Lancashire and South Cumbria
Health and Care Partnership

**Strategic Commissioning Committee (Formal)**
**11 November 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 9 September 2021, matters arising and actions to agree | Chair | Approve | Attached |
| 5. | Key Messages | Peter Tinson | Discuss | Verbal |
| **Managing 2021/22** | | | | |
| 6. | Pathology Collaboration Update | Mark Hindle | Approve | Attached |
| 7. | Quality and Performance | Kathryn Lord/ Roger Parr | Discuss / Note | Attached |
| 8. | Independent Sector Contracts | Gary Raphael | Discuss / Note | Verbal |
| 9. | Population Health Operating Model and Development Programme | Julie Higgins / Dr Andy Knox | Approve | Attached |
| 10. | Financial Report | Sam Proffitt | Discuss / Note | Attached |
| **Building the system for 2021/22 and beyond** | | | | |
| 11. | Establishing the Integrated Care Board | Jane Cass | Discuss/ Note | Verbal |
| 12. | New Hospitals Programme Quarter 2 Board Report | Jerry Hawker | Note | Attached |
| 13. | Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions | Brent Horrell | Approve | Attached |
| 14. | Development of Lancashire and South Cumbria Clinical Commissioning Group Policies<br>- Sensory Integration Therapy<br>- Photorefractive Surgery for the correction of Photorefractive Error | Brent Horrell | Approve | Attached |
| **Reports from Sub-Committees** | | | | |
| 15. | CCG Transition Board | Roy Fisher | Note | Attached |
| 16. | Quality and Performance Sub-Committee | Kathryn Lord | Note | Attached |

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| **Any Other Business** | | | | |
| 17. | Any Other Business | Chair | Note | Verbal |
| **Next meeting of the Strategic Commissioning Committee:-**<br>Thursday 13 January 2021, 1 pm – 3 pm, MS Teams (Formal meeting) | | | | |

**Development of the Integrated Care System**
Glossary of key terminology and visual attached

# Glossary of integrated care language

**Integrated Care System (ICS):** Refers to the health and care system across Lancashire and South Cumbria. There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership and an Integrated Care Board.

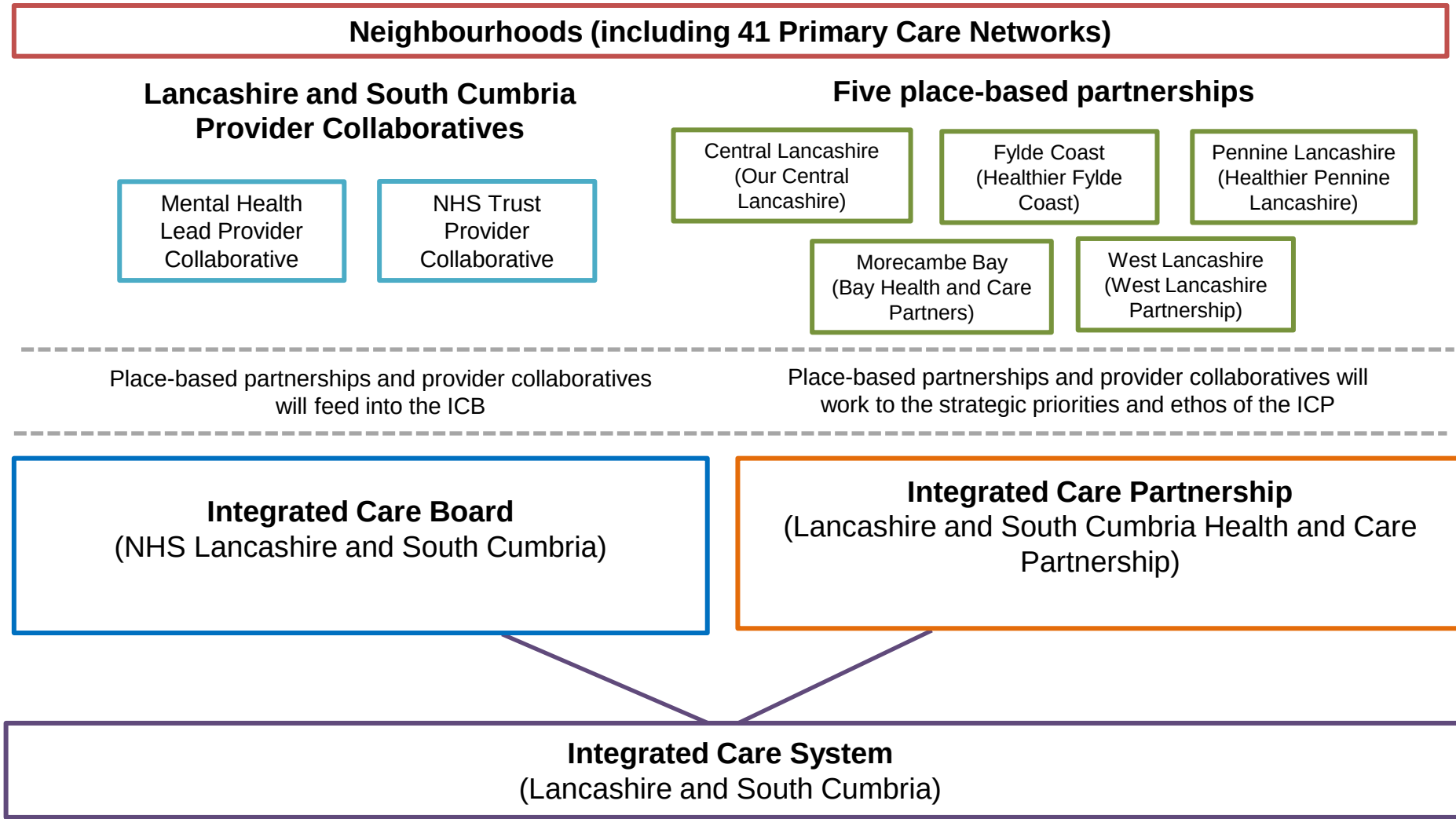
**Integrated Care Partnership:** A partnership of NHS, local authority, VCFSE and academic institutions working together on a joint health and care agenda to coordinate services and to plan in a way that will deliver improvements in population health and reduces inequalities between different groups. This is our partnership at system level called Lancashire and South Cumbria Health and Care Partnership. This term has now started to be used in the most recent national guidance. However this is different to how we have used this term previously. It was previously used to describe our five place-based partnerships.

**NHS Integrated Care Board:** This is the new NHS organisation that will be established on 1 April 2022, subject to legislation. We expect this is likely to be known publicly as “NHS Lancashire and South Cumbria”, but this is subject to the legislation being agreed through Parliamentary processes.

**Place-based partnerships:** Planners and providers working together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place. We have five place-based partnerships in Fylde Coast, Central Lancashire, Morecambe Bay, Pennine Lancashire and West Lancashire. It’s important to note that 'Integrated Care Partnership' is now being used to describe the partnership at Lancashire and South Cumbria level.

**Neighbourhoods:** Based on local populations of between 30,000 and 50,000. Neighbourhoods, in some instances, may align with Primary Care Networks and Integrated Care Communities.

**Primary Care Networks (PCNs):** GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices. Find out more on PCNs on the NHS England website.


Neighbourhoods (including 41 Primary Care Networks)
Lancashire and South Cumbria Provider Collaboratives
Mental Health Lead Provider Collaborative
NHS Trust Provider Collaborative
Five place-based partnerships
Central Lancashire (Our Central Lancashire)
Fylde Coast (Healthier Fylde Coast)
Pennine Lancashire (Healthier Pennine Lancashire)
Morecambe Bay (Bay Health and Care Partners)
West Lancashire (West Lancashire Partnership)
Place-based partnerships and provider collaboratives will feed into the ICB
Place-based partnerships and provider collaboratives will work to the strategic priorities and ethos of the ICP
Integrated Care Board (NHS Lancashire and South Cumbria)
Integrated Care Partnership (Lancashire and South Cumbria Health and Care Partnership)
Integrated Care System (Lancashire and South Cumbria)

# Find out more

- A more detailed glossary for Lancashire and South Cumbria is available on our website:
  Lancashire and South Cumbria glossary of language

- Read about national integrated care developments on the NHS England website:
  NHS England – national guidance

- Read about how we are developing integrated care locally:
  Lancashire and South Cumbria: Integrated Care

Item 4

Subject to ratification at the next meeting

# Draft - Strategic Commissioning Committee

| Minutes of Meeting | |
|---|---|
| **Date and time** | 9 September 2021, 1 pm – 3 pm |
| **Venue** | Microsoft Teams |
| **Chair** | Roy Fisher |

| **Present** | | |
|---|---|---|
| Roy Fisher (meeting Chair) | Strategic Commissioning Committee Vice Chair / CCG Chair | NHS Blackpool CCG |
| David Blacklock | Healthwatch Representative | Healthwatch Cumbria and Lancashire |
| Lindsey Dickinson | CCG Chair | NHS Chorley & South Ribble 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 |
| Paul Kingan | Chief Finance Officer (attending for West Lancashire CCG AO) | NHS West Lancashire CCG |
| Denis Gizzi | CCG Accountable Officer | NHS Central Lancashire CCGs |
| Anthony Gardner | CCG Chief Operating Officer (attending for Morecambe Bay AO) | NHS Morecambe Bay CCG |
| Andrew Bennett | Interim ICS Lead | 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 |
| David Swift | Lay Member (East Lancs CCG) | Lancashire and South Cumbria ICS |
| Kevin McGee | ICS Provider Collaborative Representative | ICS Provider Collaborative |
| Stephen Newton | Head of CMT (representing Linda Riley) | Midlands and Lancashire CSU |
| **In Attendance** | | |
| Kathryn Lord | Director of Quality and Chief Nurse | East Lancs CCG and Blackburn with Darwen CCG |
| Roger Parr | Deputy Chief Officer | NHS Blackburn with Darwen CCG |
| 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 |
| Rebecca Higgs | Business Manager | Lancashire and South Cumbria ICS |
| Pam Bowling | Corporate Office Team Leader | Lancashire and South Cumbria ICS |

| | | |
|---|---|---|
| Sandra Lishman | Corporate Office Co-Ordinator (minute taker) | Lancashire and South Cumbria ICS |
| **Public Attendees** | | |
| 7 members of the public were present | | |

## 1. Welcome and Introductions

The Vice Chair, Roy Fisher, welcomed committee members and members of the public observing, to the formal meeting of the Strategic Commissioning Committee (SCC), held virtually via Microsoft Teams. It was explained that the meeting was being recorded; the recording would be uploaded to the Lancashire and South Cumbria Health and Care Partnership (L&SCHCP) website after the meeting. Meeting papers had previously been published on the website.

## 2. Apologies for absence

Apologies were noted from David Flory, Jane Scattergood, Debbie Corcoran, Beth Goodman (Paul Kingan to represent), Adam Janjua (Kevin Toole to represent) and Linda Riley (Stephen Newton to represent).

## 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 15 July 2021

The Chair proposed the minutes be accepted as a correct record of the meeting; Graham Burgess seconded.

**RESOLVED: The minutes of the meeting held on 15 July 2021 were approved as a correct record.**

**Action log –** *New Hospital Programme Case for Change* – It was confirmed that the discrepancy within the version of Case for Change that had been brought to the last meeting had been corrected in the final published version. The action was noted and closed.

## 5. Key Messages

Andrew Bennett reported that the NHS was now moving towards the second half of the financial year (H2), with significant challenges in response to the Covid pandemic and recovery and restoration of services. Further detail was expected nationally around the planning guidance and financial settlement assumptions and what this would mean locally. Much work was being undertaken in the system around the long-term financial stability and would be reported on at future meetings.

In addition, the second reading of the Health and Care Bill had been approved and was now progressing to committee stage of scrutinising legislation through which integrated care structures, governance and accountabilities would be considered. This would lead to the end of CCGs on 31 March 2021 and the creation of new structures across Lancashire and South Cumbria and place-based partnerships. Future SCC meetings would include a glossary of terms due to the changes of abbreviations/jargon.

Changes in structures and leadership would be subject to national recruitment processes. David Flory, Independent Chair, had been appointed as the Chair Designate for the Integrated Care Board and the role of Chief Officer was currently subject to an external national recruitment process. Members paid tribute to staff for their hard work during this difficult time which was expected to continue through the winter period.

## 6. Terms of Reference

Members were advised that the purpose of this committee had been revised earlier in 2021 and the CCG Governing Bodies had approved the role and remit of the Committee at that time. The Terms of Reference had now been updated to reflect recent leadership changes and were presented for approval. It was noted that Andrew Bennett was attending the SCC in the role of interim ICS Chief Officer, with senior CCG representatives joining the voting membership. The Terms of Reference would apply until the end of March 2022.

**RESOLVED: That the Strategic Commissioning Committee approved the revised Terms of Reference.**

## Managing 2021/22

### 7. CCG Closedown

Dennis Gizzi (DG) presented the paper and updated the committee on the progress of the closedown of CCGs on 31 March 2022 when CCG undertakings would be transferred to the new statutory body.

On 19 August 2021, NHS England published several documents for consideration including a closedown procedure for CCGs, incorporating a due diligence checklist. In anticipation of this being released, an executive group and governance leads group had been established along with an information governance/information technology sub-working group. Work was also taking place with Mersey Internal Audit Agency (MIAA) on population of a programme plan. A risk register had been developed and key risks identified to date included maintaining quality and safety and sufficient workforce during closedown and loss of functions if not identified. It was confirmed that a sub-group was leading on work in relation to records management transition and archiving.

In response to a question about the closedown of CCG accounts for 2021/22 it was confirmed that CCGs were responsible for developing a plan for financial closure which would continue until the final accounts had been submitted and all due diligence completed. Consideration would need to be given to the identification of individuals and resource for this work and discussions were taking place with external audit on the detail. The new ICS Chief Officer and Finance Director would have responsibility to sign off the CCG accounts.

On behalf of the committee, the Vice Chair expressed his thanks to DG and the team for the work being undertaken on CCG Closedown.

**RESOLVED: That the Committee note the update on CCG Closedown.**

### 8. Quality and Performance

Roger Parr highlighted the following from the report, which included focus reports on Urgent Care and Cancer Services:

- The urgent care report provided an overview of urgent and emergency services, key metrics, challenges, learning and plans in place to address. New standards and quality outcomes had been released and incorporated into the urgent care reporting workplan. Performance for the 4-hour target in A&E was just under 80% across L&SC. A&E attendances remained high with greater acuity and ambulance hand-over times had increased. Bed occupancy remained high and all providers had focused actions to support earlier discharge of stranded patients in acute beds.
- Cancer - recovery and restoration of services was considered the top priority. An improvement plan had been created for cancer waits, including increased diagnostics to reduce the backlog, working with primary care to reduce inappropriate referrals and investment in cancer team.
- Diagnostic Services – the numbers of patients on waiting lists continued to fall, however, there was differential across providers in June. Endoscopy remained an issue; recovery plans were being developed and monitored through the ECRG.
- Elective Care - GP appointments had returned to pre-Covid levels and referrals into hospitals increased. The ‘type’ of appointment had changed with reductions in face-to-face appointments and

increases in telephone and video appointments. The Advice and Guidance service had been implemented across L&SC to support management of demand.

