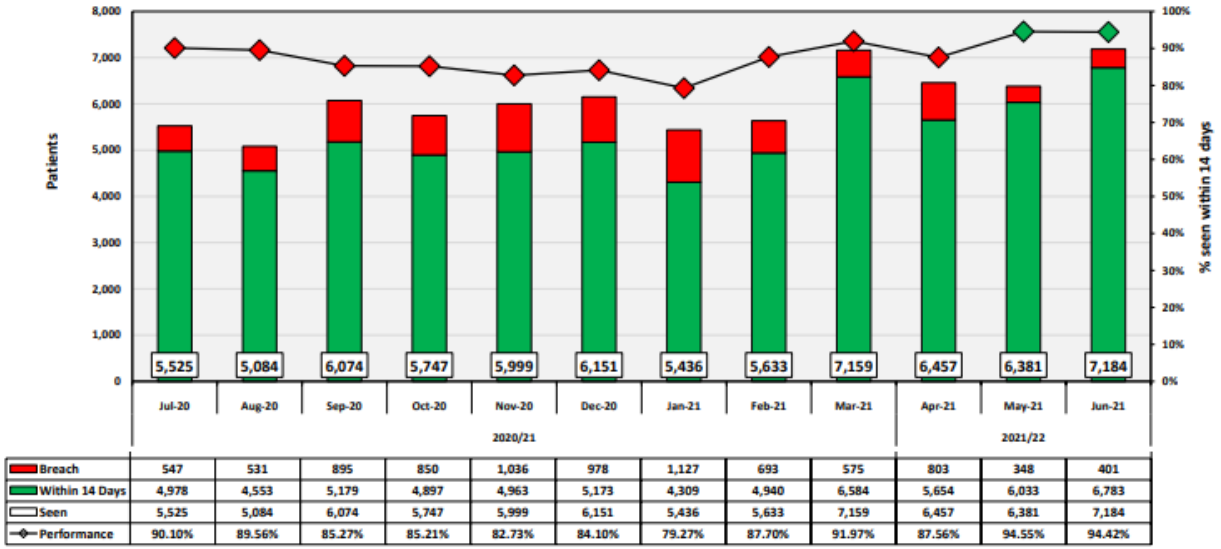
### Cancer Alliance CCGs (Jul-20 to Jun-21)




| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 563 | 564 | 946 | 883 | 1,115 | 1,050 | 1,181 | 735 | 622 | 875 | 410 | 345 |
| Within 14 Days | 5,479 | 5,029 | 5,705 | 5,373 | 5,411 | 5,697 | 4,720 | 5,407 | 7,176 | 6,135 | 6,535 | 5,625 |
| Seen | 6,042 | 5,593 | 6,651 | 6,256 | 6,526 | 6,747 | 5,901 | 6,142 | 7,798 | 7,010 | 6,945 | 5,970 |
| Performance | 90.68% | 89.92% | 85.78% | 85.89% | 82.91% | 84.44% | 79.99% | 88.03% | 92.02% | 87.52% | 94.10% | 94.22% |

| CCG | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BwDCCG | 9 | 0 | 100.00% | 5,125 | 322 | 93.72% |
| BCCG | 743 | 33 | 95.56% | 7,531 | 393 | 94.78% |
| CSRCCG | 940 | 34 | 96.38% | 8,617 | 960 | 88.86% |
| ELCCG | 100 | 7 | 93.00% | 13,518 | 832 | 93.85% |
| FWCCG | 1,002 | 33 | 96.71% | 10,487 | 752 | 92.83% |
| GPCCG | 1,108 | 51 | 95.40% | 10,736 | 1,210 | 88.73% |
| MBCCG | 1,511 | 135 | 91.07% | 15,508 | 4,157 | 73.19% |
| WLCCG | 557 | 52 | 90.66% | 6,059 | 663 | 89.06% |
| CA CCGs | 5,970 | 345 | 94.22% | 77,581 | 9,289 | 88.03% |

### Cancer Alliance Providers (Jul-20 to Jun-21)



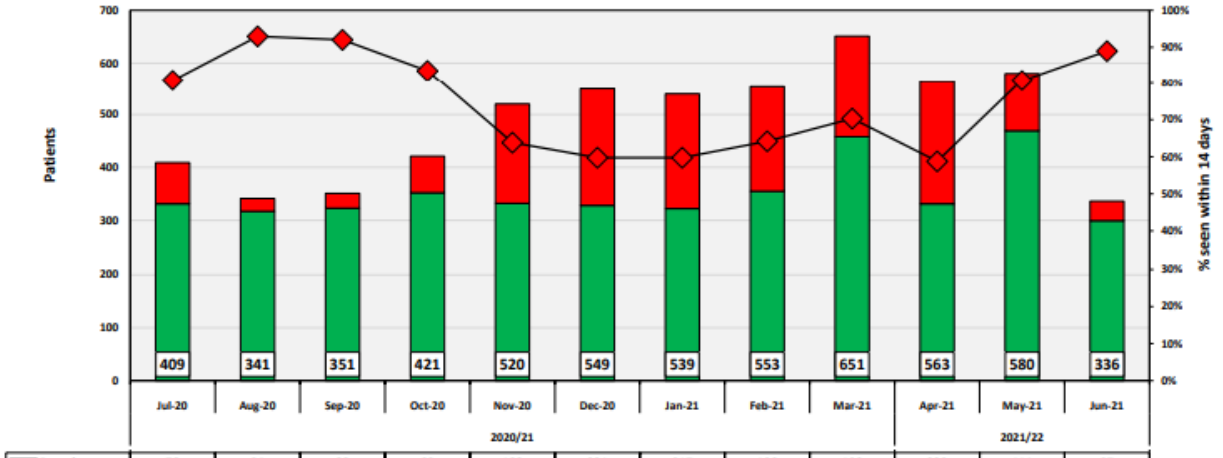

| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 547 | 531 | 895 | 850 | 1,036 | 978 | 1,127 | 693 | 575 | 803 | 348 | 401 |
| Within 14 Days | 4,978 | 4,553 | 5,179 | 4,897 | 4,963 | 5,173 | 4,309 | 4,940 | 6,584 | 5,654 | 6,033 | 6,783 |
| Seen | 5,525 | 5,084 | 6,074 | 5,747 | 5,999 | 6,151 | 5,436 | 5,633 | 7,159 | 6,457 | 6,381 | 7,184 |
| Performance | 90.10% | 89.56% | 85.27% | 85.21% | 82.73% | 84.10% | 79.27% | 87.70% | 91.97% | 87.56% | 94.55% | 94.42% |

| Provider | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BTH | 1,566 | 53 | 96.62% | 16,126 | 790 | 95.10% |
| ELHT | 1,812 | 112 | 93.82% | 19,332 | 1,157 | 94.02% |
| LTH | 2,206 | 92 | 95.83% | 20,878 | 2,382 | 88.59% |
| UHMB | 1,600 | 144 | 91.00% | 16,494 | 4,455 | 72.99% |
| CA Providers | 7,184 | 401 | 94.42% | 72,830 | 8,784 | 87.94% |

# % 2 Weeks Cancer – Urgent Referral (Breast) – June 21

## 2 Week Wait Breast Symptomatic Referrals (93% Standard)

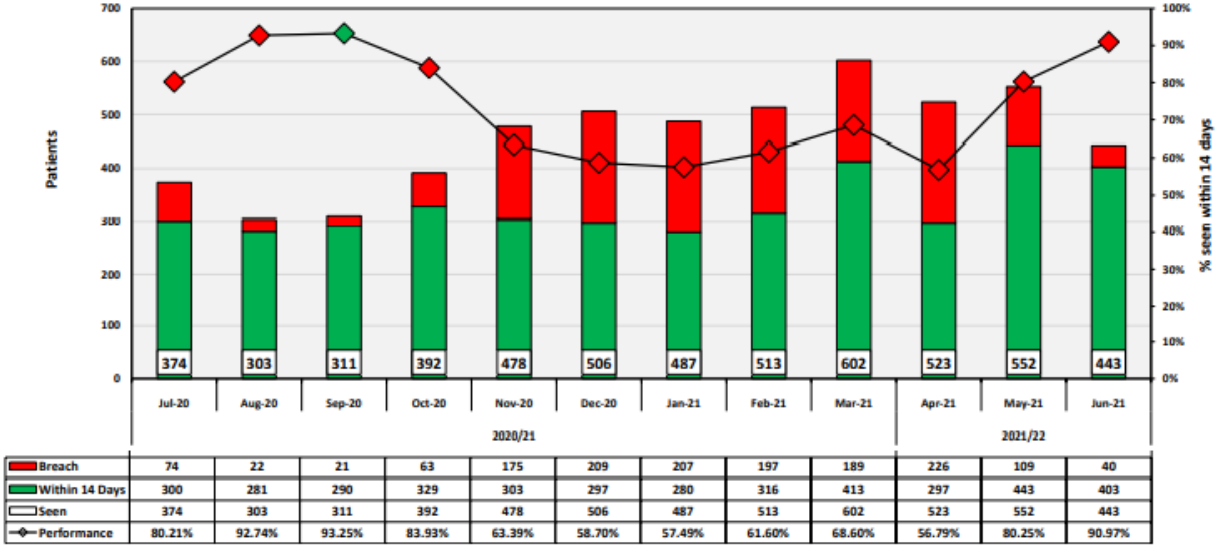
### Cancer Alliance CCGs (Jul-20 to Jun-21)




| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 78 | 24 | 28 | 69 | 188 | 221 | 217 | 198 | 193 | 232 | 111 | 37 |
| Within 14 Days | 331 | 317 | 323 | 352 | 332 | 328 | 322 | 355 | 458 | 331 | 469 | 299 |
| Seen | 409 | 341 | 351 | 421 | 520 | 549 | 539 | 553 | 651 | 563 | 580 | 336 |
| Performance | 80.93% | 92.96% | 92.02% | 83.61% | 63.85% | 59.74% | 59.74% | 64.20% | 70.35% | 58.79% | 80.86% | 88.99% |

| CCG | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BwDCCG | 2 | 0 | 100.00% | 620 | 55 | 91.13% |
| BCCG | 68 | 2 | 97.06% | 750 | 128 | 82.93% |
| CSRCCG | 53 | 4 | 92.45% | 686 | 309 | 54.96% |
| ELCCG | 10 | 0 | 100.00% | 1,391 | 104 | 92.52% |
| FWCCG | 57 | 3 | 94.74% | 625 | 140 | 77.60% |
| GPCCG | 51 | 2 | 96.08% | 755 | 352 | 53.38% |
| MBCCG | 68 | 22 | 67.65% | 642 | 452 | 29.60% |
| WLCCG | 27 | 4 | 85.19% | 344 | 56 | 83.72% |
| CA CCGs | 336 | 37 | 88.99% | 5,813 | 1,596 | 72.54% |

### Cancer Alliance Providers (Jul-20 to Jun-21)



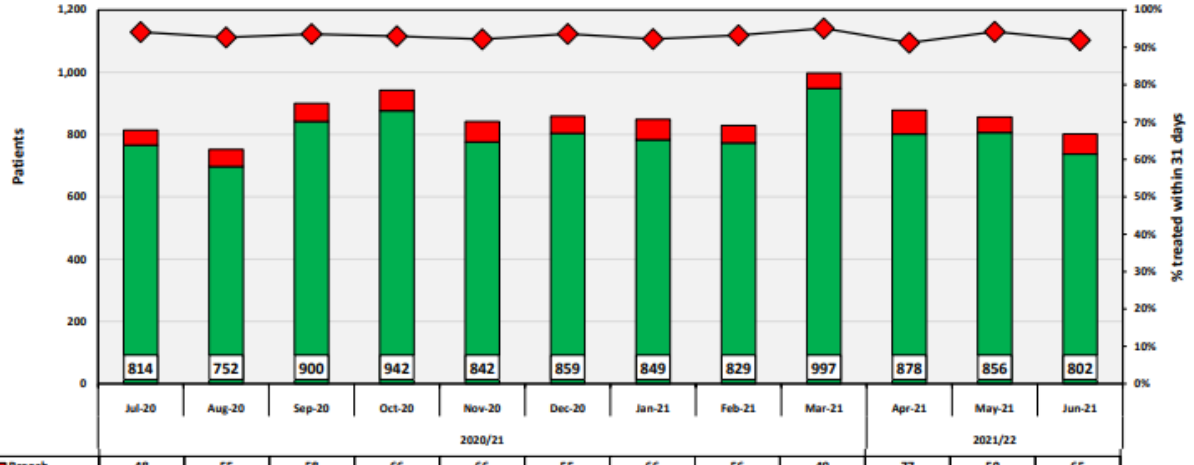

| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 74 | 22 | 21 | 63 | 175 | 209 | 207 | 197 | 189 | 226 | 109 | 40 |
| Within 14 Days | 300 | 281 | 290 | 329 | 303 | 297 | 280 | 316 | 413 | 297 | 443 | 403 |
| Seen | 374 | 303 | 311 | 392 | 478 | 506 | 487 | 513 | 602 | 523 | 552 | 443 |
| Performance | 80.21% | 92.74% | 93.25% | 83.93% | 63.39% | 58.70% | 57.49% | 61.60% | 68.60% | 56.79% | 80.25% | 90.97% |

| Provider | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BTH | 118 | 4 | 96.61% | 1,296 | 213 | 83.56% |
| ELHT | 145 | 9 | 93.79% | 2,029 | 135 | 93.35% |
| LTH | 111 | 4 | 96.40% | 1,479 | 691 | 53.28% |
| UHMB | 69 | 23 | 66.67% | 680 | 493 | 27.50% |
| CA Providers | 443 | 40 | 90.97% | 5,484 | 1,532 | 72.06% |