- The rolling 4-week recovery was strong, albeit the last week was reduced for elective admissions but for outpatients L&SC were slightly behind compared to the rest of the North West. Actual activity/recovery against targets in July were challenged. Restoration plans continued to progress covering elective admissions, out-patients, diagnostics, the independent sector and critical care. As of June 2021, the number of patients waiting to start treatment had increased to 155,000 and performance against the 18-week standard target was 70.1%. There were nearly 10,000 people waiting over 52 weeks, of which 223 had waited over 104 days. The number of over 52-week waiters had slowly decreased however the 36 to 52 weeks cohort was showing an increase for the fourth consecutive month. All trusts continued to undertake the national clinical prioritisation programme, treating patients in clinical prioritisation order.

Kathryn Lord (KL) continued taking members through the remainder of the report, providing the following highlights:

- The Covid-19 pandemic continued to present significant challenges within the community and hospital. As of 11 November 2021, unvaccinated staff would be unable to deliver care in nursing/residential/care homes and staff showing hesitancy were being encouraged to receive the vaccination. The Phase 3 Covid vaccination programme was expected to start around 20 September 2021; national guidance was awaited. Young people aged 16 and 17 years old were being invited to receive the Covid vaccine. National guidance was awaited regarding the school programme for those aged 12 to 15 years old. Separate flu and Covid vaccine programmes were being worked up; staff training was being undertaken.
- With regard to Individual Patient Activity and Continuing Healthcare, the project to address the legacy of incomplete referrals was nearly complete. Regular meetings were in place around this cohort of patients and families were being involved in the planning process.
- An increasing level of resource input and commitment from Safeguarding Teams was being required to support commissioning of placements for individuals requiring complex care. A gap in service provision for undertaking Looked After Children Initial Health Assessments for 16 to 17 years old had been identified in Central Lancashire. A pilot was underway in relation to the Court of Protection and application; due to complete around the end of December 2021.
- There was increased demand and waits for treatment for CAMHS services. A CYP transformation programme was in development to support the delivery of sustainable services across the system. Demand for the young people's eating disorder service had also increased and LSCFT were undertaking a capacity and demand review across both the adult and young people's services.
- Performance in adult mental health services was being looked at, and a 'perfect week' was planned for the beginning of October around urgent care pathways, the outcomes from which would be reported back to this committee.
- Mental health detentions – an error had been made within the paper. Performance should read that there were 40 x 136 breaches in Q1 (not Q4).
- The numbers of out of area placements was an issue but had decreased slightly this month. Work was ongoing to look at the safety of placements, admissions, discharges and flow. Weekly meetings were taking place as to how this would be managed going forward on a multi-agency basis. A geographical breakdown would be reported to members. **ACTION: Kathryn Lord/Roger Parr**
- Suicide prevention – cluster analysis was taking place to identify any hotspots and support being provided to families and engagement with local services as appropriate.
- Member Assessment Services (MAS) and older adults – A capacity and demand deep dive commenced at the beginning of August; improvements would be reported to the next committee meeting.
- Learning disabilities and autism Q1 had 22 CCG admissions with no secure admissions, some readmissions.

The Vice Chair expressed his thanks for the report and referred to the need for a balance between quantitative and qualitative data. In response it was confirmed that going forward there would be shift towards a focus on the quality elements. Andrew Bennett commented that services were extremely challenged by having

busy workloads, whilst trying to catch up from the backlog created during the pandemic and suggested that it would be useful to look at patterns over time to see whether services, which would remain under pressure for some time, were making progress or needed support.

The Chair invited comments and questions and member's discussion included reference to the following:

- The 52-week wait for the Fylde Coast was highlighted as being higher than the rest of L&SC, however this was likely to be due to the Independent Sector Spire Hospital located in that area and would be reviewed further outside the meeting. **ACTION: Roger Parr/Paul Kingan**
- In response to a question about individuals returning from abroad having received vaccinations not licensed in the UK it was suggested that any questions should be submitted via the existing Covid vaccination route.
- A question was asked as to whether the report would be developed to include both primary and secondary care data to assist in making correlations between the two. It was confirmed that this was being developed to provide a broader and enriched report going forward.
- A comment was made about primary care activity, that reputable studies outside the NHS were showing that general practice activity was generally 30% or 40% up on a comparable time 2 years ago. Activity was taking longer due to the need for infection prevention control measures and there was increased complexity. Demand was exceeding capacity and there was concern that the situation was unsustainable.
- Healthwatch Cumbria and Lancashire had produced a report on patient experience of online consultations via primary care and agreed to share with members.
  **ACTION: Sandra Lishman to circulate to members**
- There had been an increase in communications encouraging people to come forward with cancer symptoms, including campaigns from Cancer Alliance colleagues around certain types of cancer, signs to look out for and what do to. Feedback from GPs was an increase in the presentation of people with symptoms and an increase in the number of cancer referrals across L&SC.

**RESOLVED:**
**The Strategic Commissioning Committee noted the contents of the report and supported future developments.**

## 9. New Hospitals Programme Quarter 1 Report

Jerry Hawker presented the report and highlighted 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.

Much work had been undertaken over the past few months following publication of the Case for Change in July 2021. There had been 170,000 points of engagement with the public and over 20,000 staff had engaged via the 'Big Chat'. To improve direct engagement with members of the public, the website would be made more interactive and attendance increased at Health and Wellbeing Boards and Scrutiny Committee meetings. A framework model of care had been developed by clinical leads working alongside external partners. This was the clinical vision and outlined the aspirations for what future care should look like within hospitals. The framework model of care had been taken forward through the new Clinical Collaboration Board to look at how the New Hospitals Programme would work with the ICS clinical strategy to develop a hospital strategy for the future. The initial long list of options had been published on the L&SC Health and Care Partnership website, for people to review and provide feedback. The options included new hospital buildings on new sites, re-building of existing sites and refurbishment. The shortlisting process would take place during October 2021.

The Chair, on behalf of the Committee, thanked clinicians who had input into the framework model of care and invited questions and comments. Questions were asked about the flavour of the feedback received from clinicians and the public; what engagement had taken place with campaigning groups with strong views; and about the level of interest in the clinical strategy.

JH responded that work had been undertaken nationally to provide clarity on the new hospitals programme and that it could mean several different opportunities. In terms of return on investment, building on existing sites, as well as building on new sites, needed to be considered. Feedback through the 'Big Chat' and other portals, reflected a spectrum of views, including strong views for a new single hospital and equally strong views emphasising the importance of local access to local people. The engagement challenge was to listen to and hear from all people from a wide range of groups. With the support of Healthwatch engagement was taking place with the harder to reach and seldom heard groups as well as those campaigning groups with strong views. Opportunities had been extended to groups for face-to-face meetings and there had been extensive engagement with MPs.

JH explained that the framework model of care brings together clinical views around what best practice needs to look like in 2030 and beyond, taking into consideration digital and new technologies and is different to the ICS clinical strategy. Dr Curran added that the new hospitals programme is one way of implementing the ICS clinical strategy, however, there are many different parts to it. With the support of the communications team, there is to be a video launch of the ICS clinical strategy to encourage interest from front-line staff and members of the public.

**RESOLVED:**
**That the Committee note the progress undertaken in quarter 1 and note the development of the products to support business case development.**

**10a. Lancashire and South Cumbria Medicines Management Group (LSCMMG) Commissioning Policy Positions – July 2021**

Brent Horrell apprised members of the outputs of the LSCMMG meeting held in July 2021. Three local policy positions were agreed, plus two NICE technology appraisals. Specifics related to:

- Hydrocortisone Granules in Capsules for Opening (Alkindi®) as Replacement Therapy of Adrenal Insufficiency in Infants, Children and Adolescents. This would have a low-cost impact on the health economy.
- Sodium Oxybate for the treatment of narcolepsy with cataplexy in adults. Based on NICE estimates could have a relatively significant impact, however, there was awareness from the number of funding requests received over several years, uptake was expected to be 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. Change in position, previously position was specialist only, however, the proposal was to move into initiation by specialist, moving to primary care if the patient was stable, and was expected to be cost neutral.
- NICE technology appraisals (June 2021). This would have a small impact due to a small number of patients and a new drug recommended that has a similar price to medicines used at the same part of the treatment pathway.

**RESOLVED:**
**That the Strategic Commissioning Committee ratify the collaborative LSCMMG recommendations listed above.**

**10b. Commissioning Policy Development and Implementation Group (CPDIG)**

Brent Horrell reported on the outputs from the Lancashire and South Cumbria CPDIG review of three commissioning policies.

1) *Dilatation and Curettage Policy*. Minor amendment, no significant changes in terms of the clinical evidence review conducted.
2) *Male Circumcision Policy*. Evidence review conducted and no changes in terms of clinical content. One minor amendment in the title of the document.
3) *Carpal Tunnel Syndrome Surgery Policy.* The CPDIG had been working with the Trauma and Orthopaedics Network looking at the pathway for Carpal Tunnel Syndrome and the policy had been

amended to align with the new pathway. Changes were set out and primarily related to Nerve Conduction Studies. There was not expected to be any significant impact in terms of activity.

**RESOLVED: The Strategic Commissioning Committee:**

***Dilatation and Curettage Policy***

- **Accepted that the policy did not require any revision to the policy position, and that no further clinical or public engagement was required**
- **Agreed to change the title to the Dilatation and Curettage (D&C) Policy.**

***Male Circumcision Policy***

- **Agreed that no revision, no clinical or public engagement was required**
- **Approved the process taken to develop the policy**
- **Agreed to change the title to Male Circumcision Policy**
- **Ratified the Policy.**

***Carpal Tunnel Syndrome Policy***

- **Noted the content of the revised policy**
- **Approved the content of the revised policy**
- **Approved the title of the revised policy**
- **Approved the process taken to develop the policy**
- **Agreed that no further consultation should be undertaken.**

## Reports from Sub-Committees

### 11. CCG Transition Board

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

### 12. Collaborative Commissioning Advisory Group (CCAG)

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

### 13. Quality and Performance Sub-Committee

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

## Items for Information

### 14. Questions received for 15 July 2021 meeting

The questions and responses from the Strategic Commissioning Committee meeting held on 15 July 2021 were noted.

### 15. Any Other Business

**Financial Update**

Anthony Gardner reflected that the financial position of CCGs at the end of the financial year would have a direct bearing on the financial position of the newly established Integrated Commissioning Board and requested a position statement on CCG finance for a future meeting of this committee. Gary Raphael commented that the key financial issue for CCGs was achievement of the savings targets and it was noted that CCGs continued to report their financial position to their Governing Bodies. Gary Raphael confirmed that this financial information was already presented to the ICS Board and agreed that a report on H1 including a forward look to H2 would be prepared for the Committee.

**ACTION: CARL ASHWORTH/GARY RAPHAEL**

**Next formal meeting:**
**11 November 2021, 1 pm – 3 pm, MS Teams**

# Strategic Commissioning Committee

## Formal Action Log

Updated 3 November 2021

| Item Code | Action | Responsible Lead | Status | Due Date | Progress Update |
|---|---|---|---|---|---|
| SCC – 20210909 – Item 08 | **Quality and Performance**<br>52-week wait performance in Blackpool – Roger Parr/Paul Kingan to discuss outside of the meeting to understand performance due to the IS Spire Hospital being located on the Fylde Coast | Roger Parr<br>Paul Kingan | **Closed** | 14.10.21 | 30.09.21 – Roger confirmed relevant information had been shared with Paul Kingan. |
| SCC – 20210909 – Item 08 | **Quality and Performance**<br>Circulate report published by Healthwatch Lancashire and South Cumbria, looking at patient experiences of online consultations via primary care. | Sandra Lishman | **Closed** | 17.09.21 | 15.09.21 – report circulated to members. |
| SCC – 20210909 – Item 08 | **Quality and Performance**<br>To provide information to the Committee on the geographical breakdown of Out of Area placements | Roger Parr/<br>Kathryn Lord | **Closed** | 14.10.21 | 30.09.21 – Heatmap available on request for out of area placements. |
| SCC – 20210909 – Item 15 | **Any Other Business**<br>To provide a summary of CCG financial positions and briefing on H2 at a future SCC meeting. | Carl Ashworth<br>Gary Raphael | **Closed** | 11.11.21 | 03.11.21- On agenda for meeting to be held on 11.11.21. |

# Strategic Commissioning Committee

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|---|---|
| **Date of meeting** | **11 November 2021** |
| **Title of paper** | **Pathology Collaboration Update** |
| **Presented by** | **Mark Hindle, Managing Director** |
| **Author** | **Mark Hindle, Managing Director** |
| **Agenda item** | **6** |
| **Confidential** | **No** |

**Purpose of the paper**

The purpose of the paper is to update the committee on the progress made to date in the Lancashire and South Cumbria Pathology Collaboration and to advise of the priority areas of work that are currently being progressed. The process of due diligence has been completed to identify and assess the risks/ issues associated with the formation of the single pathology service. The Board were assured that no new or unknown issues have surfaced and that there is nothing that would prevent the formation of the single service. The work undertaken will also support the risk management processes of the future service. The development of the Target Operating Model is now underway. The TOM is the blueprint for the future service, describing how it will operate and how the transition will be made.

**Executive summary**

Key discussion points:

- Background and current delivery model
- Case for change
- Proposed future model
- Hub and spoke model
- Benefits
- Progress to date
- Due diligence
- Target Operating Model
- Timescales

**Recommendations**

The committee is asked to note the content of the report which is provided for information.

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

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

**Conflicts of interest identified**

**N/A**

**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: | Mark Hindle |

## PATHOLOGY COLLABORATION UPDATE

### Introduction

1.1 This paper is provided as an update for committee members about the development of a single pathology service for Lancashire and South Cumbria. It serves to outline the major programmes of work that are currently underway and the associated timescales.

### 1. Background and Current Delivery Model

Each NHS Trust has an individual laboratory based on the hospital sites providing a diagnostic service for the individual NHS Trust and the GPs in the CCG catchment area. The Trusts involved are:

- Blackpool Teaching Hospital Trust
- East Lancashire Hospital Trust
- Lancashire Teaching Hospitals NHS Trust
- University Hospitals of Morecambe Bay

Test results cannot be shared easily across the pathology laboratories in each Trust because they all have different IT systems so if a patient attends another Trust (for example for a specialist condition) their tests may have to be undertaken again which is time consuming for the patient and not cost effective.

Laboratories have different equipment providing the same tests but have different ways of interpreting tests (reference ranges) leading to inconsistencies.

### 2. Case for Change

- **National policy:** For transformational change and expectation that labs will network. The response to Covid-19 would not have been possible without networks
- **Sustainability:** Some services have vacancy rates of 33% and an ageing workforce. There is currently a difficulty in recruiting specialised and highly trained staff across all four NHS Trusts
- **Resilience of service: I**ndividual Trusts may not be able to afford modern diagnostic technologies which are only viable at scale

- **Fragmentation: As** the results can't be shared leading to duplication of tests; reference ranges can be different across Trusts
- **Duplication: O**f testing, training, quality and administrative processes and fragmentation of procurement affecting the ability of the current services to deliver efficiencies
- **Estate:** Three of the four Trusts would have to update all or part of their pathology estate in the short/medium term as current estate is poor and no longer fit for purpose

## 3. Proposed Future Model

- The four Trusts in the ICS footprint will establish a formal partnership to deliver a single pathology service across the whole of Lancashire and South Cumbria
- A high quality and sustainable service will be delivered by co-locating 'cold' pathology together in one central hub location. Emergency/urgent activity will be processed on the Trust sites from essential service laboratories
- Patients will not notice any difference but will have a better quality service (reduction in duplication and turnaround times of some tests). This applies to GP users of the service too
- IT systems and equipment are procured jointly standardising reference ranges and improving quality of service. Possibility of providing additional tests that are not currently available in the area, for example to improve cancer diagnosis

## 4. Hub and Spoke Model

- The Comprehensive Investment Appraisal Model (CIAM) identified Hub and Spoke as the best option
- For projects to be seen as viable by NHSI, the level of return needs to be at least 4:1
- Best use of resources and return on investment, this option gives a return of £8.32 for every £1 spent
- Best option for achieving the required transformation, quality and safety standards
- Endorsement from acute trusts for this option
- All routine work is undertaken in the central hub
- Emergency/urgent work will be undertaken in the Essential Services Laboratory (ESL) on each acute site
- The future model will not be a one size fits all and there will be a bespoke approach to designing ESLs to respond to geographical factors and to meet the clinical requirements and specialties of specific acute sites
- A Quality Committee is to be convened to ensure all issues/risks raised are considered and mitigated as the future model is designed.

## 5. Benefits

- Increase in new technologies e.g. digital pathology, molecular
- Ability to deliver complex tests within the region
- Ability to procure modern equipment at scale and achieve financial benefit of this
- Common equipment platforms to support patient movement around the region
- Consolidate workforce to ensure future resilience, talent mapping, training and succession planning, making the best use of resources
- Broader and more diverse career opportunities for staff
- Cohort of staff trained in emerging technologies
- Reduce spend on tired estate - Trusts can re-use in future development plans

## 6. Progress to Date/Next Steps

- Significant and effective collaborative working through Covid-19
- Strategic Outline Case agreed
- Economic case (CIAM) and delivery framework agreed – hub & spoke model to be progressed as the best value for money option
- Location for Hub identified – Enterprise Zone site in Samlesbury
- OBC drafted and with NHSE/I or approval. There is a delay in the approval of business cases due to a backlog with the national team. However, the programme has been given the green light to progress and discussions are on-going about mechanisms to access the capital
- Support from NHSE/I to proceed with developing the full business case with a target completion date of January 2022
- Significant staff engagement on-going
- Workforce models being identified
- Governance arrangements in place
- LIMs specification agreed and out to tender. A bid for national money has been submitted to support aspirations relating to LIMS and digital pathology
- Completed pre-engagement questionnaire process with the procurement team regarding blood sciences equipment tender and supplier presentations have been organised
- Appointment of modular building contractor underway and the process of developing detailed designs for the Hub will commence in August
- Host organisation agreed at Board on 30 July, Lancashire Teaching Hospitals will act as the host trust (subject to due diligence work being undertaken and all Trusts agreeing to sign the collaboration agreement)
- Due diligence process has commenced, please see below
- The development of the Target Operating Model is underway, more information is provided below
- Please see the route map that has been approved by the Pathology Collaboration Board that outlines the key programmes of work and decisions with associated timescales.

Route Map July (6).pdf

## 7. Due Diligence

The due diligence process to identify the clinical and operational risks associated with becoming a single service has been completed.

Undertaking due diligence is an absolute requirement of NHSE/I guidance and is also required by all of the Trust Boards that are involved in the collaboration. Completing this process has served to ensure that all stakeholders are aware of the potential risks and issues that exist in current services before moving into the single service.

The process was completed in consultation with clinical and managerial leaders. A plan of action was developed and a set of key lines of enquiry to support information gathering. Other core elements of the overall due diligence are finance and workforce which have been addressed separately.

## 8. Target Operating Model

Work has started to develop the Target Operating Model which will describe the transition to the future service and how it will run. This is a significant piece of work which will be delivered in phases:

**Phase 1**- Develop the TOM framework (by mid October)
**Phase 2** - Collate and articulate the aligned management state (by mid December)
**Phase 3** - Collate and articulate the TOM (by the end of March 2022), then moving into transition planning.

The TOM will develop over time:

**Apr 22 – Dec 23:** A period of aligned management where services continue to be delivered from the existing labs whilst the hub and ESLs are built/refurbished. The significant change during this phase will be the management arrangements where the service will be delivered through one entity rather than the four trusts.

**Jan 24 – Dec 24**: A transition period to the hub and spoke clinical and operational models where the services will reconfigure geographically.

**2027 onward:** The final operating state where the TOM is achieved and the benefits realised.

## 9. Conclusion

A significant amount of progress has been achieved in the last six months and this has achieved recognition and support nationally. A clear plan is in place to achieve delivery of the major project milestones as shown in the route map provided. The Committee is asked to note the progress made to date and to support the provision of information required to deliver the due diligence process.

## 10. Recommendations

The ICS Board is requested to:

1. Note the contents of the report
2. Highlight any perceived/risks and issues to support the due diligence process
3. Receive a further report at a future meeting, timescale to be agreed with the Chair.

**Mark Hindle**
**Managing Director**

19 October 2021

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **11th November 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** | **7** |
| **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 Strategic Commissioning 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

## November 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 brings 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 overall aim of the SCC is to scrutinise the Q&P report, consider risk and mitigation and ensure that quality of service delivery is maintained and improved.

1.5. 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

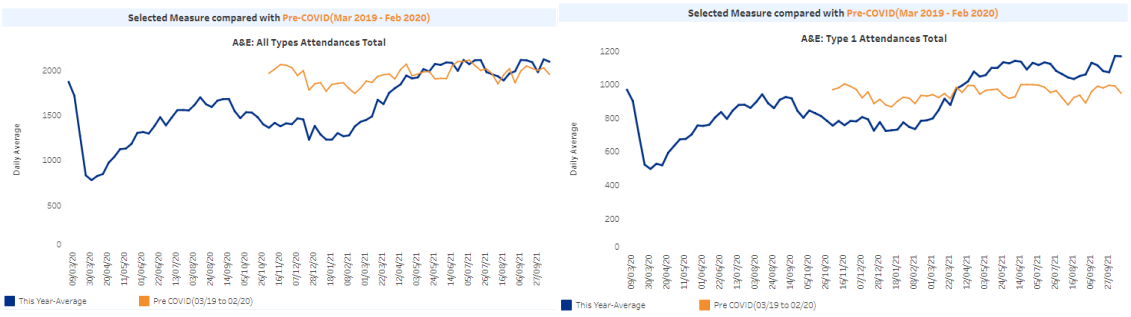
**This month the report focuses on the following elements of Quality and Performance:**

- Urgent Care
- Cancer Services
- Diagnostics
- Elective Care
- Nosocomial Infections
- Individual Patient Activity and Continuing Healthcare
- Safeguarding
- Children and Young People Mental Health
- Adult Mental Health
- Learning Disabilities and Autism
- Population Health and Health Inequities
- Complaints, MP Letters and PALS
- Glossary
- Appendices
    - Appendix 1: D codes for Endoscopy - Waiting list prioritisation
    - Appendix 2: Over 52 week waiters for L&SC CCGs split by Specialty and Provider
    - Appendix 3: Over 52 week waiters for L&SC Providers split by Specialty
    - Appendix 4: ICS Performance Metrics (separate attachment)

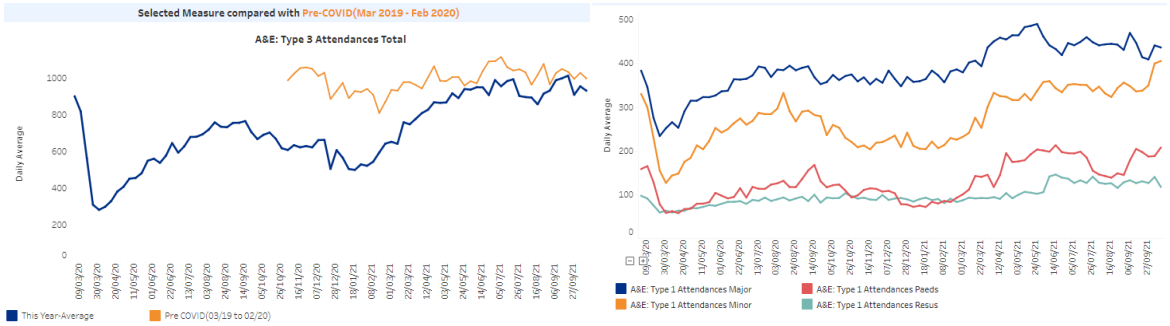
## 3. Urgent Care

3.1. In September 2021 L&SC all type A&E performance was 76.6% compared to 72.1% in C&M and 66.5% in GM against the national 95% standard. Cumulatively April 2021 to September 2021, L&SC performance is 80% compared to 76.4% for C&M and 72.1% in GM.

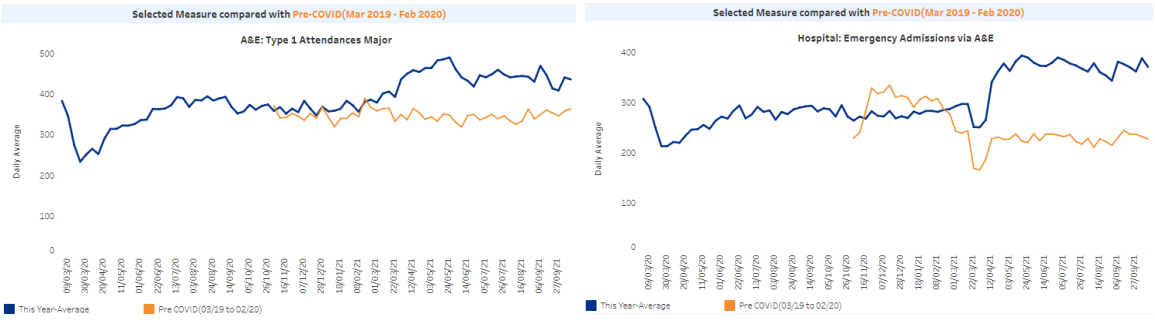
3.2. Although the total all type activity continues to be similar to pre-COVID levels there has been an increase in activity through the Type 1 departments sustained since the beginning of April 2021. This increase in Type 1 attendances has further peaked into early October 2021.




3.3. Type 3 attendances have not yet returned to pre-COVID levels indicating that people are either more acutely unwell or are not accessing this alternative urgent care pathway. On analysis of the type of patient attending the Type 1 departments a particular increase in paediatrics and those with minor conditions has been reporting during September 2021.




3.4. Those attending who are classified as 'majors' and therefore more likely to be acutely ill continue to be above the pre-COVID levels which has been a sustained increase in 'majors' activity since April 2021. In addition, the number of patients being admitted to hospital is significantly higher than pre-COVID levels with the increase in admissions being directed through A&E rather than other non-elective admission pathways.

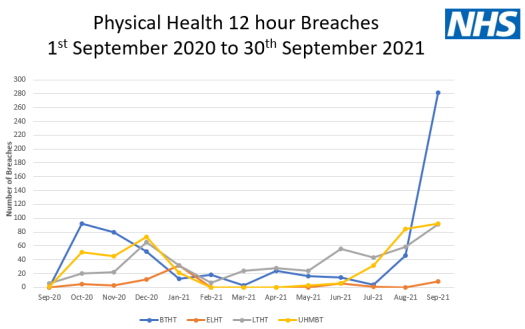


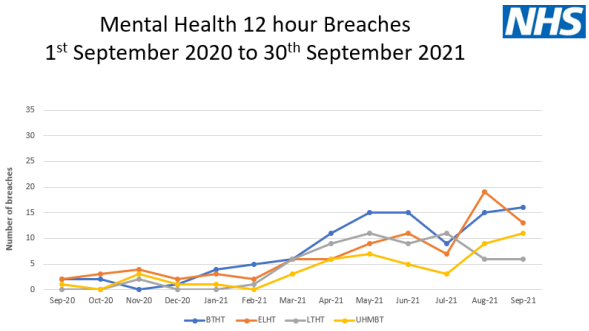

3.5. The high level of over 4 hour waits in the A&Es are mostly due to patients waiting for hospital beds impacted by a high bed occupancy rates across the system. Key reasons for the high bed

occupancy rate are that more people are being admitted to the beds and an increase in length of stay of those in the acute bed base.

3.6. 12 hour waits after decision to admit

3.6.1. In September 2021 the number of patients waiting over 12 hours in A&E after a decision has been made to admit has remained high with a significant rise at BTHT.

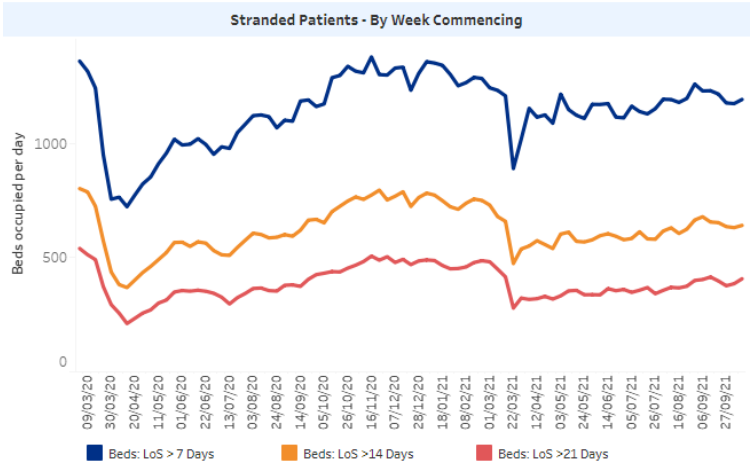



3.6.2. In September 2021 there were 472 validated physical health 12-hour DTA breaches compared to 188 in August 2021. Mental health breaches have remained relatively static at 46 in September 2021 compared to 49 in August 2021. Any potential harms relating to long stays in A&E departments are monitored by the providers through interventions such as recording early warning scores, falls risk, pressure area risk assessments and intentional rounds to ensure patients receive refreshments, access the toilet, and receive any relevant medication.

3.7. Length of Stay

3.7.1. The below chart shows the number of patients within the 4 L&SC acute trusts with a length of stay greater than 7 days analysed into subsets of over 14 and 21 days LOS.




3.8. Friends and Family Test (FFT)

3.8.1. For the month of August 2021, 78% of survey respondents reported a positive experience of using L&SC Type 1 and 3 UEC departments, with 15% reporting a negative experience. At site level an outlier to this was at RPH where 61% respondents reported a positive experience and 27% a negative experience.

3.9. 2021/22 Winter Planning

3.9.1. The Urgent and Emergency Care Network are actively engaged with the regional NHSE Urgent Care Team to provide ICS assurance of winter plans in response to the National UEC 10-point action plan published. The NHS plan builds on how the whole system will work together to ensure UEC services have resilience.


3.9.2. The regional team have completed site assurance visits at the RPH, BVH and RLI which included a check and challenge event of all system partners. The output of these are being reviewed by the regional team in October 2021.

3.10. Additional Winter Preparedness

3.10.1. Immediate actions agreed to be taken to improve the performance and patient safety across the ambulance and NHS 111 services (October 2021).

3.10.1.1. **NWAS:**

- Additional double-crewed ambulance availability at periods of peak demand – additional blue light trained drivers from within PTS / Urgent Care and expanded clinical workforce
- Maximum deployment of hear and treat and see and treat dispositions to reduce a vehicle-based response to incidents and lower acuity conveyance
- Reduction in 'lost hours' – seeking to maximise DCA deployment by reducing lost operational hours

3.10.1.2. **Wider North West/ICB System:**

- Hospital turnaround – a targeted approach at system level to reduce lost ambulance hours due to delays from arrival to handover (acknowledging national target turnaround of 30 minutes and NWAS funded 34 ½ minutes)
- Pathways / Directory of Services – a targeted approach to maximise the utilisation and responsiveness of services, reducing delays and variations to increase ambulance staff confidence in the responsiveness and delivery of services thereby reducing ED conveyance
- Mental Health – NWAS direct access into mental health crisis lines and crisis support to direct and / or refer patients / callers to services best able to respond to a mental health crisis where there was not an immediate threat to life requiring an emergency ambulance response

3.10.1.3. **UEC Recovery 10-Point Action Plan**

Each local AEDB system will undertake a stocktake and progress with the actions at system and provider level and build into local AEDB governance processes.