# % 31 Day Cancer – Definitive Treatment – June 21

## 31 Day First Treatment (96% Standard)

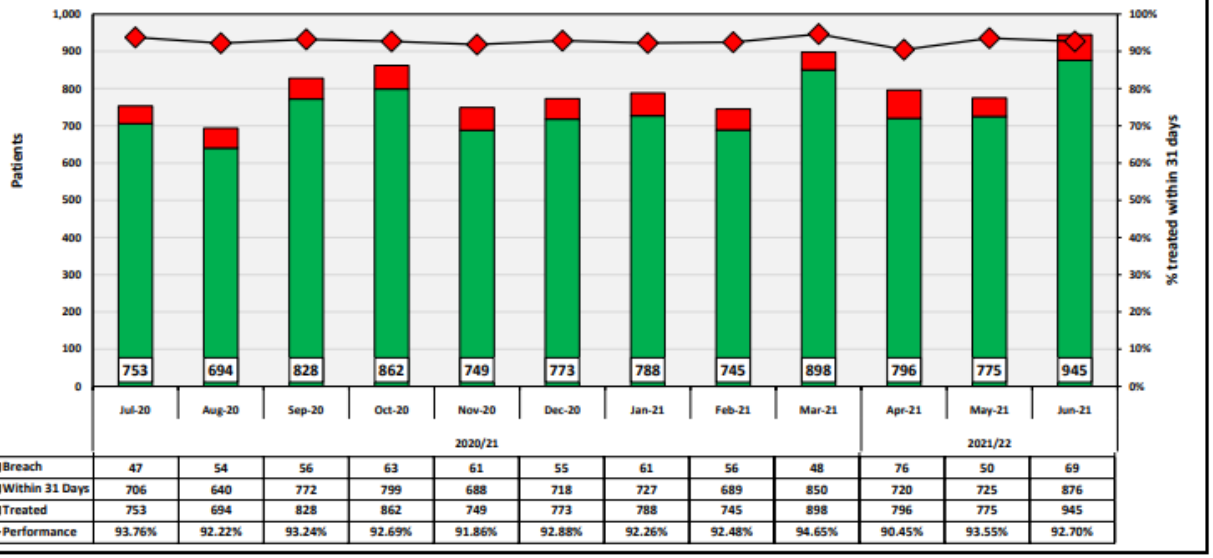
### Cancer Alliance CCGs (Jul-20 to Jun-21)




| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 48 | 55 | 58 | 66 | 66 | 55 | 66 | 56 | 49 | 77 | 50 | 65 |
| Within 31 Days | 766 | 697 | 842 | 876 | 776 | 804 | 783 | 773 | 948 | 801 | 806 | 737 |
| Treated | 814 | 752 | 900 | 942 | 842 | 859 | 849 | 829 | 997 | 878 | 856 | 802 |
| Performance | 94.10% | 92.69% | 93.56% | 92.99% | 92.16% | 93.60% | 92.23% | 93.24% | 95.09% | 91.23% | 94.16% | 91.90% |

| CCG | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BwDCCG | 10 | 1 | 90.00% | 704 | 39 | 94.46% |
| BCCG | 125 | 4 | 96.80% | 1,183 | 61 | 94.84% |
| CSRCCG | 109 | 12 | 88.99% | 1,134 | 101 | 91.09% |
| ELCCG | 45 | 6 | 86.67% | 1,867 | 118 | 93.68% |
| FWCCG | 162 | 6 | 96.30% | 1,501 | 90 | 94.00% |
| GPCCG | 107 | 15 | 85.98% | 1,031 | 92 | 91.08% |
| MBCCG | 180 | 21 | 88.33% | 2,198 | 192 | 91.26% |
| WLCCG | 64 | 0 | 100.00% | 702 | 18 | 97.44% |
| CA CCGs | 802 | 65 | 91.90% | 10,320 | 711 | 93.11% |

### Cancer Alliance Providers (Jul-20 to Jun-21)



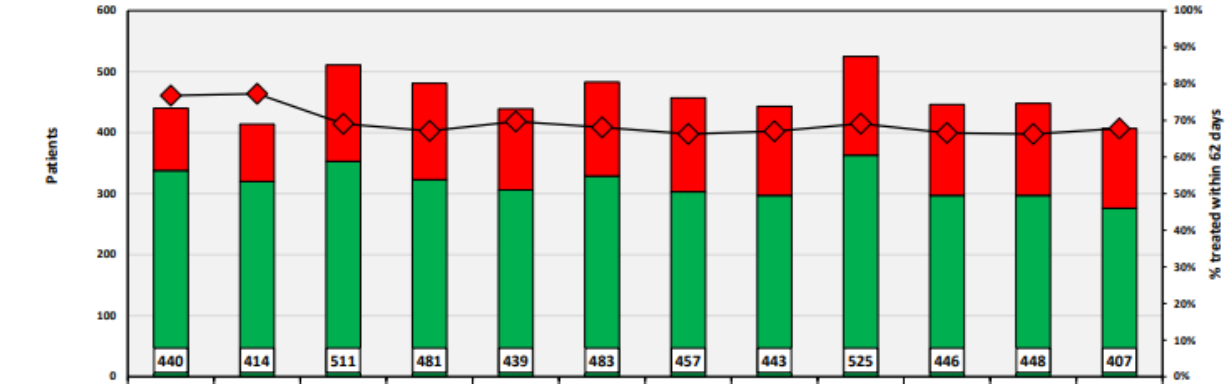

| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 47 | 54 | 56 | 63 | 61 | 55 | 61 | 56 | 48 | 76 | 50 | 69 |
| Within 31 Days | 706 | 640 | 772 | 799 | 688 | 718 | 727 | 689 | 850 | 720 | 725 | 876 |
| Treated | 753 | 694 | 828 | 862 | 749 | 773 | 788 | 745 | 898 | 796 | 775 | 945 |
| Performance | 93.76% | 92.22% | 93.24% | 92.69% | 91.86% | 92.88% | 92.26% | 92.48% | 94.65% | 90.45% | 93.55% | 92.70% |

| Provider | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BTH | 249 | 1 | 99.60% | 2,229 | 48 | 97.85% |
| ELHT | 228 | 7 | 96.93% | 2,375 | 131 | 94.48% |
| LTH | 312 | 49 | 84.29% | 3,184 | 392 | 87.69% |
| UHMB | 156 | 12 | 92.31% | 1,818 | 125 | 93.12% |
| CA Providers | 945 | 69 | 92.70% | 9,606 | 696 | 92.75% |

# % 62 Day Cancer – June 21

## 62 Day Classic Performance (85% Standard)

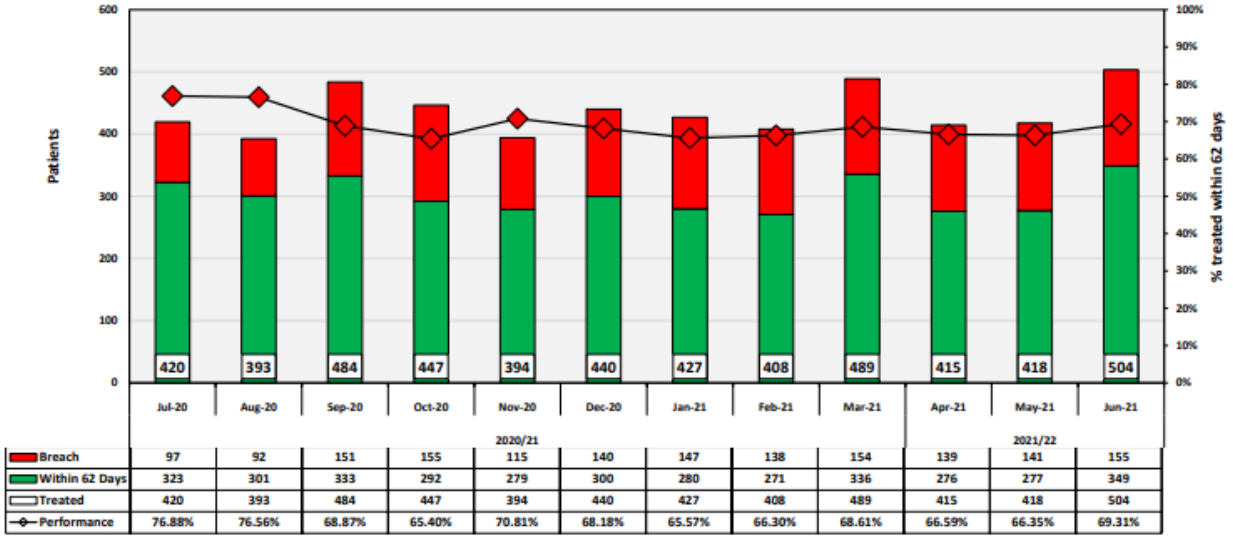
### Cancer Alliance CCGs (Jul-20 to Jun-21)




| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 102 | 94 | 158 | 158 | 133 | 154 | 154 | 146 | 162 | 149 | 151 | 131 |
| Within 62 Days | 338 | 320 | 353 | 323 | 306 | 329 | 303 | 297 | 363 | 297 | 297 | 276 |
| Treated | 440 | 414 | 511 | 481 | 439 | 483 | 457 | 443 | 525 | 446 | 448 | 407 |
| Performance | 76.82% | 77.29% | 69.08% | 67.15% | 69.70% | 68.12% | 66.30% | 67.04% | 69.14% | 66.59% | 66.29% | 67.81% |

| CCG | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BwDCCG | 4.0 | 2.0 | 50.00% | 353.0 | 87.0 | 75.35% |
| BCCG | 56.0 | 14.0 | 75.00% | 584.0 | 156.0 | 73.29% |
| CSRCCG | 58.0 | 21.0 | 63.79% | 641.0 | 215.0 | 66.46% |
| ELCCG | 21.0 | 12.0 | 42.86% | 971.0 | 264.0 | 72.81% |
| FWCCG | 93.0 | 19.0 | 79.57% | 837.0 | 206.0 | 75.39% |
| GPCCG | 61.0 | 23.0 | 62.30% | 570.0 | 204.0 | 64.21% |
| MBCCG | 90.0 | 35.0 | 61.11% | 1,188.0 | 462.0 | 61.11% |
| WLCCG | 24.0 | 5.0 | 79.17% | 350.0 | 98.0 | 72.00% |
| CA CCGs | 407.0 | 131.0 | 67.81% | 5,494.0 | 1,692.0 | 69.20% |

### Cancer Alliance Providers (Jul-20 to Jun-21)




| | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 97 | 92 | 151 | 155 | 115 | 140 | 147 | 138 | 154 | 139 | 141 | 155 |
| Within 62 Days | 323 | 301 | 333 | 292 | 279 | 300 | 280 | 271 | 336 | 276 | 277 | 349 |
| Treated | 420 | 393 | 484 | 447 | 394 | 440 | 427 | 408 | 489 | 415 | 418 | 504 |
| Performance | 76.88% | 76.56% | 68.87% | 65.40% | 70.81% | 68.18% | 65.57% | 66.30% | 68.61% | 66.59% | 66.35% | 69.31% |

| Provider | Jun-21 | | | Jul-20 to Jun-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BTH | 135.5 | 23.5 | 82.66% | 1,273.0 | 286.0 | 77.53% |
| ELHT | 131.5 | 35.5 | 73.00% | 1,311.5 | 333.5 | 74.57% |
| LTH | 147.0 | 61.5 | 58.16% | 1,517.0 | 581.5 | 61.67% |
| UHMB | 89.5 | 34.0 | 62.01% | 1,134.0 | 419.5 | 63.01% |
| CA Providers | 503.5 | 154.5 | 69.31% | 5,235.5 | 1,620.5 | 69.05% |

# % 6 Week Diagnostic Waiters – June 21

## ICS Level: Lancashire & South Cumbria

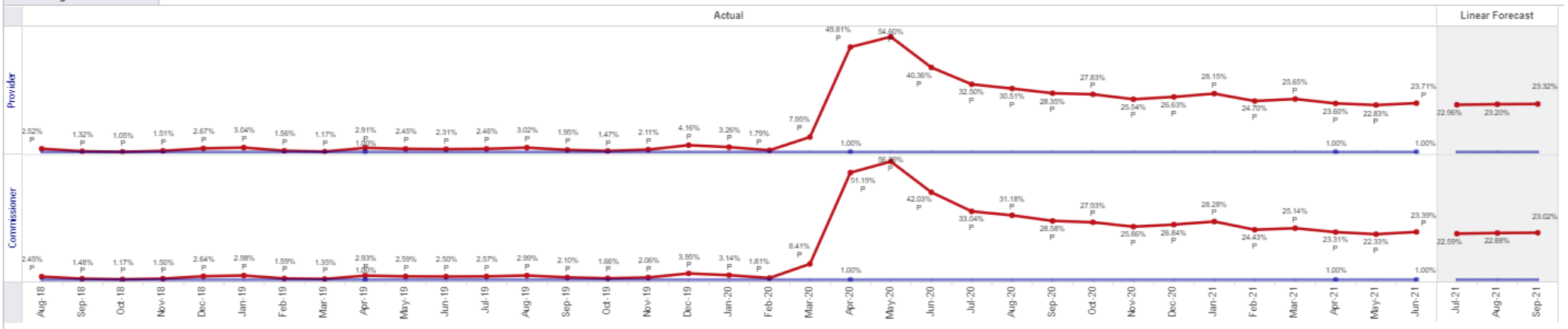
% of patients waiting 6 weeks or more for a diagnostic test

| | Provider | | YTD |
|---|---|---|---|
| Value | Jun-21 | 23.71% | 23.38% |
| Target | Jun-21 | 1.00% | 1.00% |
| Forecast | Jul-21 | 22.96% | 23.38% |

| | Commissioner | | YTD |
|---|---|---|---|
| Value | Jun-21 | 23.39% | 23.25% |
| Target | Jun-21 | 1.00% | 1.00% |
| Forecast | Jul-21 | 22.59% | 23.25% |

% Waiters 6 Wks Diagnostics

Organisation

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# % Incomplete 18 weeks RTT – June 21

## ICS Level: Lancashire & South Cumbria

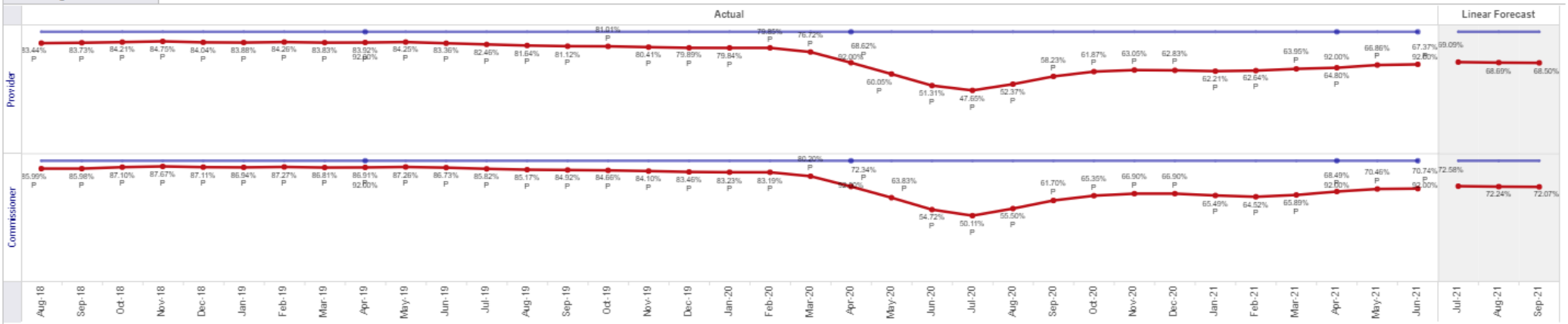
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

| | Provider | | YTD |
|---|---|---|---|
| Value | Jun-21 | 67.37% | 66.36% |
| Target | Jun-21 | 92.00% | 92.00% |
| Forecast | Jul-21 | 69.09% | 66.36% |

| | Commissioner | | YTD |
|---|---|---|---|
| Value | Jun-21 | 70.74% | 70.11% |
| Target | Jun-21 | 92.00% | 92.00% |
| Forecast | Jul-21 | 72.58% | 70.11% |