3.10.1.4. **Gold Command**

The ICS has agreed through Winter 2021/22 that the L&SC Hub will be enhanced to maximise the L&SC wide potential for the safest possible winter. Gold Command will work alongside the two cells and those groups tasked with service planning and coordination such as the critical care network.

3.10.1.5. **Access to Primary Care**

An action plan will be developed to improve access for patients to Primary Care following the release of the recent notification of additional funding.

## 4. Cancer

4.1. Summary:

- 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 workforce issues across multiple pathways and specifically in non-surgical oncology and surgical gynaecology IDS
- All patients have been treated in order of clinical prioritisation as per national guidance
- New revised regional policy released regarding 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
- Gap in treatments from screening and other routes not 2WW
- 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 in lowest quartile for performance in England, but it is likely to improve significantly when patients with a “no cancer” diagnosis are removed from the patient tracking list[1]

[1] source weekly sitrep unpublished

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.
- Backlogs are being tracked actively - and the H1 aim was to restore to pre-pandemic levels by September/ October 2021, this is looking unlikely with current COVID related operational and workforce pressures - latest sitrep shows backlog is at highest point since beginning of pandemic (>1500)
- Over 900 of these patients already have a “no cancer” diagnosis and will be removed from tracking when admin resource is available to do so
- H2 planning guidance has set a new methodology for calculating the backlog target for March 2022. New target is 407

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 (August 2021) ranking against other Alliances

| Standard | Cancer Alliance Ranking |
|---|---|
| 2WW | 3/21 (July 2/21) |
| Breast Symptomatic | 2/21 (July 1/21) |
| FDS | 12/21 (July 9/21) |
| 1st Treatment | 17/21 (July 17/21) |
| 62 Day referral to treatment | 18/21 (July 19/21) |

- COVID has caused pressures across all pathways, particularly in high volume specialities (breast, GI, urology and skin)
- 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
- 2WW performance is stable with L&SC the 3rd best performing alliance
- Performance against the 31 Day is 92% against the 96% standard with surgical pressures in Gynaecology, breast, skin lower GI, and Urology
- Our 62-day performance remains poor across the system and remains a few percentage points away from the NW and England positions. Urology, lung and lower GI contributing to most breaches

4.4. Performance

Latest published data (August)

4.4.1. The table below compares L&SCs performance against North West Alliances and the England for August 2021. This includes monitoring against the faster diagnosis standard. Performance against the faster diagnosis measure has dipped recently. This is to be an operational standard in October 2021. Trusts have made significant improvements in completeness of patient records. BTHT have seen an increase in completeness in month which has had a negative impact on performance.

| | 2ww 1st seen standards | | FDS | 31 day treatment standards | | | | 62 day referral to treatment standards | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Urgent suspected cancer | Breast symptomatic | Faster Diagnosis Standard | 1st treatment | Subsequent surgery | Subsequent drugs | Subsequent radiotherapy | Urgent suspected GP cancer | Urgent Screening | Consultant upgrade |
| BTH | 92.5% | 97.2% | 62.7% | 99.0% | 100.0% | 100% | N/A | 77.3% | 40% | 88.3% |
| ELHT | 90.1% | 97.2% | 74.5% | 94.2% | 87.9% | 100% | N/A | 74.2% | 66.7% | 89.8% |
| LTHT | 93.6% | 92.7% | 78.0% | 86.3% | 71.8% | 100% | 100% | 58.7% | 83.3% | 74.2% |
| UHMB | 91.7% | 87.0% | 80.3% | 89.9% | 76.9% | 98.6% | N/A | 59.4% | 60% | 84.3% |
| CA | 91.1% | 93.2% | 72.7% | 92.0% | 82.1% | 99.7% | 99.1% | 66.5% | 66.7% | 82.7% |
| NW | 89.7% | 88.3% | 73.4% | 95.3% | 89.5% | 99.8% | 99.5% | 71.3% | 78.2% | 81.5% |
| England | 84.7% | 79.1% | 72.6% | 93.7% | 84.9% | 99.9% | 95.6% | 70.7% | 74.8% | 80.6% |
| Standard | 93% | 93% | 75% | 96% | 94% | 98% | 94% | 85% | 90% | N/A |

4.4.2. The table above shows that in August 2021 L&SC ICS performance against the cancer waiting times targets has been challenging. The Alliance is meeting only 3 out of 9 standards. Although the Cancer waiting times standards 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. Against the 62 day standard the Alliance would require 82 fewer breaches.

4.4.3. Performance for our populations are reflected in the table below for August 2021 against the national standards:

| CCG | 2 weeks 93% std | 2 week breast 93% std | 31 day 96% std | 62 day 85% std |
|---|---|---|---|---|
| BwD | 88.4% | 95.9% | 87.0% | 63.3% |
| Blackpool | 91.6% | 100.0% | 92.2% | 67.3% |
| CSR | 93.3% | 92.2% | 91.3% | 65.2% |
| EL | 90.7% | 96.9% | 93.6% | 76.9% |
| FW | 93.3% | 95.4% | 94.9% | 77.2% |
| GP | 93.8% | 88.9% | 86.8% | 59.2% |
| MB | 91.8% | 85.9% | 90.5% | 58.5% |
| WL | 81.1% | 90.0% | 97.1% | 46.4% |
| All CCGs | 91.1% | 93.22% | 92.0% | 66.56% |

4.4.4. The Faster Diagnostic Standard becomes a constitutional target from October 2021 at 75%. H2 planning includes achieving the standard as part of cancer performance. Performance in the last few months has deteriorated. The Trusts and Alliance have established a FDS group to manage performance improvement.

4.4.5. There are several 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 a larger proportion of all breaches of the 62 day standard, second only to Urology. Surgical pressures at LTHT, our largest surgical provider and Oncology workforce pressures are extending pathways for patients.

4.4.6. Targeted investment and improvement activities are in place. Rapid Diagnostic Centre programmes in upper and lower GI and prostate are being delivered in 2021/22. System-level support from the NHS IST to focus on key areas across all trusts. Progress against a six-point plan is half way thru and on track to deliver the remaining actions over the next few months. In addition to the significant investment in endoscopy, we are leading the way nationally on the use of double faecal immunochemical test and are using the data to review processes for the use to manage demand. Following the covid pandemic the Alliance is revisiting optimal timed pathways to improve outcomes for patients, with an initial focus on Lung.

4.4.7. A new regional policy has been released to manage patients with waits over 104 days. A working group including trusts and commissioning colleagues will meet to implement the policy across the system.

4.4.8. L&SC Cancer Alliance are ranked 1st out of the 21 Cancer Alliances in England in terms of restoration of urgent cancer referral numbers in August 2021 and since March 2020. Restoration of treatments is 99% slightly below the NW and England. Data indicates that our gap in treatments is from screening and other routes (for example routine activity) not 2WW.

4.4.9. The table below shows the level of restoration in July 2021/22 compared to July 2019/20 for referrals and 1st treatments at providers in L&SC.

| Trust | Referrals Seen | 1st Treatments |
|---|---|---|
| BTH | 109% | 115% |
| ELHT | 122% | 81% |
| LTHT | 118% | 114% |
| UHMB | 122% | 89% |
| CA | 107% | 98.9% |
| NW | 113.5% | 99.2% |
| England | 105% | 100.1% |

4.5. 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 FDS
- Continue to roll out RDC 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

4.6. 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

4.7. 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:


4.8. Key Risks and Issues

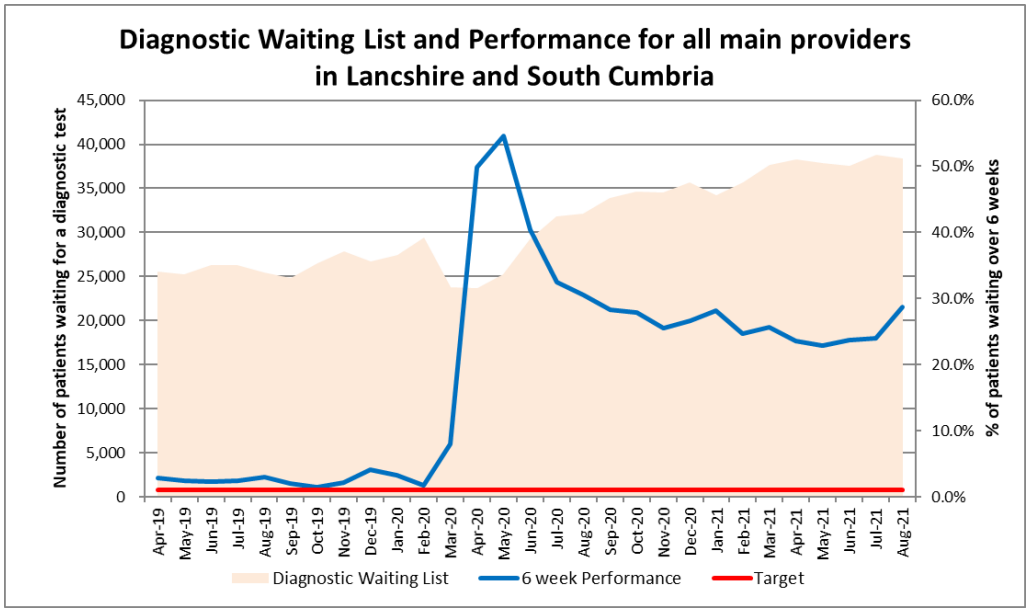
| Issue | Description | Mitigation |
|---|---|---|
| Ongoing COVID related pressures leading to reduced capacity to deliver fully restored services | Current bed occupation and COVID cases in hospital impacting on elective programme with some isolated cases of cancer surgery being cancelled | Weekly 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 | L&SC has lower ratio of diagnostic capacity compared to | Working with Diagnostics programme re: roll out of CDHs, and large investment in |

| Issue | Description | Mitigation |
|---|---|---|
| | other NW regions for key imaging and endoscopy modalities | endoscopy workforce schemes. Capital bid successful for endoscopy during 2020 - £6.9m |

## 5. Diagnostics

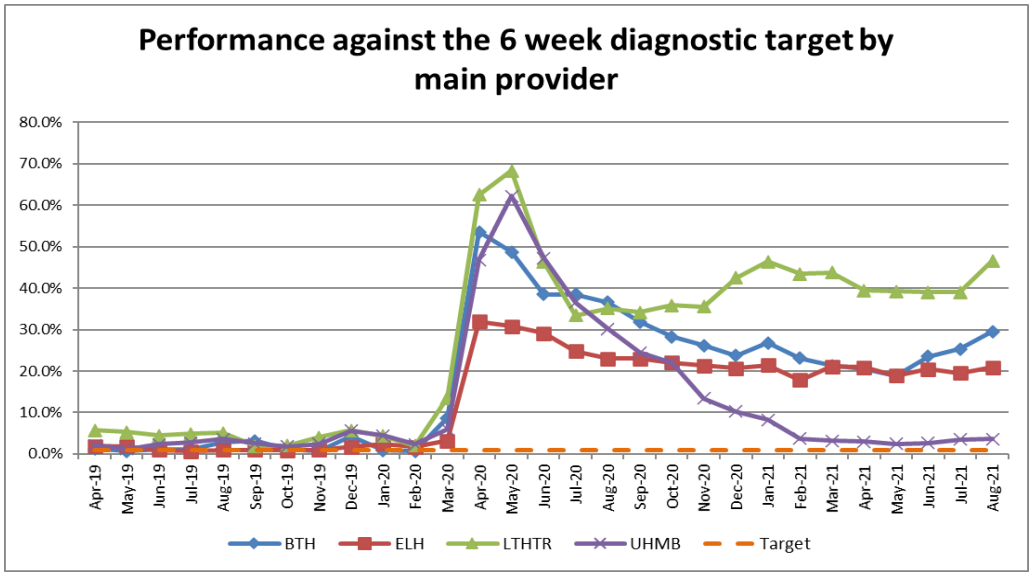
5.1. Overview of Diagnostic Performance

5.1.1. There has been a significant deterioration in performance across L&SC in the 6 week diagnostic target, despite a fall in the number of patients waiting for tests. The deterioration in performance has been driven by falling performance at both LTHT and BTHT.




5.2. Overview of Performance at Provider Level

5.2.1. The data at provider levels shows the deterioration in performance at both LTHT and BTHT (which are showing an upward trend in the past 3 months). The performance at ELHT has continued to remain steady at around 20%, with the performance at UHMB still significantly better than the other providers and steady at 3.5%.




5.2.2. The reduction in the waiting list overall is due to reductions at BTHT, UHMB and a large reduction at ELHT being offset somewhat by a large increase in the waiting list at LTHT.

5.3. Performance at Procedure Level

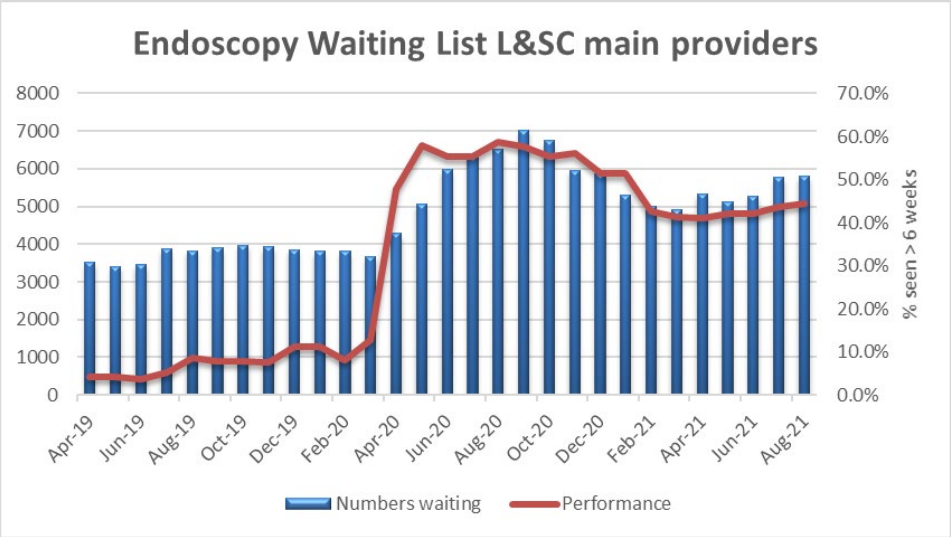
5.3.1. The general trend is deteriorating performance across all providers for both Endoscopic and non-Endoscopic diagnostic tests. The only improvement area for performance was in LTHT for Endoscopy, which showed a slight improvement from a very high base. UHMB continue to have the best performance across both Endoscopy and Non Endoscopy.

5.3.2. The largest deterioration month on month was Non Endoscopy at LTHT which was mainly attributable to Non Obstetric Ultrasound performance in August 2021, effected by a reduction in capacity partly due to COVID isolation issues. The position further deteriorated due to extra demand. Extra capacity has been identified and it is expected that the position will improve over the coming months.

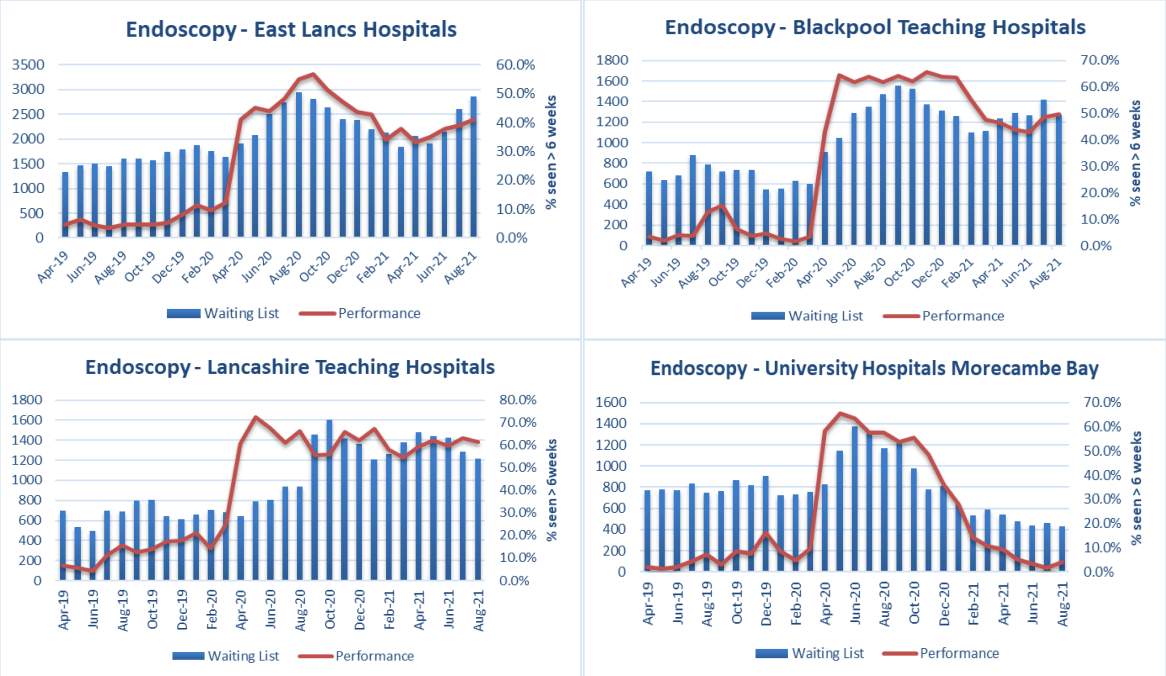
| | % of patients waiting over 6 weeks (August 21) | | |
|---|---|---|---|
| **Provider** | **Endoscopy** | **Non Endoscopy** | **All Diagnostic Tests** |
| BTHT | 49% ↑ | 20% ↑ | 30% ↑ |
| ELHT | 40% ↑ | 17% ↑ | 21% ↑ |
| LTHT | 61% ↓ | 46% ↑ | 47% ↑ |
| UHMB | 4% ↑ | 4% ↔ | 4% ↔ |

5.4. Endoscopy

5.4.1. The information at provider level shows a strong correlation between the increase in numbers waiting for Endoscopy and the deterioration in performance as a result of the pandemic. The waiting list peaked in September 2020 before falling with the resulting improvement in performance. The waiting list shows a levelling off in the month, however performance in Endoscopy has deteriorated further and is now 44.5% for August 2021. LTHT have the most challenged performance despite seeing an improvement in the month.

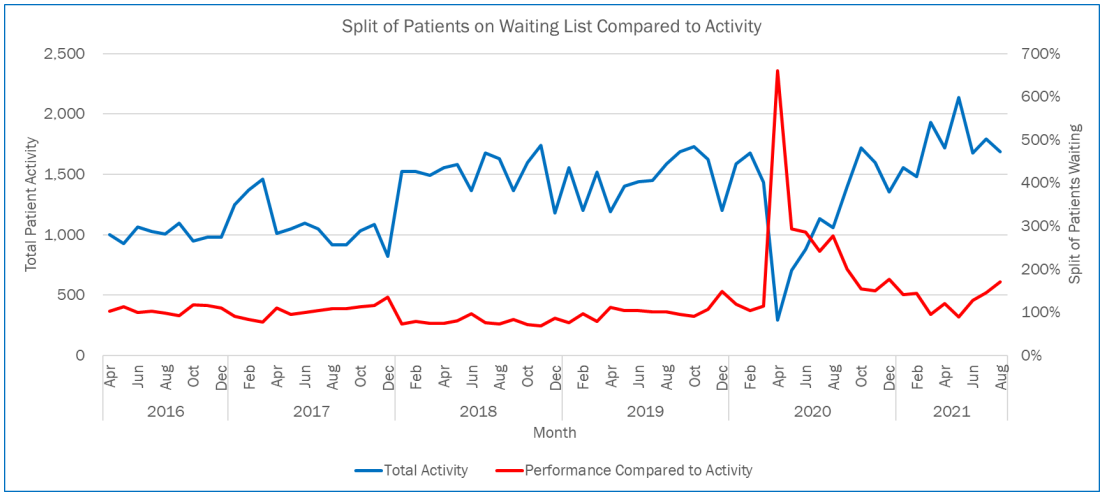



5.4.2. The performance at individual hospitals for August is showing very different patterns of performance. ELHT are experiencing an increase in the waiting list and a consequent deterioration in the performance for endoscopy. Although the waiting list fell at BTHT there was a slight worsening of performance in the month. UHMB continue on their relatively strong performance trend with a fall in their overall waiting list. LTHT are experiencing a fall in their waiting list which has been happening since a peak in April 2021. There was also an improvement in performance in August 2021 albeit from a high base.




5.4.3. The fall in the waiting list at LTHT is mainly due to an increase in the Cystoscopy activity. The performance and waiting list for Colonoscopy, Gastroscopy and Sigmoidoscopy remains challenged.

5.4.4. Although the position at ELHT worsened in the last months, the graph below shows that activity levels remain higher than at previous COVID levels. There is obviously increase sustained demand for Endoscopy at ELHT which is impacting on the performance and waiting list position.




5.4.5. At an ICS level the programme of work for diagnostics is presently working through 4 main initiatives.

**1. Community Diagnostic Hubs**

The first phase of delivery to Community Diagnostic Hubs across each of the ICPs has commenced, concentrating on diagnostic imaging particularly MRI scans. The year 2 plans have been submitted and all ICPs have included endoscopy, the financial envelope for the year 2 funding is yet to be confirmed.

**2. Increasing capacity through the North West Endoscopy Academy**

Funding has been agreed for the NW Endoscopy Academy for the financial year 2021/22. In the short term (up to Q3 of 2021/22) there will a drive to increase student nurse placements, have ICS experienced nurse trainers courses and improve in unit training resources. Longer term there will be a policy to make L&SC a best in breed destination to the national endoscopy workforce through JAG/BSG/BMJ and the creation of an ICS Staff Bank with an inhouse option to insourcing. The goal of developing a community workforce model as well as Acute, will complement the role out of Community Diagnostic Hubs.

**3. Restoring Bowel Cancer Screening Pathways**

Lancashire remains very fragile service attracting significant attention nationally. There have been 2 newly accredited colonoscopists (BTHT and ELHT). Plans being worked up to create additional capacity with insourcing at LTHT.

In Cumbria PHE are satisfied with the recovery plan, however sickness in August/ September 2021 has led to some Bowel Cancer Screening Programme lists being cancelled or offered to insource providers.

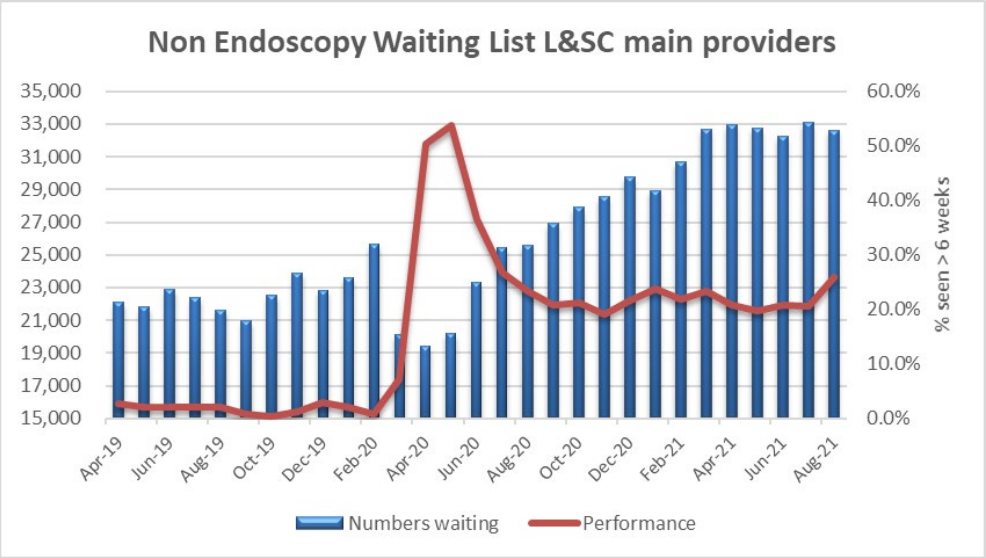
**4. Demand Management**

There is a roll out of a programme of measures including: Working with Double FIT programme to maximise uptake and benefit of FIT in Primary and Secondary Care, Cytosponge and Colon Capsule Endoscopy to Primary Care and Community Diagnostic Hubs and working with Radiology teams to improve access to CT Colonoscopy for endoscopy patients.

5.4.6. The main providers continue to work with the Clinical Validation Programme to assign the waiting list for Endoscopy to the appropriate D codes which are listed in Appendix 1.

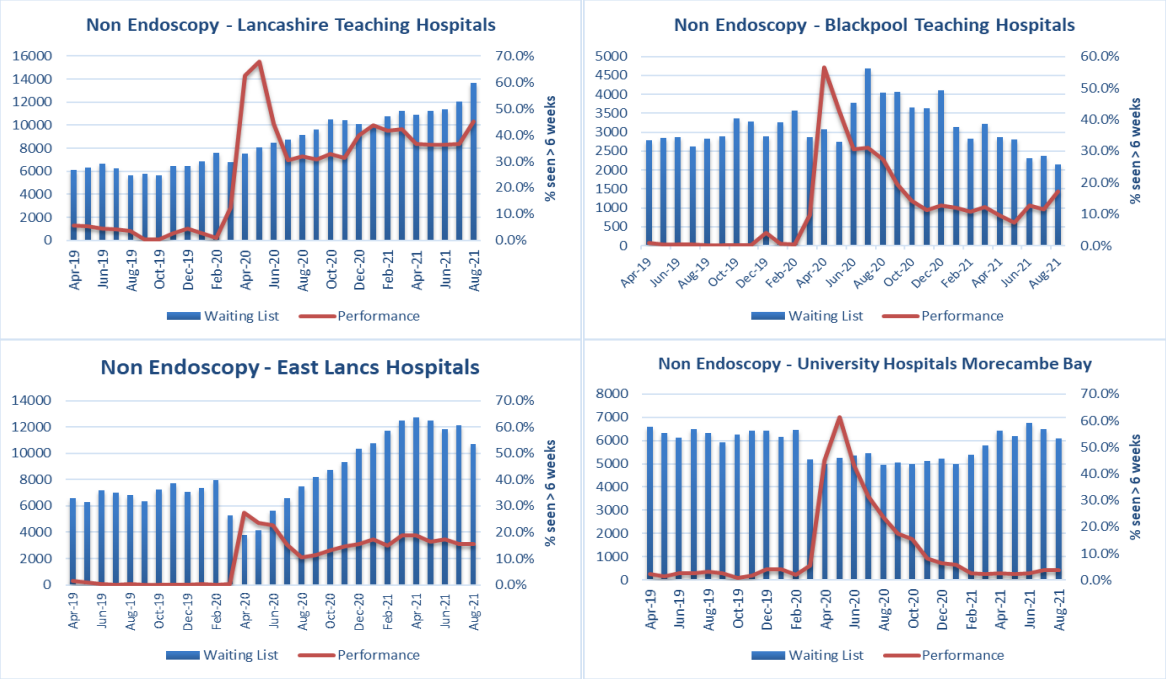
5.5. <u>Non Endoscopy</u>

5.5.1. Although the waiting list decreased for L&SC in August 2021, there was a worsening of performance mainly due to performance deteriorating in LTHT and BTHT.




5.5.2. The data for Non Endoscopic procedures at provider level shows worsening performance at LTHT and BTHT. The waiting list for BTHT has fallen whereas for LTHT it has increased month on month.

5.5.3. ELHT and UHMB have both shown a reduction in their waiting list, with a steady performance position from the previous month.




5.6. <u>Quality</u>

5.6.1. The latest information with regards to the potential impact on quality from the current demands in diagnostic shows that for August 2021 the main themes are missed incidental findings and failure to follow up once the diagnostic has been completed. A piece of work is currently being undertaken to address the concerns.

5.6.2. Delays within radiology is notable across the ICS and harms may come once they have completed their investigation and referred for treatment. Endoscopy is an area of concern and trusts have action plans in place.

5.6.3. LTHT are undergoing building works which will impact on the capacity in Endoscopy for 5 weeks from early October 2021. They are presently in discussions with the Independent Sector to secure alternative capacity.

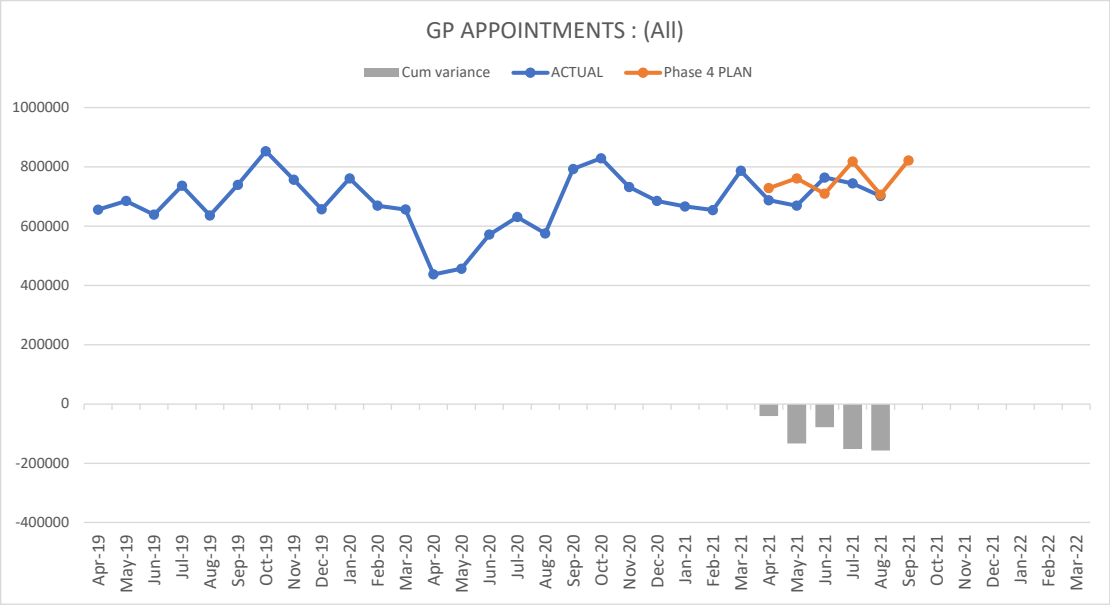
5.6.4. Services continue to be impacted by sickness absence at times and patients being unwilling to attend over continuing COVID concerns leading to extended waiting times.