**% Incomplete 18 Wks RTT**

Organisation

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# Total number of Incompletes RTT –June 21

## ICS Level: Lancashire & South Cumbria

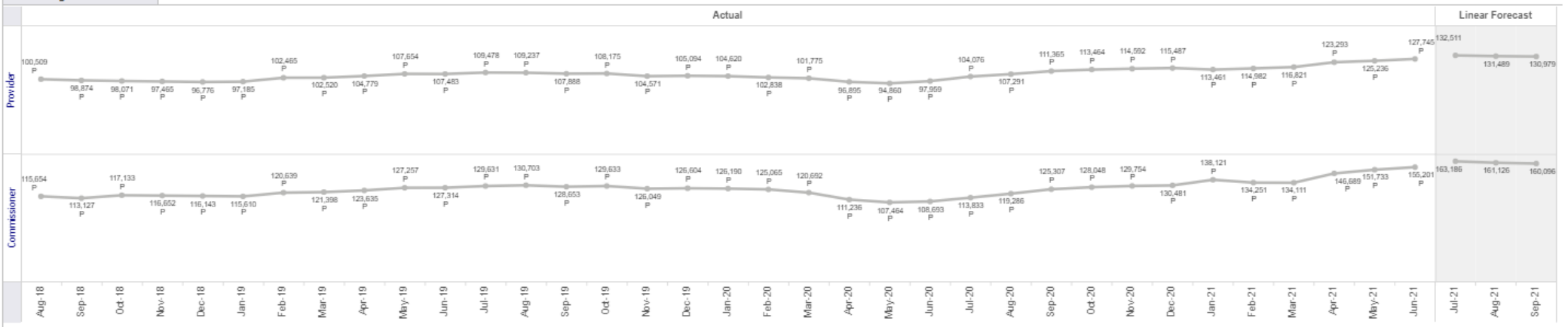
### Total Number of Incompletes under and above 18 weeks RTT

| | Provider | |
|---|---|---|
| Value | Jun-21 | 127,745 |
| Target | Jun-21 | |
| Forecast | Jul-21 | 132,511 |

| | Commissioner | |
|---|---|---|
| Value | Jun-21 | 155,201 |
| Target | Jun-21 | |
| Forecast | Jul-21 | 163,186 |

Total no. of Incompletes RTT

Organisation

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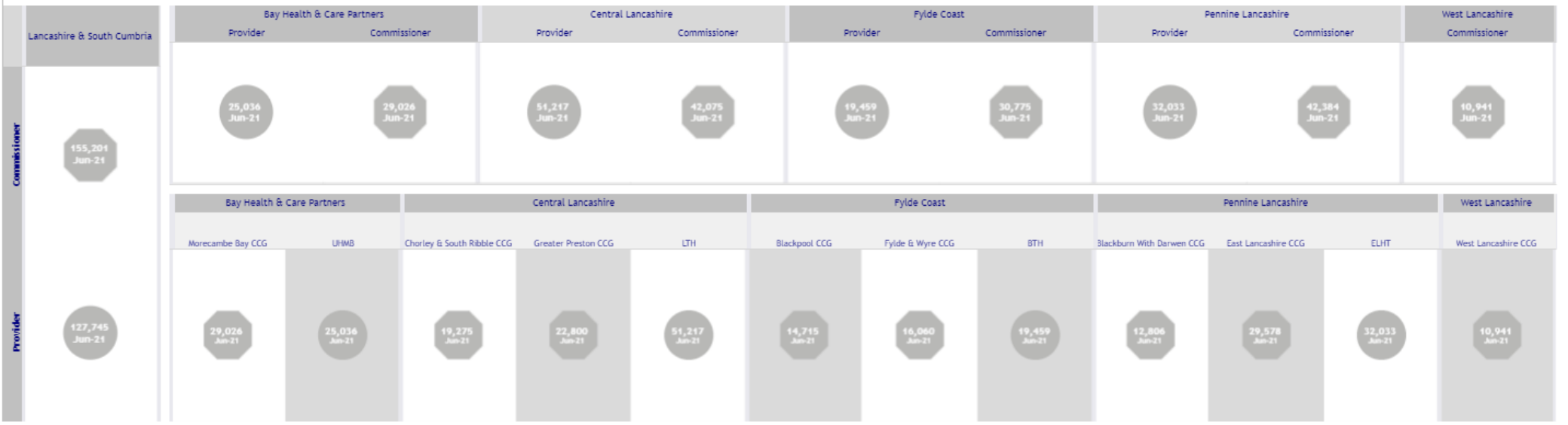
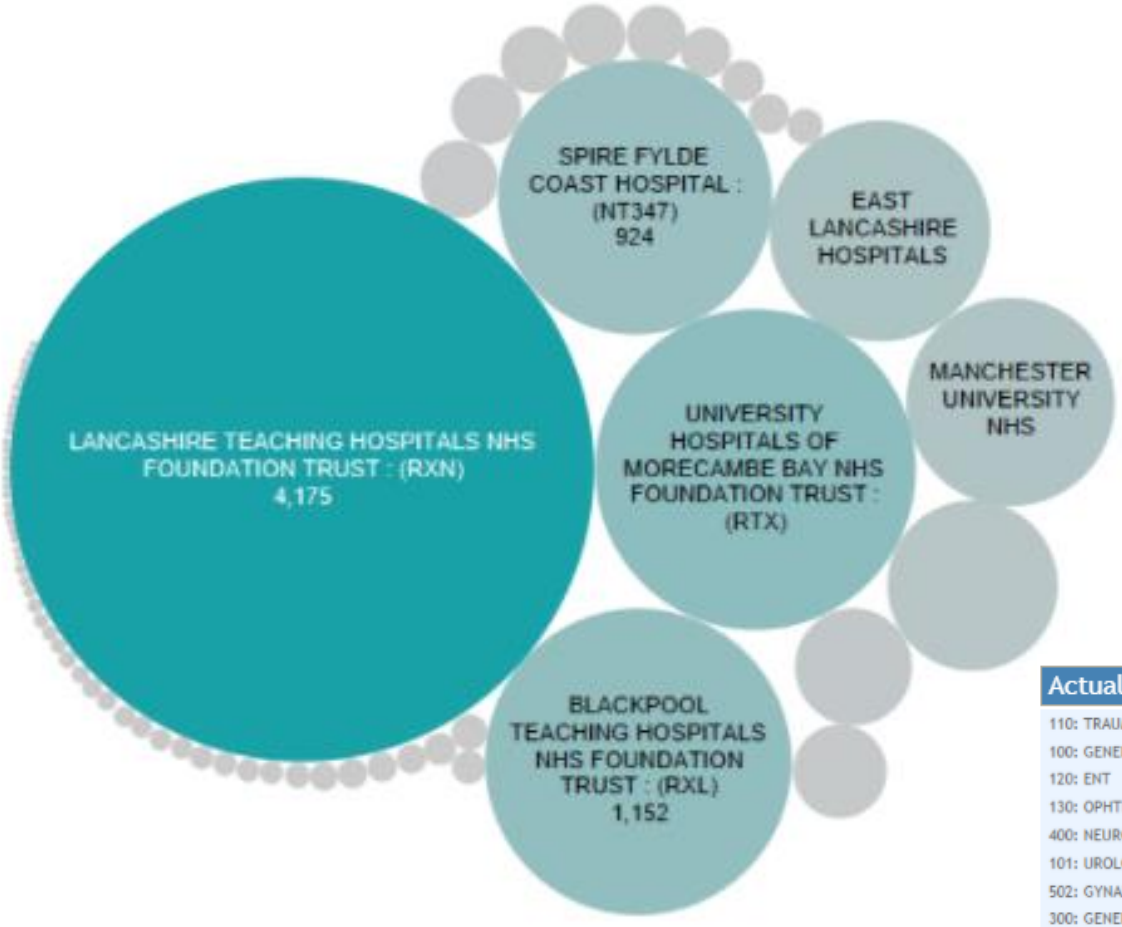
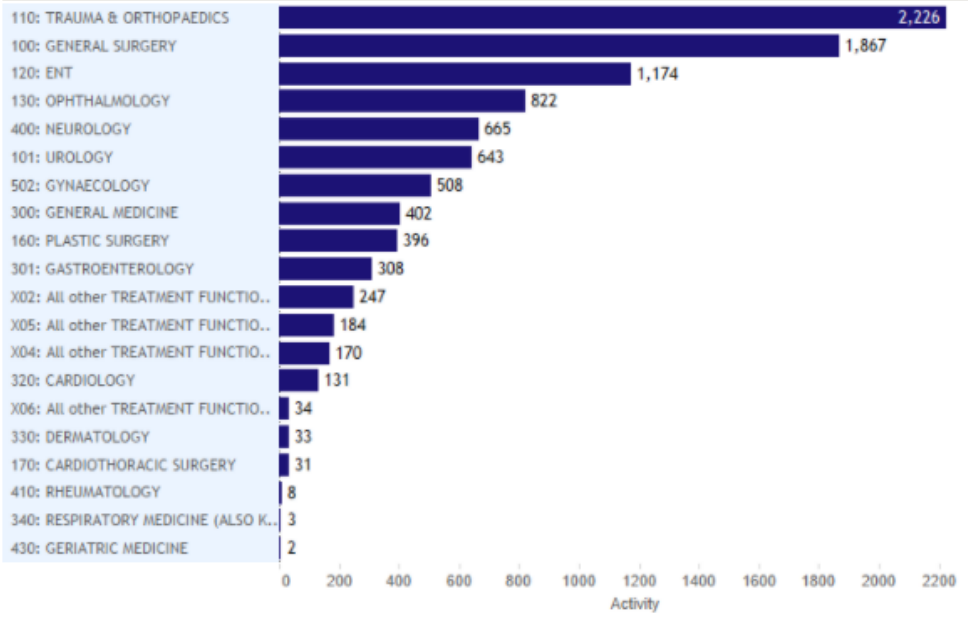


# Over 52 week waiters – June 21

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




## Actuals by Treatment Function - Over 52 Weeks **



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

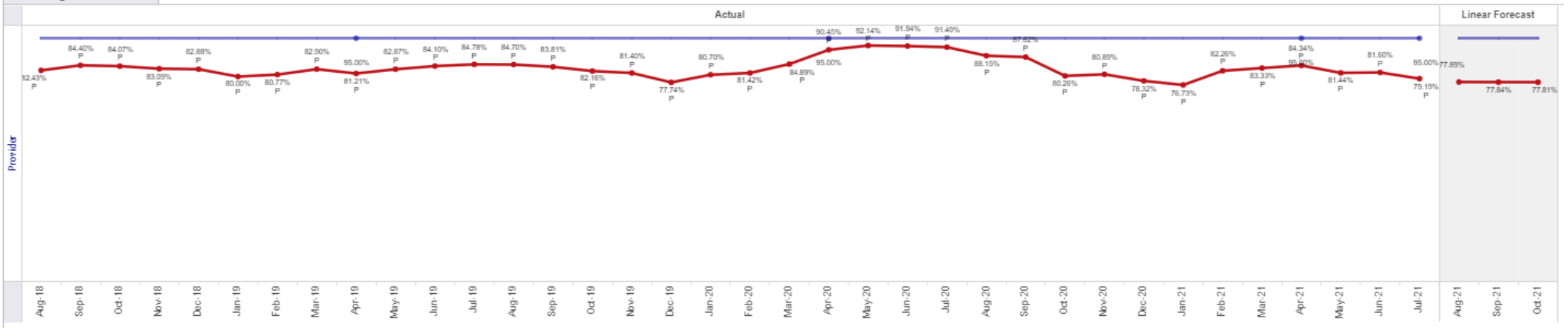
ICS Level: Lancashire & South Cumbria

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

| | Provider | | YTD |
|---|---|---|---|
| Value | Jul-21 | 79.19% | 81.56% |
| Target | Jul-21 | 95.00% | 95.00% |
| Forecast | Aug-21 | 77.89% | 81.56% |

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

Organisation




ICS

Integrated Care Partnerships \ Integrated Care Organisations

Lancashire & South Cumbria

Provider

79.19% Jul-21

| Bay Health & Care Partners | Central Lancashire | Fylde Coast | Pennine Lancashire |
|---|---|---|---|
| Provider | Provider | Provider | Provider |
| 81.42% Jul-21 | 79.18% Jul-21 | 82.89% Jul-21 | 73.92% Jul-21 |
| UHMB | LTH | BTH | ELHT |
| 81.42% Jul-21 | 79.18% Jul-21 | 82.89% Jul-21 | 73.92% Jul-21 |

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9 September 2021** |
| **Title of paper** | **New Hospitals Programme Quarter 1 Board Report** |
| **Presented by** | **Jerry Hawker, Programme SRO** |
| **Author** | **Jerry Hawker, Programme SRO** |
| **Agenda item** | **9** |
| **Confidential** | **No** |

## Purpose of the paper

For information.

## Executive summary

The purpose of this report is to provide an update on the New Hospitals Programme for the quarter 1 period, April – June 2021.

The report includes progress on the revised governance, progress against plan including the key products to support business case development along with the public, patient and workforce communications and engagement activities underway.

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)
- Provider Collaborative
- And the Strategic Commissioning Committee (SCC).

## Recommendations

It is recommended the SCC;

- Note the progress undertaken in Q1.
- Note the development of the products to support business case development (section 5).