## 6. Elective Care

6.1. Demand

6.1.1. Appointment demand and activity per working day in the month within GP practices has exceeded levels seen in the pre-COVID period (Chart 1) comparing August 21 to August 19. [Note : The GP appointment book systems from which this data is taken are not primarily designed for data analysis purposes.]

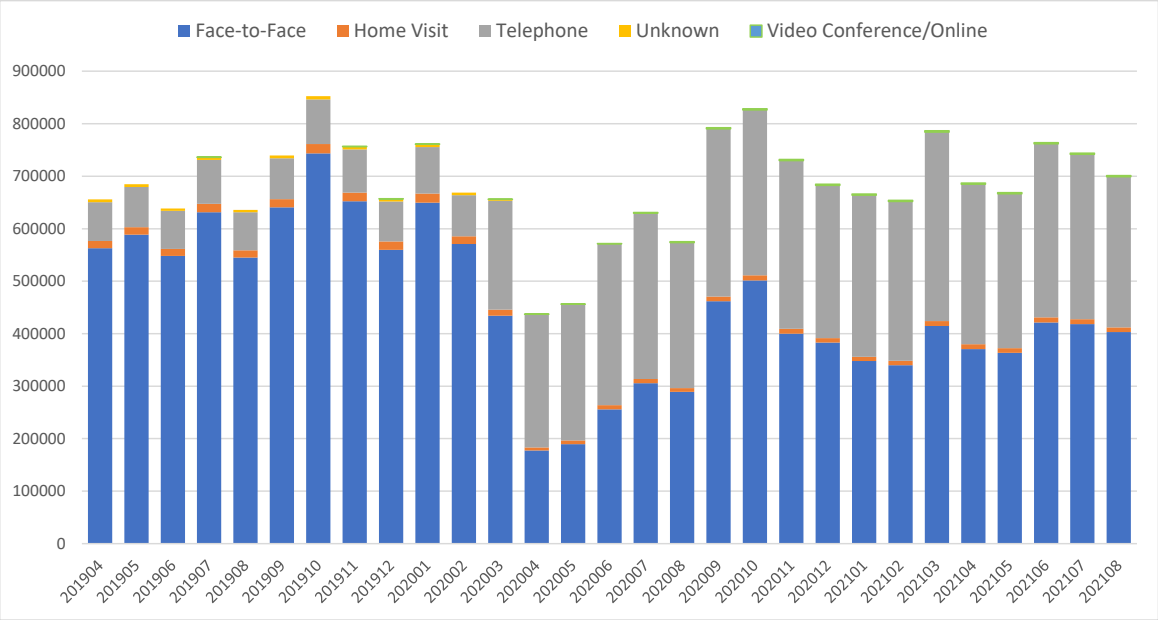
6.1.2. Chart 1 – GP Appointment trends and 2021 H1 plan




6.1.3. The 'type' of appointment has changed with reductions in face-to-face appointments and increases in telephone and video appointments.

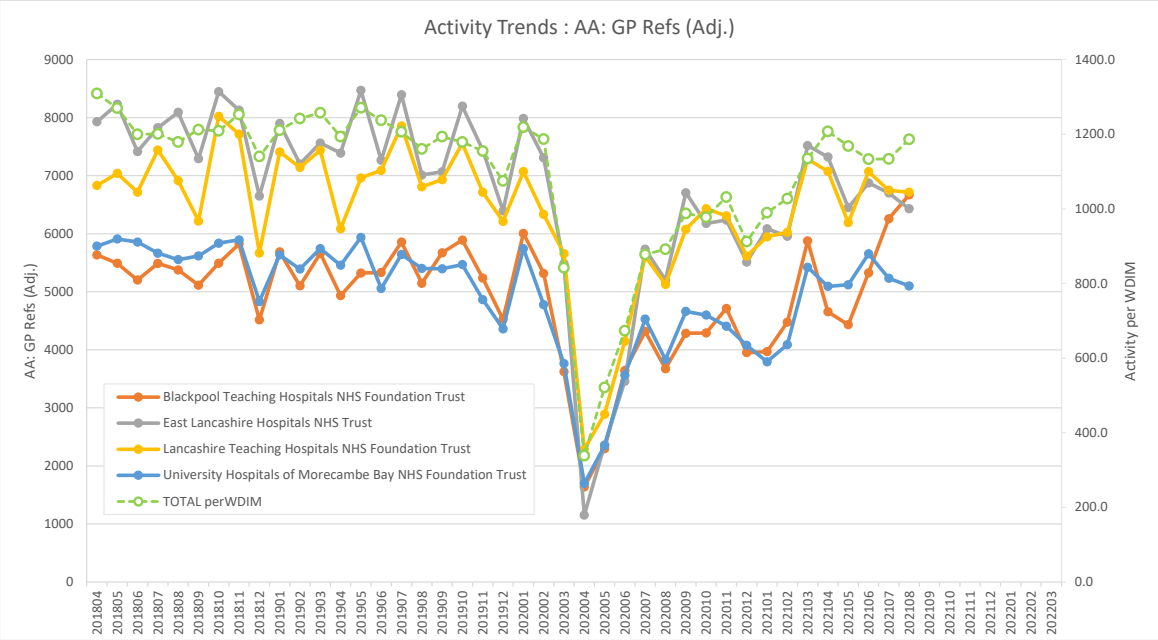
| Period | % Face to Face Appointments | % Telephone Appointments |
|---|---|---|
| April-Aug 2019 | 85.8% | 11.3% |
| April-Aug 2021 | 55.4% | 42.9% |

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 3 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-Aug 21 activity across the 4 x L&SC providers (adjusted for working days in the month) was 95.1% of the GP referral activity in Apr-Aug 19.

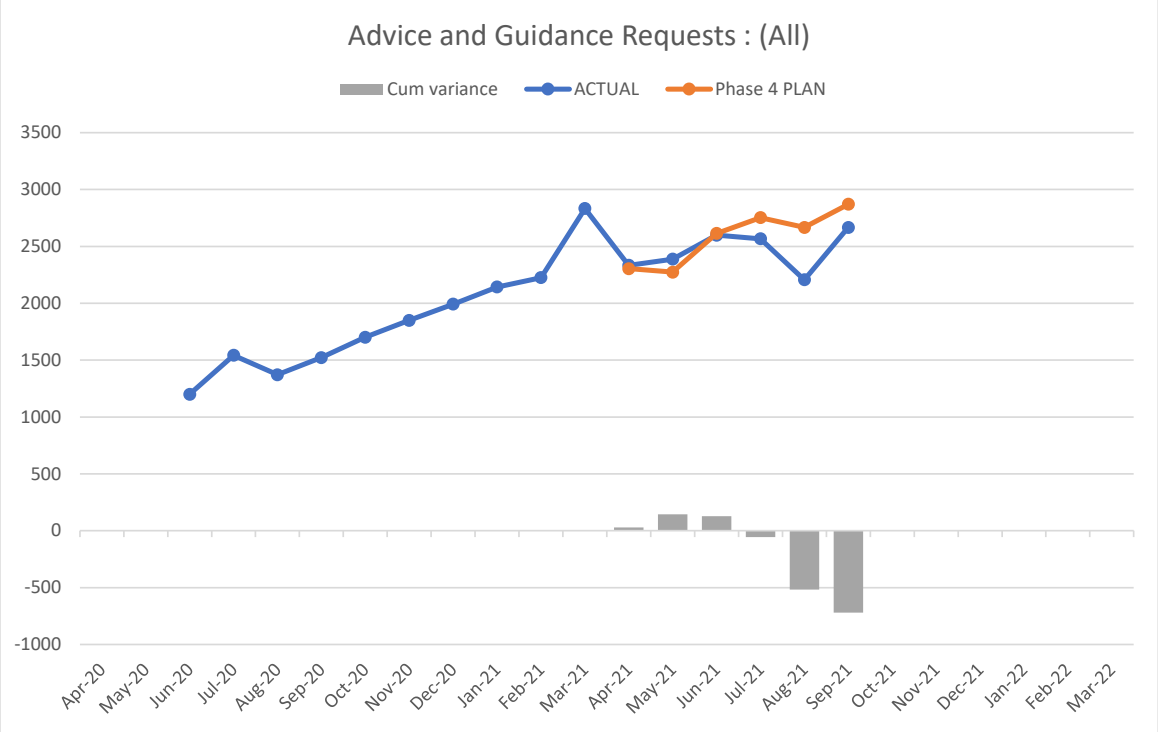
6.1.6. Chart 3 – GP referrals into the 4 main acute hospitals across L&SC




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 it is expected that this will continue [Chart 5]. 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). Current performance shows the system is currently at 5.4% with ranges from 2.1% to 9.9%.

6.1.8. Chart 4 – Advice and Guidance requests and Final Phase 4 H1 Plan




6.1.9. Figures presented to the L&SC Advice and Guidance working group indicate that across the 8 x L&SC CCGs, around 91% of all A&G activity is through the UHMB system, with around 7% via the ERS system and the small remainder via 'Consultant Connect' in WL CCG.

6.1.10. 87.3% of all Advice and Guidance requests in Apr-Sep 21 through the UHMB system were responded to within 2 days while referrals to outpatients were effectively halved (Table 1)

6.1.11. Table 1 – Pre and Post- Advice and Guidance outcomes Apr-Sep 2021

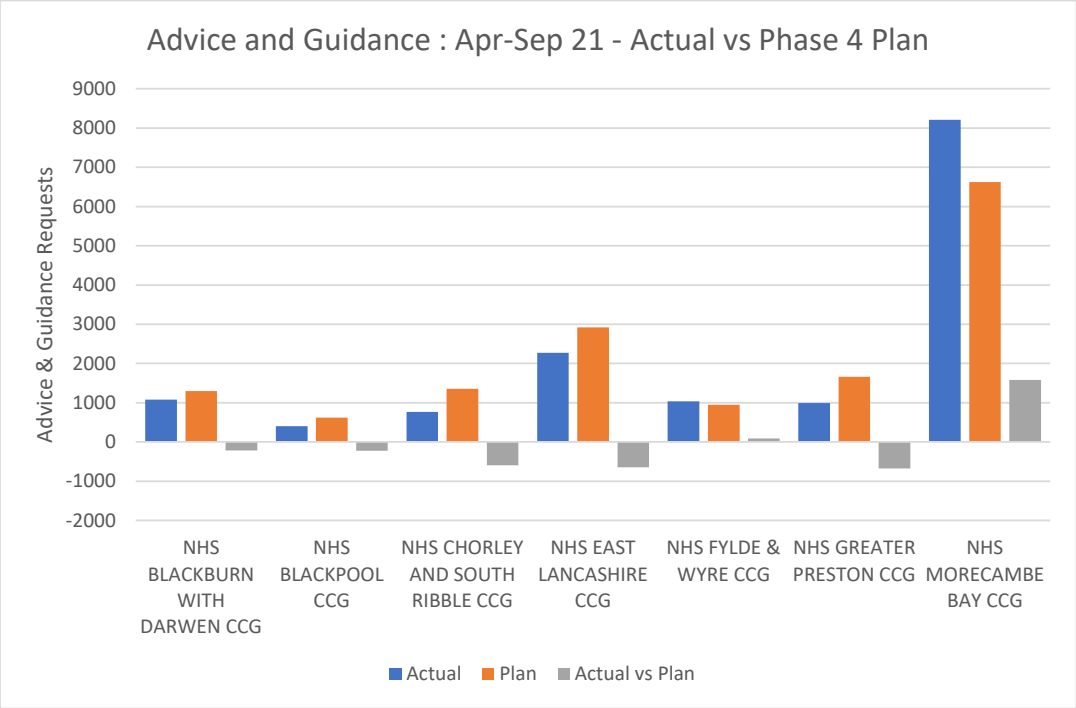
| Treatment Plan (Apr-Sep) | BEFORE | AFTER A&G | MOVEMENT | % SHIFT |
|---|---|---|---|---|
| Admit | 1708 | 1581 | -127 | -7.4% |
| Carry out further investigations | 791 | 1504 | 713 | 90.1% |
| Forced Closure | | 592 | 592 | |
| Manage patient's care myself | 923 | 4384 | 3461 | 375.0% |
| Other | 990 | 1434 | 444 | 44.8% |
| Radiology test sanctioned by radiologist | | 563 | 563 | |
| Refer to outpatients | 6324 | 3224 | -3100 | -49.0% |
| Seek advice from another source | 2423 | 469 | -1954 | -80.6% |
| (blank) | 1601 | 1009 | -592 | -37.0% |
| **TOTAL** | **14760** | **14760** | **0** | **0.0%** |

6.1.12. The volume of advice and guidance requests reported in July, August and September 2021 are 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. MB CCG (early adopter) accounts for over half of all advice and guidance requests and is also over plan.

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

| CCG Name | Actual | Plan | Actual vs Plan | % Variance |
|---|---|---|---|---|
| NHS BLACKBURN WITH DARWEN CCG | 1082 | 1298 | -216 | -16.6% |
| NHS BLACKPOOL CCG | 400 | 625 | -225 | -36.0% |
| NHS CHORLEY AND SOUTH RIBBLE CCG | 768 | 1359 | -591 | -43.5% |
| NHS EAST LANCASHIRE CCG | 2276 | 2917 | -641 | -22.0% |
| NHS FYLDE & WYRE CCG | 1036 | 949 | 87 | 9.2% |
| NHS GREATER PRESTON CCG | 989 | 1661 | -672 | -40.5% |
| NHS MORECAMBE BAY CCG | 8209 | 6624 | 1585 | 23.9% |
| **TOTAL** | **14760** | **15433** | **-673** | **-4.4%** |
| | | | | |
| Total Excluding Mbay | 6551 | 8809 | -2258 | -25.6% |

6.1.14. Chart 5 – Advice and Guidance requests by CCG : April to Sep 2021




6.1.15. Radiology, Dermatology, Cardiology and Clinical Haematology are the 4 specialties that receive the greatest number of A&G requests (40.0% of all A&G requests in Apr-Sep21). 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.

R RECOMMENDATION: Take action to promote and maximise the use of A&G across the ICS

6.2. <u>Activity</u>

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, ICS' must deliver 70%, of the elective

activity levels[2] 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 ERF 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).

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 [Adjusted] | 18803 | 18530 | 21068 | 20473 | 19063 | 20597 |
| 2021-22 | 17122 | 17146 | 19791 | 24571 | 22879 | 24721 |
| % of 'baseline' | **91.1%** | **92.5%** | **93.9%** | **120.0%** | **120.0%** | **120.0%** |

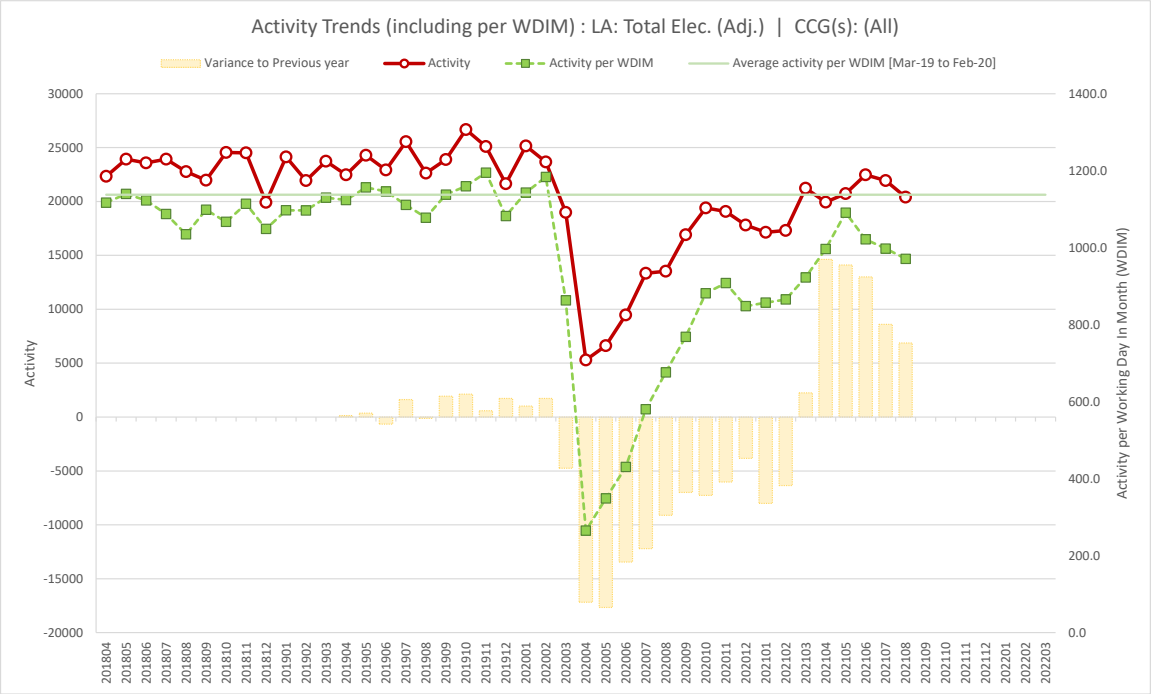
| | TOTAL ELECTIVE [All CCG Commissioned Activity] | | | | | |
|---|---|---|---|---|---|---|
| | April | May | June | July | August | September |
| 2019-20 [Adjusted] | 22467 | 21977 | 25231 | 24416 | 22630 | 25058 |
| 2021-22 | 20500 | 20329 | 23687 | 29013 | 26923 | 29617 |
| % of 'baseline' | **91.2%** | **92.5%** | **93.9%** | **118.8%** | **119.0%** | **118.2%** |

6.2.4. Activity trends based on the national dataset for CCGs (across all providers) indicates that recovery has not increased to levels in the Phase 4 plan or the national aspiration.

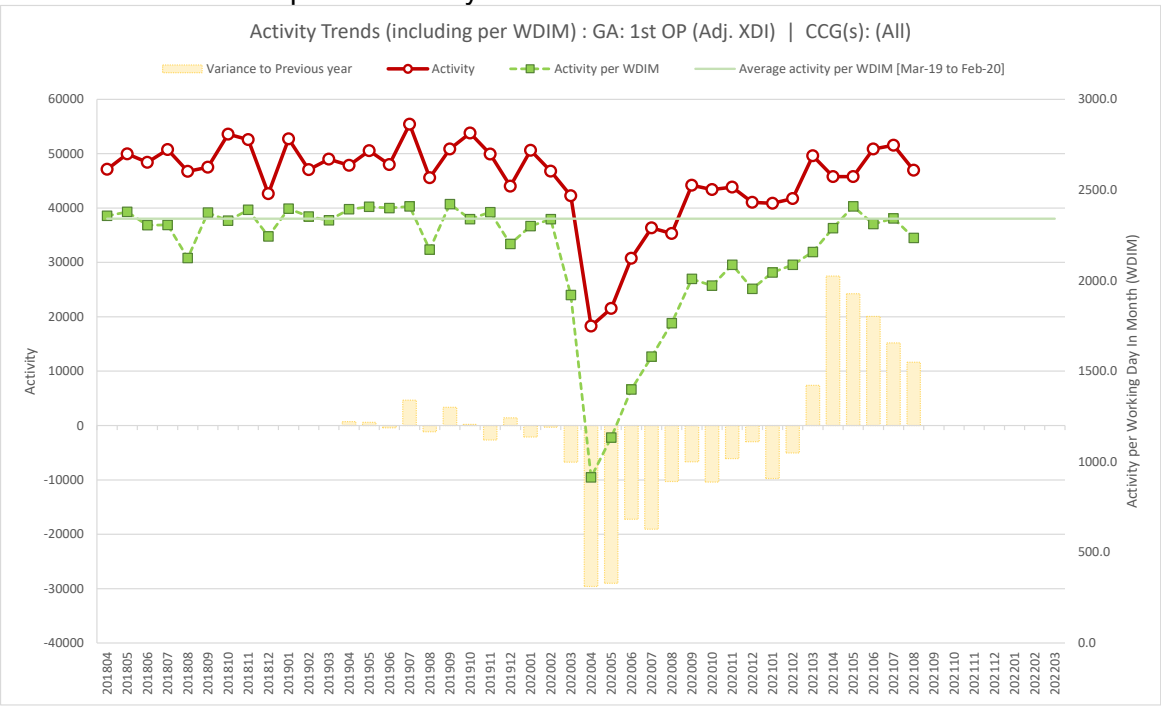
| Activity Type | Aug 2019 (Activity per WDIM) | Aug 2021 (Activity per WDIM) | Aug 21 Indicative Recovery % |
|---|---|---|---|
| Total Elective (EL+DC) | 1078.0 | 971.2 | 90.10% |
| First Outpatients | 2170.4 | 2235.1 | 102.98% |
| Follow-Up Outpatients | 4299.4 | 4298.8 | 99.99% |

[2] A sub-set of total activity

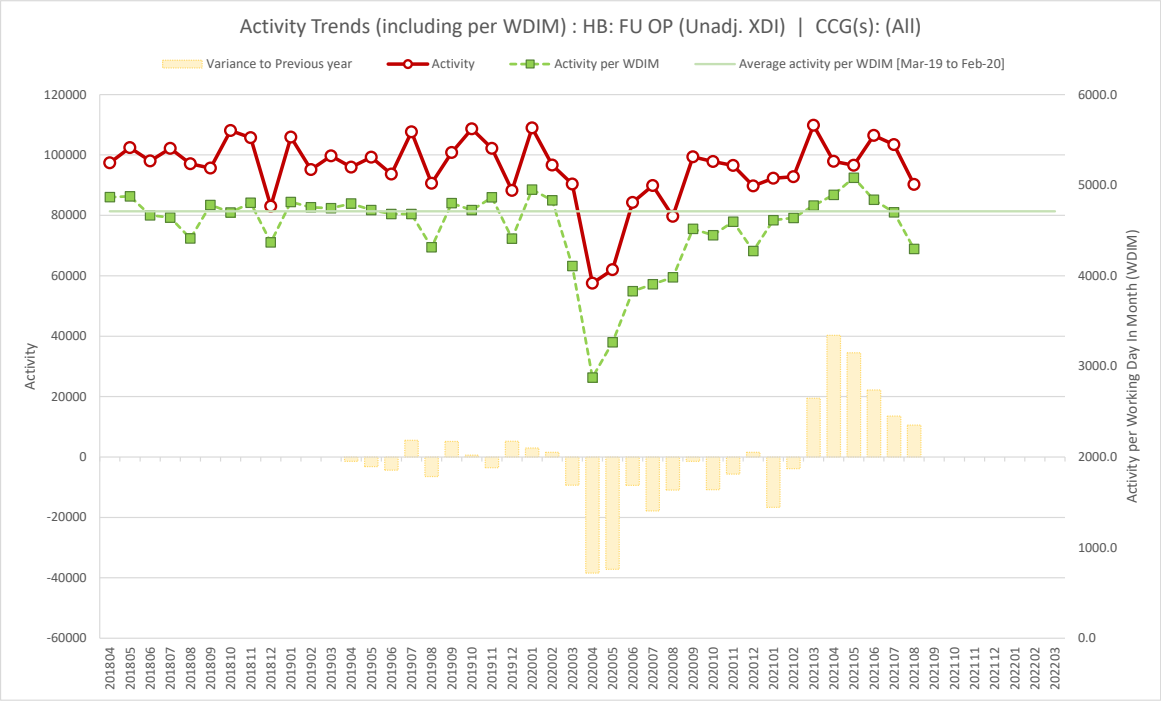
### 6.2.5. Chart – Total Elective Activity Trends – L&SC CCGs




### 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 (WAR) information has been reviewed across the North West, and for the week to 10th October 2021, the total elective recovery position (elective ordinary and daycases) was strongest in GM. There is variation at provider level underneath this L&SC position.

6.2.9. Recovery – Elective activity and daycases (w/e 10th October 2021) – ICS Level

| Name | Historic Weekly Activity | Current Weekly Activity (raw values) | Variance | % activity restored (raw values) |
|---|---|---|---|---|
| North West | 22,423 | 18,874 | 3,549 | 84.2 % |
| C&M | 8,138 | 6,312 | 1,826 | 77.6 % |
| GM | 9,297 | 8,424 | 873 | 90.6 % |
| L&SC | 4,988 | 4,138 | 850 | 83 % |

6.2.10. Recovery – Elective activity and daycases (w/e 10th October 2021) – Provider Level

| Name | Historic Weekly Activity | Current Weekly Activity (raw values) | Variance | % activity restored (raw values) |
|---|---|---|---|---|
| L&SC | 4,988 | 4,138 | 850 | 83 % |
| Blackpool Teaching | 1,225 | 1,054 | 171 | 86 % |
| East Lancashire | 1,393 | 1,061 | 332 | 76.2 % |
| Lancashire Teaching | 1,422 | 1,091 | 331 | 76.7 % |
| Morecambe Bay | 948 | 932 | 16 | 98.3 % |

6.2.11. In terms of outpatient activity (first and follow-up), national figures also report that the L&SC position is back to historic 'core' levels.

6.2.12. Recovery – Outpatient (First and Follow-up) (w/e 10th October 2021) – ICS Level

| Name | Historic Weekly Activity | Current Weekly Activity (raw values) | Variance | % activity restored (raw values) |
|---|---|---|---|---|
| North West | 185,002 | 184,515 | 487 | 99.7 % |
| C&M | 74,964 | 66,987 | 7,977 | 89.4 % |
| GM | 77,265 | 84,804 | -7,539 | 109.8 % |
| L&SC | 32,773 | 32,724 | 49 | 99.9 % |

6.2.13. Early indication weekly activity has been used by the ECRG to highlight the position in September 2021 against the Core, Core+ and Accelerator targets. The pace of restoration is different between the individual providers within the ICS. Core targets are being met based on the rolling 4 weeks to 19th September 2021. However, no Core+ or Accelerator targets are being achieved.

6.2.14.

| September | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| WAR (excludes CCG IS) | | | NW Elective and Long Waits Brief (excludes CCG IS) | | | | | | | | |
| Restoration Target | | | Rolling 4 wk av. | | | | | % Diff v latest 4 wk av. | | | |
| Core | Core+ | Accel | POD | 05-Sep | 12-Sep | 19-Sep | 26-Sep | Core | Core+ | Accel |
| 84% | 100% | 120% | OEL | 90% | | 91% | | 6% | -10% | -30% |
| 83% | 100% | 120% | DC | 89% | | 87% | | 6% | -11% | -31% |
| 90% | 100% | 120% | OPFA | 97% | | 96% | | 7% | -3% | -23% |
| 95% | 102% | 120% | OPFUP | 98% | | 99% | | 3% | -4% | -22% |
| **92%** | **101%** | **120%** | **Total** | **97%** | | **96%** | | **5%** | **-4%** | **-23%** |

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 |

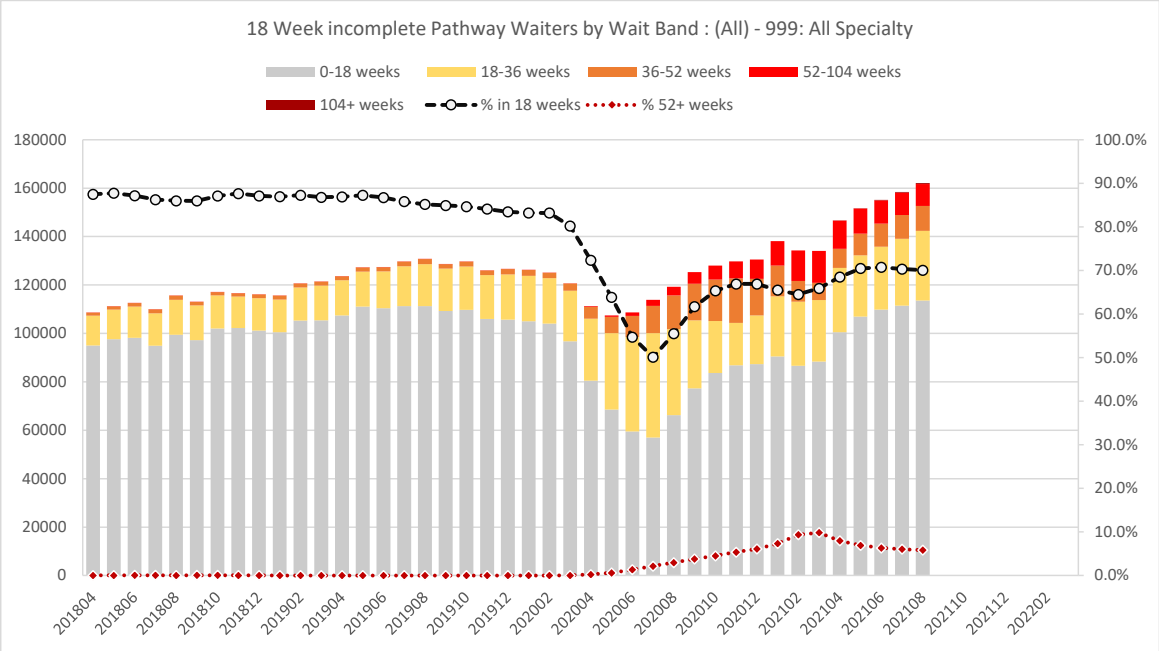
6.3. 18 Weeks Referral to Treatment Target / Incomplete Pathways / 52+ Week Waiters

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

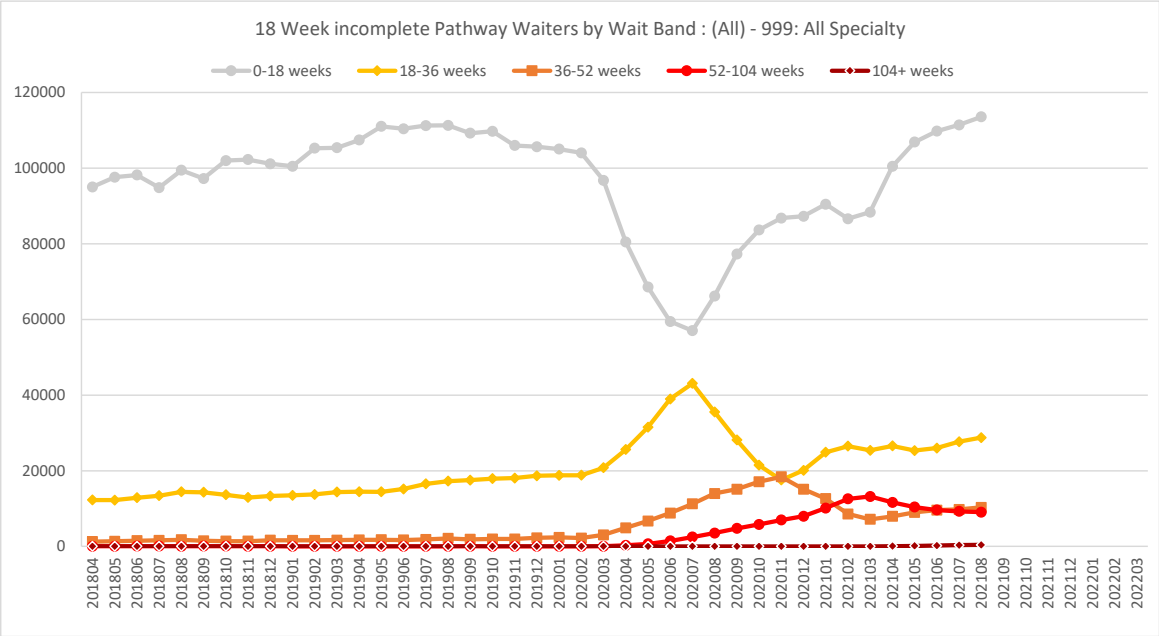
- The number of patients waiting to start treatment (incomplete pathways)
- The % of patients currently waiting up to 18 weeks to start treatment (Target 92%)
- The number and % of patients currently waiting 52+ weeks to start treatment (Target 0%)

6.3.2. The chart below shows the ICS performance (aggregated for the 8 x CCGs) against these 3 measures. Prior to the COVID pandemic, the total number of patients waiting to start treatment had stabilised and was showing signs that it was starting to reduce. In 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 August 2021 the total number of patients waiting to start treatment has increased to 162,109, performance against the 18-week standard was 70.1%, and there were 9,467 over 52-week waiters (5.8%) of which 409 had been waiting in excess of 104 weeks.