## Implications

| *If yes, please provide a brief risk description and reference number* | YES | NO | N/A | Comments |
|---|---|---|---|---|
| Quality impact assessment completed | | ✓ | | |

| | | | | |
|---|---|---|---|---|
| Equality impact assessment completed | | ✓ | | |
| Privacy impact assessment completed | | | ✓ | |
| Financial impact assessment completed | | ✓ | | |
| Associated risks | ✓ | | | A NHP risk register has been developed and discussed at the NHP Strategic Oversight Group |
| Are associated risks detailed on the ICS Risk Register? | | | ✓ | |

| | |
|---|---|
| Report authorised by: | Jerry Hawker |

# NEW HOSPITALS PROGRAMME Q1 BOARD REPORT

## 1. Introduction

1.1 This report is the 2021/22 Quarter 1 update from the New Hospitals Programme (NHP).

## 2 Background

2.1 The New Hospitals Programme is a key strategic priority for the Lancashire and South Cumbria Health and Care Partnership. It sits within the integrated care system's wider strategic vision, with the central aim of delivering world-class hospital infrastructure from which high-quality services can be provided.

2.2 The New Hospitals Programme offers Lancashire and South Cumbria a once-in-a-generation opportunity to transform our ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 Investment in Lancashire and South Cumbria's NHS hospital infrastructure will enable us to provide state of the art facilities and technology, strengthening our position as a centre of excellence for research, education and specialised care. This will significantly boost the attractiveness of the area to potential recruits and the highest calibre of clinicians.

2.4 The programme is committed to ensuring new hospitals fully embrace the benefits of digital technologies to create an agile network of care, allowing us to optimise the size of our physical footprint and minimise environmental impact. This will, in turn, enable us to provide more specialised services in our hospitals and deliver more care closer to home as part of the wider ambitions of the Lancashire and South Cumbria Health and Care Partnership.

## 3 Programme governance and risk

3.1 During Q1 an internal review was undertaken of the current governance arrangements including feedback from a range of executive and non-executive directors. A set of recommendations were proposed to streamline decision making whilst strengthening non-executive involvement. The recommendations were approved by boards leading to a revised governance structure being implemented in August 2021. To support this new way of working, a governance advisory group is now meeting monthly with

attendance from the Trust Executive Director leads and nominated Non-Executive Directors from UHMB, LTHTR and the Strategic Commissioning Committee. In addition a monthly drop in for Non-Executive Directors to meet with the SRO and Programme Director is now established.

3.2 All working groups and oversight groups are now mobilised with representation from across the ICS including lay member representation on the Communications and Engagement Oversight Group.

3.3 During Q2, MIAA (Mersey Internal Audit Agency) will begin working with the NHP to undertake an independent review of the programme governance arrangements. This will include completion and agreement to a decision making matrices in line with programme and statutory body governance frameworks as well as that of the PCBC and SOC process.

3.4 The programme has a fully populated risk register and risk management processes in place with working groups taking ownership for allocated risks and associated mitigations. The full risk register is reported to the Programme Management Group on a monthly basis with risks scoring 15 and above reported to the SOG each month.

**4 National New Hospital Programme – NHSEI, DHSC**

4.1 In May 2021 the NHP presented the draft Case for Change and Communications and Engagement Plan to a NHSEI stage 1 assurance panel. This strategic sense check provided useful feedback and guidance for the NHP, particularly with regard to strengthening the Case for Change in the context of the ICS vision and strategy. The panel confirmed their support for the NHP to proceed to developing a PCBC.

**4.2** In June 2021, the Programme received an update from the national team. The salient points are as follows:

a) Continued aim to create a national programme, consolidating learning and facilitate continual improvement in the support provided to schemes

b) Commitment to delivering the whole programme (40 new hospitals) by 2030 with the provisional assessment of timings for the L&SC scheme being construction starting in the period January 2025-September 2026 and completion between 2027-2030.

c) Specific timeline, including expected business case preparations and submission dates to be determined along with future funding aligned to the required pace of delivery.

## 5 Progress against plan (for the period April – June 2021)

### 5.1 Programme scope

System partners have been integral to refining the scope of the New Hospitals Programme. In particular, it is worth noting the programme is focused on hospital facilities/sites, with the integrated care system's clinical strategy determining the clinical model, including configuration of services. This work will continue in parallel to, and aligned with, the New Hospitals Programme. Significant progress is being made to ensure close alignment between the Provider Collaborative Board and the New Hospitals Programme.

**5.2 Key products to support business case development –** During Q1 a number of key products were developed and reviewed by the SOG prior to being presented to statutory bodies for approve/information as required. These products represent key building blocks in the development of the PCBC and SOC, including the process and methodology that supports progressing from a long list of proposals to the final short list of options to be included in the PCBC and SOC. Statutory Bodies are not required to approve all these products, but the programme has ensured that all statutory boards and committee members have been engaged, sighted and supportive of them recognising the final business cases will be constructed using them. Each product has been subject to significant engagement, input and challenge from all the NHP working and oversight groups and was presented to SOG with their support. The products are:

**5.3 Case for change** – members will be well sighted on the progress made on the Case for change over this period. Following approval by the SOG (29th April 2021) and the SCC (13th May 2021), the case for change was presented to NHSEI stage 1 assurance. Our case for change was subsequently updated responding to feedback from NHSEI stage 1 assurance and key stakeholders. The final document was approved by SCC at its meeting held in public on 15th July 2021. Agreed communications and engagement activities are now underway.

**5.4** **Communications and engagement strategy and plan** – members will be familiar with the communications and engagement strategy having received a presentation on the approach at the Board to Board held earlier in the year. Feedback from a wide variety of stakeholders resulted in a strengthened strategy which was approved by the SOG (29th April 2021) and SCC (13th May 2021) ahead of presenting to the NHSEI stage 1 assurance panel. This was well received by the panel with minor amendments required. NHSEI and colleagues from the Department of Health and Social Care remain linked in via established relationships, working and oversight groups. The plan is now well underway.

**5.5** **Framework model of care** – clinical leads have worked alongside external partners to develop a framework model of care. This is the clinical vision and outlines the aspirations for what future care should look like within our hospitals. The document will be iterative throughout the course of the programme. The latest version of the framework model of care will be presented to the Clinical Oversight Group (COG) and SOG in August 2021. Given this is interdependent with the work of the Provider Collaborative Board (PCB), work is underway ensure alignment. Finally, the North West Senate will undertake an informal review of the framework. This is in the role of critical friend to help support the NHP to further develop the document ahead of a formal Senate review as part of NHSE stage 2 assurance.

**5.6** **Key assumptions –** A robust set of assumptions have been developed combining local intelligence and National guidance and will be used to develop the long list of proposals and associated sizing and costing of hospital facilities. The assumptions include the key outputs from the demand and capacity modelling. These phase 1 working assumptions were approved by SOG on 9th July 2021. It is worth noting that:

a) These assumptions do not include planned or future service reconfiguration in line with the agreed scope of the programme – SOG agreed to the principle that these are included once any formal consultation is complete.

b) Some assumptions require wider system commitment to delivery e.g. Investment in Integrated Community services / Intermediate Care services etc.

5.7 **Long list of proposals –** A long list of proposals have been developed exploring different scenario's around new builds (new site), rebuilds (existing sites) and refurbishment. These have been used to support our understanding of the feasibility of different approaches and continued discussions with the National team on aligning

potential options with affordability and deliverability. The long list of proposals have been shared with the SCC and used to support Board discussions with LTHTR.

5.8 **Critical Success Factors (CSFs) –**The CSF's help to provide a framework for assessing all proposed options against the Case for Change, National ambitions/requirements and our local ambitions and objectives. CSFs will be used to underpin the process to appraise the long list of options to determine a shortlist to be carried forward to the PCBC.

5.9 It is important the Board notes the strong interdependency between the Programme assumptions and critical success factors and the requirement to demonstrate that all options included in the business cases are affordable, clinically viable and deliverable.

## 6 Programme timeline

6.1 The programme remains on track to deliver the final business case by mid-2024 and to start building in 2025, with new hospital facilities opening by 2030.

6.2 The programme will be subject to a series of checks and balances, including scrutiny and agreement from decision makers within the NHS, the Government and local authorities. As our proposals develop, there will be greater clarity regarding the scope of any public consultation.

## 7 Public, patient and workforce communications and engagement

7.1 A number of key communications, involvement and engagement activities got underway this period namely:

a) Colleague summit – attended by c1000 attendees over 2 events. Colleagues from across L&SC received and update on the NHP and dedicated time for questions and answers with a panel made up of senior leaders from across L&SC.

b) The Big Chat – as at 25th June 2021 this online workshop had received contributions equivalent to 80+ workshops. The first phase of the Big Chat closed early July and has now launched with new themes for discussion focused around the case for change. Subsequent conversations will focus on proposals and appraisal criteria. The Big Chat is open to all NHS staff across L&SC along with the Trust membership and governors from UHMB and LTHTr.

c) Healthwatch workshops – to meet our ambition to involve a wider audience, Healthwatch has launched a series of small workshops and outreach focusing on

those who are digitally excluded, marginalised, harder to reach groups and people representing protected characteristics groupings.

d) Finally, the launch of proactive promotions of the brand and social media channels went live this period:

- New Hospitals Programme website
- like the New Hospitals Programme on Facebook
- follow the New Hospitals Programme on Twitter

## 8 Board development

8.1 Following an initial joint Boards session (UHMB and LTHT) in Q4 2020/21, subsequent Board developing sessions (separate and joint) were held this quarter. Boards focused on the case for change and draft long list of proposals with a focus on the capital funding available and how best to maximise this in addressing the case for change. These were highly engaged sessions with broad alignment demonstrated.

## 9 Dependencies

9.1 Members will recognise that with any complex programme such as this there are many dependencies and interdependencies. This period, the NHP has focused on understanding these aligned to the demand and capacity assumptions and programme risks. As a reminder, at business case stage the NHP can only proceed with options that are affordable, clinically viable and deliverable. The NHP therefore has dependency relationships including but not limited to a-d below.

a) Successful and timely delivery of out of hospital services.

b) Successful and timely delivery of planned or future service reconfiguration and associated clinical models.

c) Agreement to the capital funding available.

d) Depending on c above and any resulting scenarios requiring new sites/land, there is a dependency on land availability.

9.2 A series of mitigation actions have been agreed to manage the dependencies and interdependencies including; alignment of the NHP work with the Provider Collaborative and discussions with the national programme team etc.

## 10 Stakeholder management

10.1 The Board will recognise there will be a breadth of stakeholders in such a programme. During Q1, there has been the launch of proactive internal and external

communications including stakeholder updates with MPs and local authorities. A report was submitted and presented to the Cumbria Health Overview and Scrutiny Committees (HOSC) in July 2021 and an informal update with the Lancashire Scrutiny Officer was held. Formal engagement is underway with MPs across the region with a focus on the case for change and the process the NHP is following. In addition, the NHP has progressed discussions with the Lancashire Local Enterprise Partnership (LEP) Health Sector Board and the programme is looking forward to working with Board partners over the coming period.

## 11 Next period – Q2 2021/22

**11.1** The next quarter will see significant progress in translating the key products developed in Q1 into the PCBC/SOC (subject to options). The next quarter will also be crucial in our negotiations with the National team regarding finalizing the capital envelop.

## 12 Conclusion

12.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 1 2021/22.

## 13 Recommendations

13.1 The SCC is requested to:

- Note the progress undertaken in Q1.
- Note the development of the products to support business case development (section 5).

**Rebecca Malin**
**Programme Director**
**July 2021**

**Jerry Hawker**
**Programme SRO**

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9th September 2021** |
| **Title of paper** | **Lancashire and South Cumbria Medicines Management Group (LSCMMG) Commissioning Policy Positions – July 2021** |
| **Presented by** | Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU |
| **Author** | Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU |
| **Agenda item** | **10** a |
| **Confidential** | No |

| **Purpose of the paper** |
|---|
| For decision |
| **Executive summary** |
| The Lancashire and South Cumbria Medicines Management Group (LSCMMG) has developed recommendations for medicine reviews, medicine pathway, medicine policy and the implementation of NICE technology appraisals for adoption across Lancashire and South Cumbria. |
| **Recommendations** |
| That the SCC ratify the collaborative LSCMMG recommendations on the following:<br>- *Hydrocortisone Granules in Capsules for Opening (Alkindi®) as Replacement Therapy of Adrenal Insufficiency in Infants, Children and Adolescents (< 18 Years Old)*<br>- *Sodium Oxybate for the treatment of narcolepsy with cataplexy in adults*<br>- *Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication*<br>- *NICE Technology Appraisals (June 2021).* |
| **Governance and reporting** (list other forums that have discussed this paper) |

| **Meeting** | **Date** | **Outcomes** |
|---|---|---|
| | | |

| **Conflicts of interest identified** |
|---|
| |

| **Implications** | | | | |
|---|---|---|---|---|
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | | |
| Equality impact assessment completed | | ✓ | | |

| | | | | |
|---|---|---|---|---|
| Privacy impact assessment completed | | | | |
| Financial impact assessment completed | | | | |
| Associated risks | ✓ | | | |
| Are associated risks detailed on the ICS Risk Register? | | | | |

| | |
|---|---|
| Report authorised by: | |

Lancashire and South Cumbria
Health and Care Partnership

**Lancashire and South Cumbria Medicines Management Group (LSCMMG)**
**Commissioning Policy Positions**

**July 2021**

## 1. INTRODUCTION

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

- *Hydrocortisone Granules in Capsules for Opening (Alkindi®) as Replacement Therapy of Adrenal Insufficiency in Infants, Children and Adolescents (< 18 Years Old)*
- *Sodium Oxybate for the treatment of narcolepsy with cataplexy in adults*
- *Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication*
- *NICE Technology Appraisals (June 2021).*

## 2. DEVELOPMENT PROCESS

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

2.2 The review process includes the following key steps:

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

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

- *Hydrocortisone Granules in Capsules for Opening (Alkindi®) as Replacement Therapy of Adrenal Insufficiency in Infants, Children and Adolescents (< 18 Years Old)*
  *Alkindi New Medicine Assessment SCC.docx*

- *Sodium Oxybate for the Treatment of Narcolepsy with Cataplexy in Adults*

  *Sodium Oxybate SCC.docx*

- *Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for Symptom Improvement in Adult Patients with Moderate to Severe Spasticity due to Multiple Sclerosis (MS) who have not Responded Adequately to Other Anti-Spasticity Medication*

  *Sativex New Medicine Assessment SCC.docx*

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

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

***N/A***

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

***Hydrocortisone Granules in Capsules for Opening (Alkindi®) as Replacement Therapy of Adrenal Insufficiency in Infants, Children and Adolescents (< 18 Years Old)***

*4.1* Hydrocortisone granules in capsules for opening (Alkindi®) as replacement therapy of adrenal insufficiency in infants, children, and adolescents (< 18 Years Old) was prioritised for review by the LSCMMG following a request by East Lancashire CCG.

4.2 The LSCMMG agreed an AMBER0 RAG rating for the treatment of infants and children (birth to < 18 years) with adrenal insufficiency receiving divided doses of < 5 mg for whom hydrocortisone must otherwise be individually prepared by manipulation such as by compounding (or crushing) or by production of special solutions in order to produce age-appropriate doses, or hydrocortisone given as off-label buccal tablets.

4.3 Prescribing of hydrocortisone granules may therefore be continued following initiation or recommendation by a specialist. The dose of hydrocortisone and the patient's clinical condition should have been stabilised and reviewed prior to prescribing responsibility passing to primary care clinicians.

4.4 The potential cost burden to the Lancashire and South Cumbria health economy is not expected to be significant (£21,385 to £39,984).

***Sodium Oxybate for the Treatment of Narcolepsy with Cataplexy in Adults***

4.5 Sodium oxybate for the treatment of narcolepsy with cataplexy in adults was prioritised for review by the LSCMMG following a request by Greater Preston, Chorley/South Ribble CCGs.

4.6 LSCMMG was asked to review the current Black RAG rating for sodium oxybate when used in adults (≥19 years) for the treatment of narcolepsy with cataplexy. There are inconsistencies across England regarding access to sodium oxybate when a child transitions to adult services, the former having funding arrangements in place with NHS England allowing access to the drug.

4.7 The LSCMMG agreed usage of Sodium oxybate as a last line treatment therapy in hospital or specialist settings only, altering the Black RAG position (not recommended in LSC) to a Red RAG rating. The recommendation was contingent on 3 monthly reviews being undertaken, and the clarification of the supply route by service providers. The group advised that supply should be monitored using Blueteq to ensure appropriate supply.

4.8 Based on NICE population estimates, it can be estimated that approximately 67 patients in Lancashire and South Cumbria may be eligible for treatment with sodium oxybate. 30 days' supply at maximum dose costs £1,080 therefore approval of use in adults could cost up to £880,380 per year in the region if all eligible patients were treated with the drug. Based on the number of previous IFRs received, the uptake is expected to be significantly lower than this estimate.

***Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for Symptom Improvement in Adult Patients with Moderate to Severe Spasticity due to Multiple Sclerosis (MS) who have not Responded Adequately to other Anti-Spasticity Medication***

4.9 Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication was prioritised for review by the LSCMMG following discussions on a proposed shared care document for the drug. The New Medicines Assessment was requested to inform a RAG rating for the drug and the appropriateness of a shared care document.

4.10 LSCMMG agreed to an Amber 0 RAG rating. Prescribing may be continued in primary care following specialist initiation/recommendation with ongoing prescribing guidance to be developed. The LSCMMG also advised that costs should be captured and monitored for those drugs which are not within current prescribing budgets.

4.11 The recommendation is expected to be cost neutral to the Lancashire and South Cumbria health economy as cost are expected to be transferred from specialist provider services to primary care.

***NICE Technology Appraisals (June 2021).***

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

4.13 Two CCG commissioned NICE TAs were identified: **Budesonide orodispersible tablet** for inducing remission of eosinophilic oesophagitis (TA708); and **guselkumab** for treating active psoriatic arthritis after inadequate response to DMARDs (TA711).

4.14 TA guidance recommendations for **budesonide orodispersible tablets** and **guselkumab** are not expected to create significant costs or capacity issues in the Lancashire and South Cumbria health economy.

4.14..1 NICE do not expect this TA guidance for **budesonide orodispersible tablets** to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the overall incremental cost of treatment is low and eosinophilic esophagitis is a rare condition affecting around 13,000 people in England.

4.14..2 NICE do not expect this TA guidance for **guselkumab** to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option and is available at a similar price to the current treatment options.

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

***N/A***

## 6. CONCLUSION

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

- *Hydrocortisone Granules in Capsules for Opening (Alkindi®) as Replacement Therapy of Adrenal Insufficiency in Infants, Children and Adolescents (< 18 Years Old)*
- *Sodium Oxybate for the treatment of narcolepsy with cataplexy in adults*
- *Delta-9-Tetrahydrocannabinol (THC) and Cannabidiol (CBD) (Sativex®) for symptom improvement in adult patients with moderate to severe spasticity due to multiple sclerosis (MS) who have not responded adequately to other anti-spasticity medication*
- *NICE Technology Appraisals (June 2021).*

Brent Horrell, Head of Medicines Commissioning,

NHS Midlands and Lancashire CSU

Lancashire and South Cumbria
Health and Care Partnership

**Strategic Commissioning Committee**

| | |
|---|---|
| **Date of meeting** | 9 September 2021 |
| **Title of paper** | Development of Lancashire & South Cumbria Clinical Commissioning Policies – **Dilatation and Curettage Policy (D&C)** |
| **Presented by** | Brent Horrell |
| **Author** | **Julie Hotchkiss FFPH**, Consultant in Public Health, Midlands & Lancashire Commissioning Support Unit |
| **Agenda item** | 10 b |
| **Confidential** | No |

## Purpose of the paper

To inform the SCC of the outcome of the review of the policy for **Dilatation and Curettage (D&C)** undertaken by the L&SC CPDIG and to assure the SCC of the process taken.

## Executive summary

The existing Policy for Dilatation and Curettage which was previously ratified in March 2018 became due for review in March 2021.

No new indications for the use of dilatation and curettage have been identified.

New NICE Guidance was published in May 2021 on the management of Heavy Menstrual Bleeding[1]. It has not amended the original recommendation in the 2007 guidance[2] that dilatation and curettage alone should be used as a diagnostic tool, nor the direction that dilatation and curettage should not be offered as a treatment option.

The first round of Evidence-Based Interventions guidance[3] initially published in November 2018, included 1B - Dilatation & curettage for heavy menstrual bleeding as a Category 1 procedure, i.e., not to be done at all, which was the same as the LSC policy position.

There is no requirement change to the policy position, that dilatation and curettage is commissioned for evacuation of retained productions of conception, but not for Heavy Menstrual Bleeding.

Activity reports for listed EBI procedures can be obtained from the national EBI Dashboard. The baseline year for EBI1 was 2017/18 recorded 12 procedures performed within the L&SC footprint.
Reporting shows that activity has been reducing gradually as the Policy is adhered to.

There is a move to make all policy titles start with the name of the condition or procedure to make it easier for users to find the document, therefore the title of this policy would be "Dilatation and Curettage (D&C) Policy".

## Recommendations

That the SCC:

- Accept that the Policy does not require any revision to the policy position, and that no further clinical or public engagement is required.

- Agree to change the title to Dilatation and Curettage (D&C) Policy.

| **Governance and reporting** (list other forums that have discussed this paper) | | |
|---|---|---|
| **Meeting** | **Date** | **Outcomes** |
| CPDIG | 22/07/2021 | Approved and recommended for submission to SCC |

| **Conflicts of interest identified** |
|---|
| None |

| **Implications** | | | | |
|---|---|---|---|---|
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | X | |
| Equality impact assessment completed | X | | | As part of the original policy development in 2018. |
| Privacy impact assessment completed | | | X | |
| Financial impact assessment completed | | | X | |
| Associated risks | | | None | |
| Are associated risks detailed on the ICS Risk Register? | | | X | |

| Report authorised by: | Brent Horrell |
|---|---|

Lancashire and South Cumbria
Health and Care Partnership

**Lancashire Clinical Commissioning Groups (CCGs)**

**Policies for the Commissioning of Healthcare**

| ~~Policy for Dilatation and Curettage (D&C)~~<br><br>Dilatation and Curettage (D&C) Policy | | |
|---|---|---|
| | **Version Number:** | **Changes Made:** |
| Version of July 2021 | | Word order of title changed. |
| Version of: 16.03.2018 | V1.1 | OPCS/ICD codes added. |
| Version of: March 2018 | V1 | Ratified policy agreed by Healthier Lancashire and South Cumbria's Joint Committee of Clinical Commissioning Groups |

~~Policy for Dilatation and Curettage (D&C)~~
Dilatation and Curettage (D&C) Policy

| | |
|---|---|
| | 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 polices in that suite. |
| | |
| **1** | **Policy Criteria** |
| | |
| **1.1** | The CCG will commission Dilatation and Curettage (D&C) in the following circumstance:<br><br>- For patients requiring evacuation of retained products of conception (ERPC). |
| | |
| **1.2** | The CCG will not commission Dilatation and Curettage (D&C) in the following circumstances:<br><br>- As a diagnostic tool for Heavy Menstrual Bleeding (HMB).<br>- As a therapeutic treatment for HMB. |
| | |
| **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** | Dilatation and curettage (D&C) is a procedure performed under general anaesthetic in which the lining of the uterus (the endometrium) is biopsied (diagnostic D&C) or removed (therapeutic D&C) by scraping with a sharp metal instrument (curettage). |
| | |
| **2.3** | The scope of this policy includes requests for Dilatation and curettage (D&C) for patients referred with:<br><br>• Heavy Menstrual Bleeding (Menorrhagia)<br>• Evacuation of retained products of conception (ERPC) |
| | |
| **2.4** | The CCG recognises that a patient may have certain features, such as:<br><br>• Having Heavy Menstrual Bleeding ~~(HMB)~~<br>• Wishing to have a service provided for Heavy Menstrual Bleeding<br>• Being advised that they are clinically suitable for Dilatation and Curettage ~~(D&C)~~ and<br>• Be distressed by Heavy Menstrual Bleeding and by the fact that that they may not meet the criteria specified in this commissioning policy.<br><br>Such features place the patient within the group to whom this policy applies and do not make them exceptions to it. |
| | |
| **2.5** | For the purpose of this policy the CCG defines Heavy Menstrual Bleeding (HMB) (Menorrhagia) as excessive menstrual blood loss which interferes with the woman's physical, emotional, social and material quality of life, and which can occur alone or in combination with other symptoms[1]. ~~Current studies estimate that between 4% and 51.6% of women experience HMB.~~[1] ~~NICE guidelines indicate that there is limited epidemiological data available on women presenting with HMB in primary care.~~[2] |
| | |
| **2.6** | NICE Clinical Guideline (NG88) 'Heavy menstrual bleeding: assessment and management'[1] recommends the following:<br><br>• Dilatation and curettage alone should not be used as a diagnostic tool for HMB.<br>• Dilatation and curettage should not be used as a therapeutic treatment for HMB.<br><br>~~There is limited evidence on the effectiveness of D&C for the treatment of HMB. NICE (2007) identified one observational study that showed that any effectiveness was temporary.~~[3]<br>D&C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective[2]. |

| | |
|---|---|
| | |
| **3** | **Appropriate Healthcare** |
| | |
| **3.1** | This policy relies on the criterion of appropriateness in that the CCG considers that other ways of managing HMB are more appropriate for commissioning than D&C.<br><br>This is in line with NICE guideline CG44 (2007) which recommends that D&C should no longer be used as either a diagnostic or therapeutic tool for patients with HMB.[2] |
| | |
| **4** | **Effective Healthcare** |
| | |
| **4.1** | The CCG considers that Dilatation and Curettage ~~(D&C)~~ is not effective alone as a diagnostic tool or as a therapeutic treatment for Heavy Menstrual Bleeding.<br><br>This is in line with NICE Guideline NG88[1]. |
| | |
| **4.2** | The CCG considers that Dilatation and Curettage ~~(D&C)~~ is an effective procedure for Evacuation of Retained Products on Conception (ERPC). |
| | |
| **5** | **Cost Effectiveness** |
| | |
| **5.1** | The CCG does not call into question the cost effectiveness of Dilatation and Curettage ~~(D&C)~~ and therefore this policy does not rely on the Principles of Cost-Effectiveness.<br><br>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~~ be cost-effective in this patient before confirming a decision to provide funding. |
| | |
| **6** | **Ethics** |
| | |
| **6.1** | The CCG does not call into question the ethics of Dilatation and Curettage ~~(D&C)~~ and therefore this policy does not rely on the Principle of Ethics.<br><br>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. |
| | |
| **7** | **Affordability** |
| | |
| **7.1** | The CCG does not into call into question the affordability of Dilatation and Curettage (D&C) 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. |
| | |
| **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:<br>• 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.<br>• 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. National Collaborating Centre for Women's and Children's Health (2007) Heavy menstrual bleeding. Clinical Guideline~~<br><br>1. Heavy menstrual bleeding: assessment and management. NICE guideline [NG88] Published: 14 March 2018 Last updated: 24 May 2021. https://www.nice.org.uk/guidance/ng88<br>2. Evidence-Based Interventions: Guidance for CCGs v2. First published: 28 November 2018 Updated: 11 January 2019. NHS England Medical Directorate and Strategy and Innovation Directorate. NHS England Publications Gateway Reference: 08659<br><br>~~2. NICE (2007) Heavy menstrual bleeding: assessment and management https://www.nice.org.uk/guidance/cg44~~ |

| | |
|---|---|
| | 3. ~~National Collaborating Centre for Womens Health (2007) Heavy Menstrual Bleeding. Evidence Tables. https://www.nice.org.uk/guidance/cg44/evidence/evidence-tables-pdf-195071294~~ |

*Date of adoption:* *08.03.2018, will be September 2021*
*Date for review:* *08.03.2021, will be September 2021*

| **Appendix 1 - OPCS & ICD codes**<br>The codes applicable to this policy are: | |
|---|---|
| **OPCS codes** | **ICD codes** |
| Q101, Q103, Q108, Q109 | N924, N925, N926, N920, N921, N922, O028, O029 |

Lancashire and South Cumbria
Health and Care Partnership

**Strategic Commissioning Committee**

| | |
|---|---|
| **Date of meeting** | 9 September 2021 |
| **Title of paper** | Development of Lancashire & South Cumbria Clinical Commissioning Policies – **Male Circumcision Policy.** |
| **Presented by** | Brent Horrell |
| **Author** | **Julie Hotchkiss FFPH**, Consultant in Public Health, Midlands & Lancashire Commissioning Support Unit |
| **Agenda item** | 10 b |
| **Confidential** | No |

**Purpose of the paper**

To inform the SCC of the outcome of the review of the policy for Male Circumcision undertaken by the L&SC CPDIG and to assure the SCC of the process taken.

**Executive summary**

The existing Policy for Male Circumcision was due to be reviewed in November 2020.

The current policy was originally drafted in September 2016 and after going through the development process was ratified in November 2017.

There have been no new indications for circumcision in males. NICE Guidance has not been updated and The Royal College of Surgeons guidance from 2013 (reference 4 in the Policy) has not been superseded. Therefore that no changes were necessary at this time.

There is no change to the ethical position that circumcision will not be funded for non-therapeutic purposes.

To make it easier for users to find the document, the title of this policy will become the "Male Circumcision Policy".

**Recommendations**

1.1 That the SCC:

- Agree that no revision, no clinical or public engagement is required
- Approve the process taken to develop the policy.
- Agree to change the title to Male Circumcision Policy.
- Ratify the Policy.

**Governance and reporting** (list other forums that have discussed this paper)

| Meeting | Date | Outcomes |
|---|---|---|
| CPDIG | 22/07/2021 | Approved and recommended for submission to SCC |

**Conflicts of interest identified**

None

| Implications | | | | |
|---|---|---|---|---|
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | X | |
| Equality impact assessment completed | X | | | Completed when the Policy was originally developed. |
| Privacy impact assessment completed | | | X | |
| Financial impact assessment completed | | | X | |
| Associated risks | | X | | |
| Are associated risks detailed on the ICS Risk Register? | | | X | |

| | |
|---|---|
| Report authorised by: | Brent Horrell |

| ~~Policy for Male Circumcision~~<br><br>Male Circumcision Policy | | |
|---|---|---|
| | **Version Number:** | **Changes Made:** |
| **Reviewed July 2021** | **1.2** | **Changed word order of title.**<br><br>**No change to content required.** |
| **Version of: December 2017** | **1.1** | **OPCS and ICD codes added to appendices** |
| **Version of: November 2017** | **1** | **Pan-Lancashire and South Cumbria ratified policy** |

**Lancashire and South Cumbria Clinical Commissioning Groups (CCGs)**

**Policies for the Commissioning of Healthcare**

# Male Circumcision 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 polices 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** | **Scope and definitions** |
| | |
| **2.1** | Circumcision is a surgical procedure with a range of medical indications. |
| | |
| **2.2** | The scope of this policy relates to requests for Male Circumcision. |
| | |
| **2.3** | The scope of this policy does not include Female circumcision which has no medical indication and is prohibited in law by the Female Genital Mutilation Act 2003 (Ref 1) and is the subject of multi-agency guidelines from the Department of Health (Ref 2). |
| | |

| | |
|---|---|
| **2.4** | The CCG recognises that a patient may:<br><br>• suffer from a condition for which male circumcision has been offered.<br>• wish to have a service provided for their condition,<br>• be advised that they are clinically suitable for the treatment, and<br>• be distressed by their condition, and by the fact that that this service is not normally commissioned by this Commissioning Organisation.<br><br>Such features place the patient within the group to whom this policy applies and do not make them exceptions to it. |
| | |
| **2.5** | For the purpose of this policy the CCG defines male circumcision as the surgical procedure to remove of all or part of the foreskin of the penis. |
| | |
| **3** | **Appropriate Healthcare** |
| | |
| **3.1** | The CCG considers that the purpose of circumcision is to prevent, diagnose and treat a medical condition and therefore, accords with the Principle of Appropriateness. |
| | |
| **4** | **Effective Healthcare** |
| | |

| | |
|---|---|
| **4.1** | If the CCG is satisfied by evidence in relation to a particular treatment or service that the probable effect on a population of patients is that the benefits of the treatment or service will substantially outweigh the harm done by the treatment or service, then the CCG regard the treatment or service as effective (Ref 4). |
| | |
| **4.2** | Male circumcision will be funded for therapeutic reasons only (as described in section 8). |
| | |
| **4.3** | The reported benefits of male circumcision, reduction of urinary tract and sexually transmitted infections and reduction of penile cancer risk are insufficient to justify its therapeutic use (Ref 3). |
| | |
| **5** | **Cost Effectiveness** |
| | |
| **5.1** | The CCG recognises that the outcome cost effectiveness of this treatment is within the threshold, and that the service satisfies the criterion of cost effectiveness. |
| | |
| **6** | **Ethics** |
| | |
| **6.1** | The Commissioning Organisation recognises that this service satisfies the criteria within the 'Ethical' component of the Principles for Commissioning Health and Health Care document. |
| | |

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| **7** | **Affordability** |
| | |
| **7.1** | The CCG recognises that this service satisfies the criteria within the 'Affordability' component of the Principles for Commissioning Health and Health Care document. |
| | |
| **8** | **Policy** |
| | |
| **8.1** | The CCG will commission male circumcision when one or more of the following criteria are satisfied (Ref 4): |
| **8.1.1** | Congenital abnormalities with functional impairment |
| **8.1.2** | Distal scarring of the preputial orifice |
| **8.1.3** | Painful erections secondary to a tight foreskin |
| **8.1.4** | Recurrent bouts of infection (Balanitis / Balanoposthitis) |
| **8.1.5** | Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepucial ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin). |
| **8.1.6** | Lichen sclerosus (balanitis xerotica obliterans) -chronic inflammation leading to a rigid fibrous foreskin. |
| **8.1.7** | Pain on intercourse secondary to a tight foreskin (Phimosis) |
| **8.1.8** | Traumatic injury |
| **8.1.9** | Potentially malignant lesions of the prepuce, or those causing diagnostic uncertainty. |
| **8.1.10** | Exceptionality has been demonstrated in accordance with section 9 below. |
| | |
| **8.2** | The CCG will not commission male circumcision for non-therapeutic purposes such as cultural, religious or cosmetic reasons (Ref 5) |
| | |
| **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. |
| | |
| **10** | **Force** |
| | |
| **10.1** | This policy remains in force until it is superseded by a revised policy. |
| | |
| **11.** | **References** |
| | |

1. Female Genital Mutilation Act 2003 http://www.legislation.gov.uk/ukpga/2003/31
2. Female Genital Mutilation: multi-agency practice guidelines. Department of Health, February 2011 https://www.gov.uk/government/publications/female-genital-mutilation-multi-agency-practice-guidelines
3. Siefried N, Muller M, Deeks J, Volmink J. Male circumcision for prevention of heterosexual acquisition of HIV in men. Cochrane Database of Systematic Reviews 2009, Issue 2. http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD003362/pdf_fs.html
4. Royal College of Surgeons Commissioning guide: Foreskin conditions (October 2013) http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/foreskinconditions
5. British Medical Association (2006), London. The law and ethics of male circumcision: guidance for doctors. J Med Ethics 2004; 30: 259-263 http://jme.bmj.com/content/30/3/259.full.pdf+html

**Date of adoption:** **02 November 2017, will be September 2021**
**Date for review:** **02 November 2020, will be September 2024**

## Appendix 1

**1.1 Codes**

The codes applicable to this policy are:

| OPCS codes | ICD codes |
|---|---|
| N303 | N47, L900, T00-T14, C600, L905, L910, N483 |

Lancashire and South Cumbria
Health and Care Partnership

**Strategic Commissioning Committee**

| | |
|---|---|
| **Date of meeting** | 9 September 2021 |
| **Title of paper** | Development of Lancashire & South Cumbria Clinical Commissioning Policies - **Policy for Carpal Tunnel Syndrome Policy.** |
| **Presented by** | **Brent Horrell**<br><br>Chair of Lancashire & South Cumbria CPDIG, and MLCSU Medicines Optimisation Lead |
| **Author** | **Julie Hotchkiss FFPH**, Consultant in Public Health, Midlands & Lancashire Commissioning Support Unit |
| **Agenda item** | 10 b |
| **Confidential** | No |

**Purpose of the paper**

To present the revised policy (V1.1) for the Treatment of Carpal Tunnel developed by the L&SC CPDIG and to assure the SCC of the process taken.

**Executive summary**

The existing Lancashire and South Cumbria LSC) policy was ratified by JCCCG on 5 September 2019.

A task and finish group from the Trauma and Orthopaedics Network has produced a new Carpal Tunnel Syndrome (CTS) pathway. This will become the national Getting It Right First Time (GIRFT) CTS Pathway. The revised Policy (Appendix1) accommodates the new CTS pathway.

As part of Elective Care Recovery Programme diagnostics are being reviewed. There is currently high demand for Neurophysiology. A provider-led group has reviewed when to use Nerve Conduction Studies to assess Carpal Tunnel Syndrome.

Both the EBI and LSC policies made reference to Nerve Conduction Studies, but in neither case were they a requirement.

The LSC Policy has been amended to reflect EBI Policy with the following additional criteria:

- The patient has severe progressive carpal tunnel syndrome, and the documented specialist opinion is that surgery is needed promptly to prevent irreversible median nerve/muscle damage" following local clinical engagement.
- In the case of patients with mild to moderate carpal tunnel for whom symptom onset occurred during pregnancy, the patient must be at least 12 weeks post-partum.

The criteria for surgical treatment have not changed, and patients will not be required to have Nerve Conduction Studies, therefore the patient journey should be improved with the new pathway. There should be a net benefit to patients.

The Final version of the CTS Pathway will be appended to the amended Carpal Tunnel Syndrome Surgery Policy.

Lancashire and South Cumbria
Health and Care Partnership

It is suggested that the title of the Policy become Carpal Tunnel Syndrome Surgery Policy rather than the existing Policy for Surgical Treatment of Carpal Tunnel Syndrome. The rationale for the change is to make it easier to find, particularly if listed alphabetically

**Recommendations**

That the SCC:

- Note the content of the revised policy.
- Approve the content of the revised policy.
- Approve the title of the revised policy.
- Approve the process taken to develop the policy.
- Agree that no further consultation should be undertaken.

**Governance and reporting** (list other forums that have discussed this paper)

| **Meeting** | **Date** | **Outcomes** |
|---|---|---|
| CPDIG | 22/07/2021 | Approved and recommended for submission to SCC |

**Conflicts of interest identified**

None

**Implications**

| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
|---|---|---|---|---|
| Quality impact assessment completed | | | x | |
| Equality impact assessment completed | x | | | Completed in 2018. |
| Privacy impact assessment completed | | | x | |
| Financial impact assessment completed | | | x | |
| Associated risks | | x | | |
| Are associated risks detailed on the ICS Risk Register? | | | x | |

| Report authorised by: | Brent Horrell |
|---|---|

| Carpal Tunnel Syndrome Surgery Policy | | |
|---|---|---|
| | **Version Number:** | **Changes Made:** |
| Version of July 2021 | 2.2 | After consideration of changes to the Carpal Tunnel Syndrome pathway the policy has been amended to require use of it. This included removal of reference to nerve conduction studies and neurophysiology and the insertion of standard anaesthetic approach. The word order of the title has been changed. |
| Version of: October 2019 | 2.1 | Ordering of section 1 re-ordered to provide further clarity. |
| Version of: September 2019 | 2.0 | Updated policy ratified by Healthier Lancashire and South Cumbria's Joint Committee of Clinical Commissioning Groups (JCCCGs). |
| Version of: December 2017 | 1.1 | OPCS and ICD codes added to appendices |
| Version of: November 2017 | 1.0 | Pan-Lancashire and South Cumbria ratified policy |

**Lancashire and South Cumbria Clinical Commissioning Groups (CCGs)**

**Policies for the Commissioning of Healthcare**

# Carpal Tunnel Syndrome Surgery Policy

| | **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 polices in that suite. |
| | |
| | This policy is based on the CCG's Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted). |
| | |
| **1** | **Policy** |

| | |
|---|---|
| **1.1** | To be eligible for the surgical release of the carpal tunnel patients must meet the requirements of section 1.2 below and:<br>a) The documented specialist opinion is that the likely benefit from surgery outweighs the risk of harm for the patient<br>**AND**<br>b) The patient must have followed the Carpal Tunnel Syndrome Pathway (see Appendix 1) |
| **1.2** | The CCG will commission the surgical release of carpal tunnel when ONE OR MORE of the following criteria are met: |
| **1.2.1** | The patient has sleep disturbance or limited ability to undertake activities of daily living due to symptom severity AND the patient's symptoms have not resolved despite 8 weeks of conservative treatment, including activity modification and either nocturnal wrist splinting or a single steroid injection (unless contraindicated) |
| | **OR** |
| **1.2.2** | There is permanent reduction in sensation in the median nerve distribution |
| | **OR** |
| **1.2.3** | There is muscle wasting or weakness of thenar abduction |
| | **OR** |
| **1.2.4** | The patient has severe progressive carpal tunnel syndrome and the documented specialist opinion is that surgery is needed promptly to prevent irreversible median nerve/muscle damage |
| | |
| **1.3** | In the case of patients with mild to moderate carpal tunnel for whom symptom onset occurred during pregnancy, the patient must be at least 12 weeks post-partum |
| | |
| **1.4** | The CCG recognises that the type of surgical procedure undertaken (endoscopic or open surgery) will depend both on clinical factors (including the presence of swelling over the carpal tunnel) and the experience of the surgeon. |
| | |
| **1.5** | Wide Awake Local Anaesthetic No Tourniquet (WALANT) should be the standard form of anaesthesia in the absence of patient specific factors |
| | |
| **2** | **Scope and definitions** |
| | |
| **2.1** | This policy relates to the surgical release of the carpal tunnel as a treatment for carpal tunnel syndrome.<br><br>Carpal tunnel syndrome (CTS) is a relatively common condition caused by compression of the median nerve within the carpal tunnel in the wrist. This can arise for a variety of reasons, including fluid retention, particularly in pregnancy. This gives rise to pain, numbness or tingling in the thumb, index and middle fingers. In severe cases it may cause nerve |

| | |
|---|---|
| | damage and weakness/wasting of the muscles of the hand, especially the thumb (thenar wasting). Patients often report their symptoms are worse at night and may disturb sleep.<br><br>Symptoms do not necessarily progressively worsen and, in up to a third of cases, will resolve without treatment or with simple self-care. Carpal tunnel syndrome in pregnancy often resolves within 12 weeks of delivery, but 50% of women have persisting symptoms at 1 year. Non-surgical treatments, such as steroid injections or wrist splints, are used to treat mild to moderate symptoms. Surgical release (decompression) of the carpal tunnel may be carried out if non-surgical approaches fail to relieve symptoms. |
| | |
| **2.2** | The scope of this policy includes requests for decompressing the carpal tunnel by either open or arthroscopic surgical techniques. |
| | |
| **2.3** | The CCG recognises that a patient may:<br><br>• suffer from carpal tunnel syndrome,<br>• wish to have a service provided for their condition,<br>• be advised that they are clinically suitable for surgical release of the carpal tunnel, and<br>• be distressed by their condition, and by the fact that they may not meet the criteria specified in this commissioning policy.<br>Such features place the patient within the group to whom this policy applies and do not make them exceptions to it. |
| | |
| **3** | **Appropriate Healthcare** |
| | |
| **3.1** | The CCG considers that the purpose of surgical release of the carpal tunnel is to improve the health of patients by reducing pain, discomfort and disability. |
| | |
| **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 CCG considers that there is some evidence for the effectiveness and cost effectiveness of non-surgical management options.<br><br>For some patients, a single local corticosteroid injection has been shown to be effective for short term symptomatic relief in mild to moderate cases, but evidence suggests repeat injections may not provide significant added clinical benefit [4]. |

| | |
|---|---|
| | For some patients, wrist splinting in the neutral position may alleviate the symptoms of carpal tunnel syndrome with few complications. One study in which patients were randomised to splinting or to surgery reported splinting provided symptom relief and avoided surgery for 37% of patients[5]. However, there is limited evidence on its effectiveness in comparison with other methods of conservative management or for the effectiveness of different designs or regimes of splint wearing[6]. |
| | |
| **4.2** | The CCG considers that there is sufficient evidence with which to draw firm conclusions regarding the effectiveness of surgical release of the carpal tunnel. |
| | |
| **4.3** | The CCG considers that surgical release of the carpal tunnel is more effective at relieving symptoms than splinting[1,2,3]. However, splinting can provide relief of symptoms, particularly overnight, for patients with mild to moderate carpal tunnel syndrome and is a relatively simple, low cost intervention[5]. |
| | |
| **4.4** | The CCG recognises that early surgery is likely to be the most effective treatment option if there is evidence of nerve compression or significant functional impairment[2]. |
| | |
| **4.5** | The CCG recognises that there is evidence of good outcomes and high levels of patient satisfaction following surgery. |
| | |
| **4.6** | Major complications of surgical release are rare. Complications such as, persistent symptoms, reduced grip strength, neurovascular injury and wound complications have been reported - usually in less than 1% of surgical patients. However, scar tenderness and pillar pain are reported more frequently and may persist for up to two years[7].<br><br>The CCG therefore considers that, in circumstances other than those described in section 1 of the policy, the potential risks associated with surgery outweigh the potential benefits. |
| | |
| **5** | **Cost Effectiveness** |
| | |
| **5.1** | The CCG considers that in mild to moderate cases, management of carpal tunnel syndrome by conservative methods (which may include splinting, activity modification and, if appropriate, a single local corticosteroid injection), before considering surgery, represents the most cost-effective treatment strategy. This policy therefore relies on the principle of cost-effectiveness by requiring conservative management to be used before considering surgery. |
| | |
| **6** | **Ethics** |
| | |
| **6.1** | The CCG considers that the surgical release of the carpal tunnel meets |

| | |
|---|---|
| | the criterion for ethical healthcare delivery and therefore this policy does not rely on the Principle of Ethics. |
| | |
| **7** | **Affordability** |
| | |
| **7.1** | The CCG does not call into question the affordability of surgical carpal tunnel release and therefore this policy does not rely on the Principle of Affordability. |
| | |
| **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:<br>• 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.<br>• 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. NHS England (2018). Evidence Based Interventions: Guidance to CCGs https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-statutory-guidance-v2.pdf<br>2. American Academy of Orthopaedic Surgeons (AAOS). Clinical practice guideline on the treatment of carpal tunnel syndrome. Rosemont (IL): American Academy of Orthopaedic Surgeons (AAOS); 2008 Sep.<br>3. Shi Q, MacDermid JC. (2011) Is surgical intervention more effective than non surgical treatment for carpal tunnel syndrome? A |

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8. .

**Date of adoption:** **05 September 2019 will be September/ October 2021**
**Date for review:** **05 September 2022 will be September/ October 2024**

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9 September 2021** |
| **Title of paper** | **Update Report from the CCG Transition Board** |
| **Presented by** | **Andrew Bennett, Executive Director of Commissioning, LSC ICS** |
| **Author** | **Dawn Haworth, Senior Programme Manager** |
| **Agenda item** | **11** |
| **Confidential** | **No** |

| **Purpose of the paper** |
|---|
| The purpose of this report is to provide the Strategic Commissioning Committee with an update on the work of the CCG Transition Board in relation to its key areas of work within the scope of the Lancashire and South Cumbria Integrated Care System Reform Programme. |

| **Executive summary** |
|---|
| The purpose of the CCG Transition Board is to co-ordinate the planning and implementation of transitional commissioning arrangements for 2021/22 and the transactional arrangements to close down eight CCGs by June 2022.<br><br>At the August meeting of the CCG Transition Board the agenda focussed on the following areas:<br>1. CCG Close down process<br>2. Commissioning Functions Update<br>3. HR and OD Workstream Update<br>4. Communications & Engagement Update<br><br>The attached highlight report summarises the progress against these items, as reported at the Transition Board. Note that areas highlighted in yellow indicate those where national guidance is awaited.<br><br>There are no risks for escalation to the Strategic Commissioning Committee at this stage. |

| **Recommendations** |
|---|
| Strategic Commissioning Committee are asked to<br>• **Note** the report |

| **Governance and reporting** (list other forums that have discussed this paper) | | |
|---|---|---|
| **Meeting** | **Date** | **Outcomes** |
| | | |

| **Conflicts of interest identified** |
|---|
| All members of the CCG Transition Board are affected by the System Reform Programme |

| Implications | | | | |
|---|---|---|---|---|
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | N/A | |
| Equality impact assessment completed | | | N/A | |
| Privacy impact assessment completed | | | N/A | |
| Financial impact assessment completed | | | N/A | |
| Associated risks | | | N/A | |
| Are associated risks detailed on the ICS Risk Register? | | | N/A | A Risk and Issues Log for the System Reform Programme has been established |

# L&SC ICS
## CCG Transition Board
## Monthly Highlight Report

Lancashire and South Cumbria Health and Care Partnership

### Workstream Summary

| Worksream | ID No | Scope, Objectives, Deliverables | Workstream Leads | Programme Status |
|---|---|---|---|---|
| Commissioning Reform | C | *Plan and implement the transitional commissioning arrangements for 2021/22 and the transactional arrangements to close down eight CCGs by June 2022* | Chair = Roy Fisher | Programme Minor Delays |
| Workforce & Organisational Development | E | *Closedown and disestablishment of 8 x CCGs across LSC, including safe and effective transfer of affected workforce to new NHS L&SC organisation* | Exec Lead = Sarah Sheppard | Programme On Track |
| Communications & Engagement | G | *Ensuring effective communication and engagement with all stakeholders, including those staff who are affected by the transition of activities associated with the closedown of CCGs* | Exec Lead = Andrew Bennett | Programme On Track |

### Commissioning Reform - Objectives

| ID No | Scope, Objectives, Deliverables | Workstream Leads | Current Activity | Finish | Current Status |
|---|---|---|---|---|---|
| **C01** | **Define transitional Commissioning governance arrangements** | Andrew Bennett | | 31/03/22 | Complete |
| **C02** | **Develop and agree transitional functional allocation of resources** | Andrew Bennett | Three key pieces of work are underway:<br>1. Strategic commissioning functions<br>A timeline and approach has been agreed drawing on learning from the accelerator groups. Proposals to be concluded by end of Sept 21.<br>2. Corporate functions<br>Functions have been mapped against those set out in the ICS Design Framework and work is underway to identify senior SME leads who will determine arrangements for their transition and/or transformation.<br>3. 'Accelerator' areas<br>Proposals in final stages of development.<br><br>Paper going to CCG Transition Board in August 2021 which proposes transition to new operating model to take place from September 2021 for accelerators and during Q3 for other functions. This proposal is supported by Transitonal Ways of Working Principles created by HR team. | 29/06/22 | In Progress but with minor issues/delays |
| **C03** | **Agree plan for transactional close-down of CCGs** | Denis Gizzi<br>Helen Curtis | MIAA will provide project support to close down and have been asked via the Exec Group to produce an initial project plan for closedown, the next meeting of the Exec Group is on 16th July. Further national guidance on closedown is still awaited. | 29/06/22 | In Progress but with minor issues/delays |

### Communications & Engagement - Objectives

| ID No | Scope, Objectives, Deliverables | Workstream Leads | Current Activity | Finish | Current Status |
|---|---|---|---|---|---|
| **G01** | **Strategic narrative documents and toolkits for use by senior leaders to set out language and messaging and to shape communications, engagement, involvement with all stakeholders** | Neil Greaves<br>Hannah Brooks | Senior leadership toolkit completed and shared. Delivering Integrated Care Summary Document complete and shared. Terminology in ICP common narrative updated and shared week commencing 19 July. Work just begun on provider collaborative narrative with an aim to be shared by the end of Q3. Communications and engagement review panel being established to quality check and challenge communications and engagement approaches and materials relating to the system developments. | 31/03/22 | In Progress but with minor issues/delays |
| **G02** | **Co ordinating communications and engagement plans for all stakeholders at system and place levels, including those staff who are affected by the transition of activities associated with the closedown of CCGs** | Neil Greaves<br>Hannah Brooks | First engagement meeting on 15 June with ICP engagement leads and ICP programme directors. Outputs of the session include an approach to align ICP engagement plans with consistent timing, approach communications objectives and evaluation methods. Regular meetings between ICP Programme Directors and ICP Communications and Engagement leads in the process of being established. | 31/03/22 | In Progress no issues/delays |
| **G03** | **Oversight, planning and direction to support communications and engagement of system reform across LSC and consistent key messages for staff, providers, partners and public** | Neil Greaves<br>Hannah Brooks | Monthly staff briefings established (first one sent 14.05.21) for staff affected by transition of activities from closedown of CCGs and regular wider stakeholder briefings established (first one sent 28.05.21). Bi-monthly colleague briefings established in July. Regular communications and engagement network meetings to ensure all partners up to date with key messages and language to be used to describe Lancashire and South Cumbria system. First set of MP letters from ICS Chair and Chief Officer produced with updates about system reform (shared 12.07.21). | 31/03/22 | In Progress no issues/delays |

### Workforce - Objectives

| ID No | Scope, Objectives, Deliverables | Workstream Leads | Current Activity | Finish | Current Status |
|---|---|---|---|---|---|
| **E01** | **Develop critical path and key deliverables** | Cath Owen | | 14/05/21 | Complete |
| **E02** | **Development of overarching principles and guidance (local)** | Cath Owen | | 14/05/21 | Complete |
| **E03** | **CCG closedown/disestablishment (inc. transfer of workforce and relevant HR systems)** | Cath Owen | Awaiting national HR technical guidance in respect of formal transfer of staff and other key HR priorities - due mid-August, however this is understood to be either TUPE or a nationally supported Transfer Order. Membership of CCG closedown group (managed by Helen Curtis) and have developed key actions that will be required, pending guidance (linked to critical path above)<br><br>Close down activities are being planned and reported via the closedown group. | 31/03/22 | In Progress no issues/delays |
| **E04** | **Recruitment into NHS LSC senior leadership team and associated governance arrangements** | Cath Owen | Chair confirmed and authorised by NHSEI subject to legislation being approved by parliament. CEO appointment likely to take place during September. | 31/03/22 | In Progress no issues/delays |
| | | | OD support programme offer made available by NHSEI for AOs and | | |

| | | | | | |
|---|---|---|---|---|---|
| **E05** | **Organisational development** | Cath Owen | Senior Directors within CCG. OD support programme for all staff to be developed and made available by end of Q3. | 31/03/22 | In Progress no issues/delays |
| **E06** | **Staff engagement and consultation** | Cath Owen | Several communciations now issued. 2 x all-staff brieifng sessions taken place. Monthly Staff Side engaged and being regulalry updated via establshed formal mechanisms. NW Social Partnership Forum updated on progress. | 31/03/22 | In Progress no issues/delays |

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9 September 2021** |
| **Title of paper** | **Collaborative Commissioning Advisory Group (CCAG) update** |
| **Presented by** | **Peter Tinson** |
| **Author** | **Jill Truby Committee Secretary** |
| **Agenda item** | **12** |
| **Confidential** | **No** |

| **Purpose of the paper** |
|---|
| To provide the Strategic Commissioning Committee with a summary of the most recent business discussed at the Collaborative Commissioning Advisory Group meeting held on 13 July 2021. |
| **Executive summary** |
| The CCAG met on 13 July 2021 and received the following reports:<br>• Minutes of the Primary Care Programme Board<br>• Primary Care<br>• Elective Care<br>• NW Women's and Children's transformation programme<br>• Future potential funding requirements for SEND for the ICS<br>• Specialist Nursing Services<br>• Population Health Operating Model and Development Programme |
| **Recommendations** |
| The SCC is asked to note the report. |

**Governance and reporting** (list other forums that have discussed this paper)

| **Meeting** | **Date** | **Outcomes** |
|---|---|---|
| | | |

| **Conflicts of interest identified** |
|---|
| |

| **Implications** | | | | |
|---|---|---|---|---|
| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
| Quality impact assessment completed | | | N/A | |
| Equality impact assessment completed | | | N/A | |
| Privacy impact assessment completed | | | N/A | |
| Financial impact assessment completed | | | N/A | |
| Associated risks | | | | |

| | | | | |
|---|---|---|---|---|
| Are associated risks detailed on the ICS Risk Register? | | | N/A | |
| Report authorised by: | Peter Tinson | | | |

## Collaborative Commissioning Advisory Group (CCAG) update

### 1. Introduction

1.1 The CCAG met on 13 July 2021 and received the following reports:

- Minutes of the Primary Care Programme Board
- Primary Care
- Elective Care
- NW Women's and Children's transformation programme
- Future potential funding requirements for SEND for the ICS
- Specialist Nursing Services
- Population Health Operating Model and Development Programme

### 2. Reports

2.1 Minutes of the Primary Care Programme Board

The minutes of the extra ordinary meeting of the Primary Care Programme Board held on 1 June 2021 were presented for noting.

The CCAG noted the minutes

2.3 Primary Care

Members received a presentation on Primary Care Transformation Work Programme Update.

Highlights of the presentation included:

- Three Primary Care Work Programmes
- Primary Care Reform Work Programme
- Reform Work Programme - Timeline and Sign off
- Primary Care Collaborative Work Stream
- Collaborative Work Programme - Timeline and Sign off
- Primary Care COVID -19 Work Programme
- Next Steps:
  - Engagement to take place with other transformation programmes to develop detailed plans regarding shared collaborative items
  - Integrating primary and community working arrangements
  - Attempting to release capacity from the primary care COVID-19 work programme to the primary care reform and collaborative programmes
  - With rising COVID-19 prevalence and increased primary care pressures there will be the need to review the impact on primary care, flex recourses and adjust timescales where required
  - This dependent upon distributed leadership and support arrangements

The CCAG noted the update

2.4 Elective Care

The planned care workstream was established in 2018 through the Commissioning Reform exercise, to help support development of the emerging ICS. The Planned Care group operates under a distributed leadership model with input from each L&SC CCG, NHSE/I and system partners acting collaboratively.

The presentation delivered to members summarised the key actions currently being delivered and set out an aspiration for the role of the team moving forward. This is supported by several proposed actions that will empower the team to deliver its priorities.

Members considered this was a refreshing way of working with lots of opportunity to join primary and community care with connection into provider and clinicians. Great opportunity to bring together strategic commissioning although it was acknowledged that West Lancashire provider services was slightly different.

The CCAG:

- Noted the content of the paper and the Planned Care team's contribution to COVID recovery including the aspirations of the Planned Care group and its role in the future system
- Supported the proposed actions and ongoing role as an integral part of system recovery and transformation

2.5 NW Women's and Children's transformation programme

Members received a presentation on the North West Women's and Children's transformation programme. Highlights of the presentation included:

- Programme background
- Project overview which includes neonatal, paediatric surgery and critical care and paediatric cancer reviews
- Potential timeline with case for change and gateway 1 before April 22
- Quarterly Formal Programme Board Meetings:
- Attendees
    - NW Programme Team
    - NW ODN network Directors and Clinical Leads
    - ICS Acute provider Collaborative Leads
    - ICS Women's and Children's Leads
- Triumvirate approach at all stages and in all activities, with functional expertise to lead specific activities

Members were informed that this was a programme to improve services for women, young people, and children in the North West by ensuring sustainability, reflecting best clinical practice, and delivering the best outcomes for patients and their families.

A small amount of funding was available at regional level with posts that will be aligned to the ICS. The next stages are to develop a case for change, clinical senate to set up independent panel and a further 12 months to consultation. 5yr plan to implementation.

The CCAG noted the transformation programme

2.6 Future potential funding requirements for SEND for the ICS/Specialist Nursing Services

In March 2021 the Collaborative Commissioning Board asked for a paper that provided an indication of the benefits of investing in children's services for SEND along with an indication of the services that may require funding due to the SEND improvements. The paper provided CCAG with clarity regarding the principles that underpin the ongoing SEND improvements for health, with a need to focus on early action to increase self-management for families with children or young people with SEND; integration and collaboration between services and sectors; a culture shift towards outcomes-based service redesign; and addressing health inequalities.

The paper also provided an indication of the potential long-term impacts of investing in SEND services, using research that has been carried out in this area. It goes on to illustrate the issues with regards to measuring impact, with an indication of the areas that CCAG needs to understand may have ongoing or future financial implications. Finally, the paper suggested a roadmap for the future of SEND.

Members were informed that a monitoring visit was expected end of September. The team was working very hard to deliver this complex programme which included principles, future direction, and funding.

It was emphasised that financial conversations would be required in the context of H2 and broader challenges.

It was agreed that discussion was required regarding as to how funding prioritisation decisions will be made at an ICS level. This needed to be coupled with a challenge for bringing other costs down including at the Provider Collaboration Board.

It was agreed that this programme ticks all the boxes for investment going forward. It was suggested that the years be split into two in relative to the financial framework.

The CCAG:

- Noted the work that is on-going in this area, the principles underpinning SEND improvements across the ICS, the long-term benefits to adult services and the position in relation to measurement.
- Supported the funding request to go forward to the Strategic Commissioning Committee for:
  Second part of the ASD waiting list management
  Specialist community nursing (as outlined in the supplementary paper) including Special School Nursing and Bladder and Bowel services as previous presented to CCB.
- Noted the range of services that are expected to have future financial implications
- Committed to supporting the ongoing programme management of SEND and note the Lead Director will work to agree a short-term and medium-term configuration of the support required.
- Recommended to Strategic Commissioning Committee (SCC) that they approve the investment requested and develop the workforce programme which will support the implementation of the proposed L&SC specialist children's community nursing model offer, phased over four years.

2.8 Population Health Operating Model and Development Programme

The paper sets out the initial draft proposal for the population health operating model and development programme in response to Lancashire and South Cumbria Health and Care Partnership's commitment to invest on a recurrent basis in population health developments across the system. It provides the following:

- A summary of the proposal that includes:
  - The vision, goals, and approach.
  - Clear context and key challenges.
  - Overview of the operating model for Lancashire and South Cumbria through the six strands of enabling capabilities.
  - High-level overview of impact, interdependencies, funding requirements and next steps.

Following engagement through each of the aforementioned process, feedback will be incorporated into the model and finalised for presentation through required governance forums for approval.

The CCAG supported the principles and recommended to SSC.

## 3. Conclusion

3.1 This paper is a summary of the CCAG meeting held on 13 July 2021.

## 4. Recommendations

4.1 The SCC is requested to:

1. Note the contents of the report

Jill Truby
31 August 2021

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **9 September 2021** |
| **Title of paper** | **Report from the ICS Quality and Performance Sub-Committee** |
| **Presented by** | **Kathryn Lord, Director of Quality and Chief Nurse, Pennine Lancashire CCGs** |
| **Author** | **Una Atton, Executive Support Officer, Pennine Lancashire CCGs** |
| **Agenda item** | **13** |
| **Confidential** | **No** |

| **Purpose of the paper** |
|---|
| This report is to provide the Strategic Commissioning Committee (SCC) with the most recent business discussed at the ICS Quality and Performance Sub-Committee meeting of 2 September 2021 including risks which have been identified. |
| **Executive summary** |
| The key points to be brought to the attention of the SCC are issues noted by the Quality and Performance Sub-Committee on the following areas:<br>• Care Home Sector – Staffing Risk<br>• Urgent Care – Provider Collaboration Action Plan<br>• Development of Planning towards Population Health Management<br>• Advice and Guidance Facility in Primary Care<br>• Comms and Engagement with regard to current GP Services. |
| **Recommendations** |
| The SCC is asked to:<br>• Note the contents of the report<br>• Provide comments on the issues raised. |

**Governance and reporting** (list other forums that have discussed this paper)

| **Meeting** | **Date** | **Outcomes** |
|---|---|---|
| **N/A** | | |

**Conflicts of interest identified**

**None**

**Implications**

| *If yes, please provide a brief risk description and reference number* | **YES** | **NO** | **N/A** | **Comments** |
|---|---|---|---|---|
| Quality impact assessment completed | | | | |
| Equality impact assessment completed | | | | |
| Privacy impact assessment completed | | | | |

| | | | | |
|---|---|---|---|---|
| Financial impact assessment completed | | | | |
| Associated risks | | | | |
| Are associated risks detailed on the ICS Risk Register? | | | | |

| | |
|---|---|
| Report authorised by: | Kathryn Lord, Director of Quality and Chief Nurse, Pennine Lancashire CCGs |

**Report from the ICS Quality and Performance Sub-Committee**

## 1. Care Home Sector – Staffing Risk

1.1 A significant risk was raised with regard to the mandatory Covid-19 vaccination of care home staff; all care home staff need to have proof of having taken up both vaccinations by 11.11.21. This poses the risk of significant under staffing of care homes for both residents and remaining staff. Work is underway across the system with providers to mitigate the risk and encourage vaccine take-up. Communications to the public will also be considered.

## 2. Urgent Care – Provider Collaboration Action Plan

2.1 Following the deep dive report into the Urgent Care position it was agreed that assurances are needed on the actions being taken to ensure safety, effectiveness and experience during the increasing pressures in the Urgent Care system. It was suggested that a representative from the Provider Collaborative be invited to the Quality and Performance Sub-Committee to discuss the actions that are being taken.

## 3. Development of Planning towards Population Health Management (PHM)

3.1 It was identified that issues such as lack of recruitment and retention of workforce across the system has led to significant “firefighting” and a lack of time to focus on tangible improvement strategies. It was agreed that PHM would provide the keys to substantial reform and long term solutions, however, resource is needed to drive this forward.

## 4. Advice and Guidance Facility in Primary Care

4.1 It was noted that the Advice and Guidance facility for Primary Care is very effective, however, it is not consistent across the ICS. It was agreed that support is needed for an equitable and robust system of Advice and Guidance; this will be brought to the attention of the Elective Care Recovery Group.

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## 5. Comms and Engagement – GP Services

5.1 It was noted that although total GP appointments have moved back to pre-COVID levels the 'type' of appointment has changed with reductions in face-to-face appointments and increases in telephone and video appointments. It was agreed that public communication and engagement are needed in this regard so that the public are well informed of the different types of appointments and services available and to also manage expectations of patients.

## 6. Conclusion

6.1 Members of the Quality and Performance Sub-Committee agreed that items 1 – 5 above should be brought to the attention of the SCC for acknowledgment and further discussion.

## 7. Recommendations

7.1 The SCC is requested to:

1. Note the content of the report;
2. Provide comments on the issues raised.

Una Atton
02.09.21

Item 14

# Questions and responses from the Strategic Commissioning Committee on 15 July 2021

**Question 1**

Question on membership of boards and scrutiny. Whilst you have supplied links to the positions on boards, you have failed to supply a list of the names and employers of the board members and who appointed them and for how long for each of ICS NHS Board, ICS Partnership Board, Systems Leaders Executive, Programme Delivery Board, SCC, Care Professionals Board, the Finance Investment Group, Provider Board and Collaborative Commissioning Board.

**Answer to question 1:**

Membership of the Integrated Care System Board meeting and the Strategic Commissioning Committee meeting can be found in the attached documents [link to excel spreadsheets] and also at the bottom of this document, noting that there are sometimes other people in attendance due to specific agenda items.

**Question 2**

You often refer to Provider Collaborator board - is this another separate board? What are its terms of reference, composition and names and employer details of each member and confirmation who appointed each of them and for how long?

**Answer to question 2:**

There is a developing partnership between the provider organisations in Lancashire and South Cumbria. This is comprised of our four acute Trusts along with our mental health Trust:

- Blackpool Teaching Hospitals
- East Lancashire Hospitals
- Lancashire Teaching Hospitals
- University Hospitals of Morecambe Bay
- Lancashire and South Cumbria Foundation Trust

These organisations are beginning to work together more collaboratively to address mutual challenges and mutual opportunities to improve health outcomes for our population by working together through the Provider Collaborative Board, though this is not currently a formal Board and is not a meeting that is held in public. All decisions continue to be made at the individual Trust Boards.

**Question 3**

You did not answer on the matter of scrutiny, in the terms of reference document the only mention of scrutiny is to NHSEI. Can you confirm there is no accountability to the partner organisations, to the population in Lancashire & South Cumbria and no scrutiny by any partner bodies, independent body, any patients groups or any members of the public?

**Question 4**

In the link to the ICS board it states "and twelve districts have a right of veto Lancashire and South Cumbria-wide decisions."- why is there a reference to the 12 districts when they are not represented on the Board?

**Question 5**

Please provide a hard copy of the ICS Partnership Agreement

**Answers to questions 3, 4 and 5:**

Thank you for raising a number of questions about the role and current terms of reference for the ICS Board. It is important to explain at the outset that the ICS Board has operated as a partnership board over the last 2-3 years, bringing partners from the NHS, local government and the voluntary, community, faith and social enterprise sector together to agree collective priorities. The current Board does not have statutory functions.

In relation to the issue you raised about scrutiny, we were keen for the Board to hold its meetings in public as an important demonstration of public accountability. As soon as practicable after David Flory took up the role of independent Chair last year, we moved to bi-monthly meetings held in public. ICS directors are also regular attendees at Health Scrutiny Committee meetings (and Health and Wellbeing Boards) during which there is discussion about some of the main service and structural issues facing the ICS.

Whilst I note your question relates to the ICS Board, I would point out that the Strategic Commissioning Committee has sustained the approach of its predecessor (the Joint Committee of CCGs) of holding its meetings in public.

The ICS Chair and Chief Officer are now having further discussions with our colleagues from Healthwatch Together about our working arrangements over the next year in order to strengthen public involvement in the work of the ICS.

Thank you for picking up a rather clumsy phrase on the ICS website about rights of veto. You are correct that District Councils are not represented on the current membership of the Board. We will review this statement as soon as possible.

In relation to a Partnership Agreement, there was some discussion about the value of such a document around 18 months ago, at a time when the governance arrangements of the ICS were under review. After some consideration, the partners did not feel the timing was right to develop such a document.

Looking to the future, I am sure you are aware that the government legislation is moving through Parliament. This will create a statutory NHS organisation (likely to be known as an Integrated Care Board) in Lancashire and South Cumbria. The new organisation will have a Board working under a published constitution, it will have statutory functions and a membership informed by the final terms of the legislation. This NHS organisation will also be responsible for establishing a wider Health and Care Partnership for Lancashire and South Cumbria in conjunction with Local Authorities and other partners. We would expect both bodies to hold meetings in public. We are planning to ensure members of the public and key partners are kept up to date with the implementation of these changes once the legislation has passed into law.

I hope this information is helpful to you.

**Question 6**

The Health & Social Care bill was announced yesterday and provides for ICS to make local decisions about staff pay, terms and conditions? Is this the end of national, collective bargaining agreements and the end of Agenda for Change?

**Answer to question 6:**

The ability for an ICS to locally determine pay and conditions for staff mirrors the arrangements that currently exist in CCGs. However, we are awaiting further detailed HR technical guidance but to date we have not been provided with any information with regard to locally determined pay.

It is highly unlikely that steps would be taken to move away from Agenda for Change terms and conditions as a consequence of creating ICSs.

We will continue to provide support for all staff that are directly affected by a change in legislation, in line with our national NHS People Promise.

**Additional questions and information:**

- A question was received regarding elective and diagnostic work at Burnley and Blackburn hospitals which has been responded to directly by East Lancashire Hospitals NHS Trust.
- Another question was raised specific to Lancaster which has been responded to directly by Morecambe Bay CCG.
- Information about the membership of the ICS Board and Strategic Commissioning Committee have been made available on the website www.healthierlsc.co.uk
- A meeting has been set up to discuss some additional questions raised by a member of the public. Once discussed, responses to these will be shared in the papers of the next meeting.