6.3.3. 18 week Incomplete Pathway Waiters – L&SC



6.3.4.




6.3.5. The number of over 52 week waiters has continued to slowly decrease in August 2021 although the 104+ week waiter numbers continue to grow. The 36-52 week cohort is showing an increase for the fifth consecutive month while the 0-18 band has continued to grow and is now at its highest position over the past 4 years.

6.3.6. 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 August 2021 return, 409 patients across L&SC had been waiting in excess of 104 weeks. 66% of these 104+ week waiters are reported to be waiting at LTHT. 25.4% of the 104+ day waiters are under the General Surgery specialty (across multiple providers) with 13% waiting for Plastic Surgery at LTHT.

6.3.7. Table – 104+ week waiters by provider and specialty (August 2021)

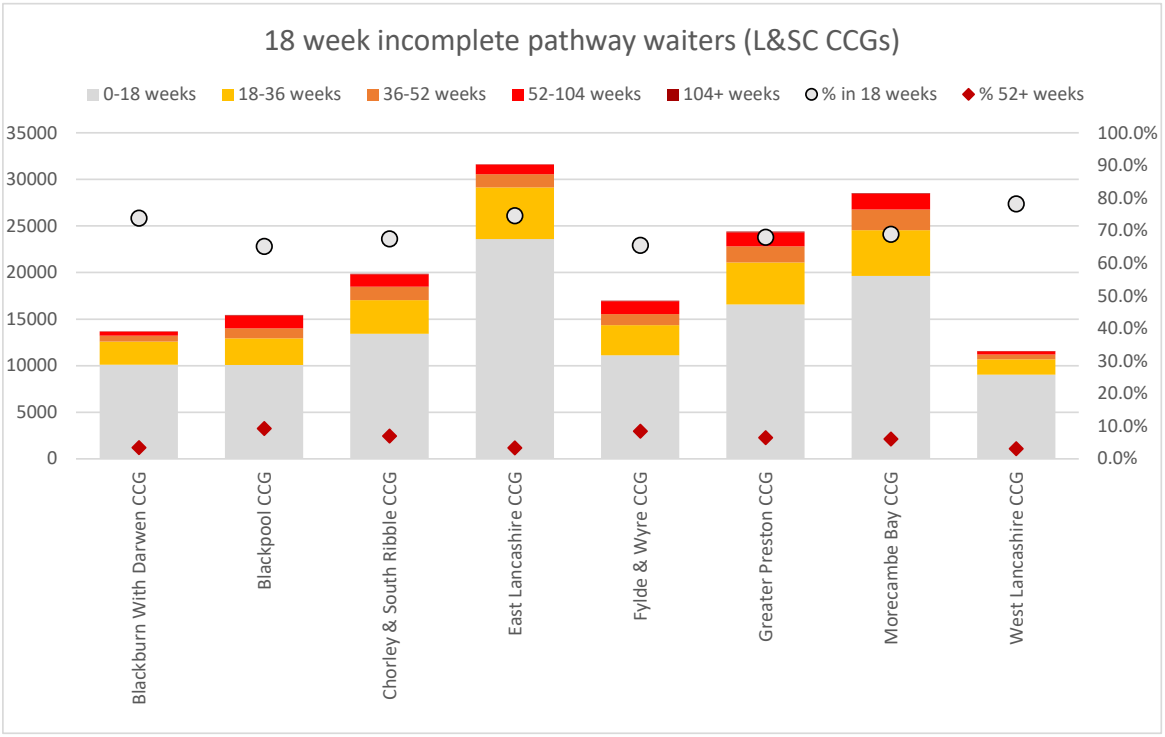
| PROVIDER | LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | MANCHESTER UNIVERSITY NHS FOUNDATION TRUST | SPIRE FYLDE COAST HOSPITAL | UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST | WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST | ALL OTHER | TOTAL | % TOTAL |
|---|---|---|---|---|---|---|---|---|---|
| 100: GENERAL SURGERY | 64 | 27 | 6 | 1 | 1 | 0 | 5 | 104 | 25.4% |
| 101: UROLOGY | 19 | 13 | 1 | 0 | 0 | 0 | 0 | 33 | 8.1% |
| 110: TRAUMA & ORTHOPAEDICS | 10 | 3 | 0 | 19 | 2 | 4 | 5 | 43 | 10.5% |
| 120: ENT | 63 | 1 | 6 | 1 | 2 | 0 | 2 | 75 | 18.3% |
| 130: OPHTHALMOLOGY | 15 | 0 | 5 | 7 | 1 | 0 | 0 | 28 | 6.8% |
| 160: PLASTIC SURGERY | 53 | 0 | 0 | 0 | 0 | 0 | 0 | 53 | 13.0% |
| 300: GENERAL MEDICINE | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0.7% |
| 400: NEUROLOGY | 25 | 0 | 0 | 0 | 0 | 0 | 0 | 25 | 6.1% |
| 502: GYNAECOLOGY | 7 | 0 | 8 | 3 | 0 | 0 | 0 | 18 | 4.4% |
| X05: All other TREATMENT FUNCTIONS in the Surgical group nc | 0 | 0 | 1 | 0 | 0 | 1 | 2 | 4 | 1.0% |
| X04: All other TREATMENT FUNCTIONS in the Paediatric group | 0 | 0 | 10 | 0 | 0 | 0 | 2 | 12 | 2.9% |
| X02: All other TREATMENT FUNCTIONS in the Medical Services | 11 | 0 | 0 | 0 | 0 | 0 | 0 | 11 | 2.7% |
| **Grand Total** | **270** | **44** | **37** | **31** | **6** | **5** | **16** | **409** | **100.0%** |
| % TOTAL | 66.0% | 10.8% | 9.0% | 7.6% | 1.5% | 1.2% | 3.9% | **100.0%** | |

6.3.8. The following table and chart show the variation in numbers of patients waiting to start treatment and the % waiting 18 weeks and 52+ weeks at the end of August 2021 by CCG. 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 8% of patients are waiting 52+ weeks.

6.3.9. Table - Waiting list variation between CCGs (August 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 | 10108 | 2489 | 616 | 446 | 28 | 13687 | 73.9% | 3.5% |
| Blackpool CCG | 10071 | 2851 | 1089 | 1376 | 65 | 15452 | 65.2% | 9.3% |
| Chorley & South Ribble CCG | 13416 | 3617 | 1463 | 1304 | 79 | 19879 | 67.5% | 7.0% |
| East Lancashire CCG | 23597 | 5536 | 1439 | 1018 | 32 | 31622 | 74.6% | 3.3% |
| Fylde & Wyre CCG | 11118 | 3231 | 1196 | 1371 | 63 | 16979 | 65.5% | 8.4% |
| Greater Preston CCG | 16590 | 4489 | 1737 | 1506 | 86 | 24408 | 68.0% | 6.5% |
| Morecambe Bay CCG | 19644 | 4913 | 2231 | 1689 | 47 | 28524 | 68.9% | 6.1% |
| West Lancashire CCG | 9040 | 1630 | 531 | 348 | 9 | 11558 | 78.2% | 3.1% |
| **Grand Total** | **113584** | **28756** | **10302** | **9058** | **409** | **162109** | **70.1%** | **5.8%** |

6.3.10.




6.3.11. 75.1% of all over 52-week waiters for the CCGs are at the four main providers in the ICS, with 46.1% at LTHT (See Appendix 1). Four specialties account for 59% of all long waiters (as at the end of August 2021):

| Specialty | August 2021 | % Total 52+ week waiters |
|---|---|---|
| Trauma & Orthopaedics | 2,014 | 21.3% |
| General Surgery | 1,767 | 18.7% |
| ENT | 1,080 | 11.4% |
| Ophthalmology | 724 | 7.6% |
| **Top 4** | **5,585** | **59.0%** |

6.3.12. 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 (2,005) with 88.3% 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]

6.3.13. The Elective Activity Co-Ordination Team working to the ECRG is tracking the 52+ week and 104+ week information on a weekly basis. The team is working with Clinical Networks to

support efficient delivery, plans to support and sustain continued reduction in 52 week waits while exploring areas in which mutual aid could be delivered.

6.3.14. For patients waiting over 52 and 104 weeks processes are in place at each provider across L&SC to identify any harm as a result of the long waits; to date no harms have been identified or StEIS incidents declared, however as previously stated there needs to be an acknowledgement that some harms may only start to emerge when patients are actually brought in for treatment. CCG quality teams are working closely with provider colleagues to agree the implementation of the Clinical Harms Review requirements. A paper was submitted to the most recent ECRG meeting with a recommendation that each Acute Trust provides a definitive position on how they intend to meet the requirements outlined in the Harm Review Guidance, any associated risks and the mitigation plans.

6.3.15. All quality teams continue to be acutely aware that the current position in respect of long waits is a key line of enquiry with the need to continually seek opportunities to check and triangulate information/intelligence 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, survey feedback, NHS Choices intelligence, media and at all quality review meetings.

## 7. Nosocomial Infections

7.1. Introduction

7.1.1. This section provides an overview of Nosocomial COVID-19 infection presence within the L&SC ICS.

7.2. Overview

7.2.1. The number of COVID-19 patients in L&SC hospitals as of Monday 18th October 2021 was at 182, this is an increase of 35% from the previous week (11th October 2021) and the highest it has been during this current wave. As of 18th October there are currently 19 patients in Critical Care beds across L&SC hospitals this is an increase of 7 from the previous week (11th October 2021). Positive COVID-19 tests in L&SC for all ages groups continue to rise and are up a further +11% at the time of this report, to 484 per 100,000.

7.2.2. The Fylde Coast has again seen the biggest increase and now has the highest case rate, while Morecambe Bay, previously the highest, has seen fewer positives over the past week.

7.2.3. In all ICP areas apart from Morecambe Bay the case rate is now at its highest since late July 2021. Positive COVID-19 for those aged 60+ has increased 23% this week (18th October 2021) to 1,181 this is a new high for the current wave. Positive COVID-19 for those aged 60+ in Pennine Lancashire have, though, been falling in recent days. Wyre has seen one of the biggest increases in the past week (11th October 2021) and now has the highest all ages case rate and also has the greatest number of positives for those aged 60+ in L&SC.

7.2.4. As of 18th October 2021 there are currently 19 patients in Critical Care beds across L&SC hospitals this is an increase of 7 from the previous week (11th October 2021).

7.3. Outbreaks

7.3.1. On 18th October 2021 at BTHT there were 2 active outbreaks at Clifton Hospital. Common themes identified from the outbreaks relate to the challenges in terms of ensuring routine 3 and 5-7 day repeat screening is carried out, Divisions are working to improve this with their staff.

7.3.2. The majority of positive patients are asymptomatic and continue to be identified through routine testing day 3, 5 and tend to have been double vaccinated. The recent outbreaks have also been coterminous with the resumption of visiting and whilst visitors are advised to do Lateral Flow Test before visiting, this cannot be enforced.

7.3.3. LTHT have reported no outbreaks for this reporting month. In order to ensure sustained reduction the trust continues to undertake:

- Point of care testing for ED presentations
- 3x per week surveillance testing for COVID-19 for all inpatients (some wards do Monday/ Wednesday/ Friday and other wards do Tuesday/ Thursday/ Saturday) which allows us to pick up COVID-19 infections early before outbreaks develop out of control
- IT system to –
  - Identify potential contacts of COVID-19 (shared a bay with a COVID-19 positive patient in the 48 hours before a positive result and until 10 days after)
  - Communicate positive test results to bed-managers as soon as they are available
  - Provide a quick-view to aid in the identification of nosocomial infections and outbreaks
  - Monitor ward performance in terms of compliance with swabbing policy
- Active investigation of all nosocomial transmission events (even if single cases) to identify likely source. If no patient source identified (bay contact with confirmed cases) or possible visitor source, then screening of all staff members in the ward area related to the likely period of infection.
- Patient masking
- Visitors asked to provide evidence of negative Lateral flow tests every 72 hours

7.3.4. In addition, LTHT are looking at creating a suite of redi-rooms (which would be reused between patients) in the COVID-19 part of ED, so that they can prevent any transmission events in patients presenting with flu-like symptoms, who could have Flu or COVID-19 in preparation for the winter and flu season.

7.3.5. ELHT have reported no outbreaks for this reporting month.

7.3.6. UHMB reported 2 outbreaks at RLI however they have now been closed. Common themes identified from the recent outbreaks are:

- Lack of isolation facilities
- Poor toilet facilities
- Large bay areas or nightingale wards
- Lack of domestic staff unable to maintain routine work
- Low numbers of staff reporting on Lateral Flow Tests
- Poor mask compliance
- Delayed discharges for medically fit patients
- Frequent bed moves

7.3.7. All cases continued to be discussed weekly at the Post Infection Review and outbreak meeting, and external outbreak calls continue twice weekly with the Trust, PHE and MB CCG.

7.4. <u>Regulated Care</u>

7.4.1. The number of outbreaks across the care home settings continue to fluctuate.
7.4.2. Number of Care Homes in Outbreaks and Incidents as of 18th October 2021

| CCG | Care Homes in Outbreak | Care Homes in Incident |
|---|---|---|
| MB CCG | 6 (↓1 previous month) | 2 (↓4 previous month) |
| Central Lancashire ICP | 3 (↓ 2 previous month) | 5 (↑ 3 previous month) |
| B CCG | 2 | 0 |
| WL CCG | 1 (↓2 previous month) | 1 (no change) |
| EL CCG | 9 (↑ 2 previous month) | 4 (no change) |
| BwD CCG | 2 (↑1 previous month) | 1 (no change) |

7.4.3. Within MB CCG, work is underway with the local authority and the local COVID-19 testing team, to establish an improved process for local testing. Capacity is available from the UHMB testing team, however, the process to request, obtain and report needs improving. The national Pillar 2 Testing system has indicated significant delays in result reporting (6-7 days), which is greatly impacting the discharge process from hospitals to care settings. Work is being prioritised to address this.

7.4.4. A number of homes across Central Lancashire have reported delays in receiving test results in relation to recovery testing this has been escalated to the Testing Cell but homes have been advised to continue to contact 119 to obtain the results.

7.4.5. Currently visiting professionals to care homes only need a negative test to enter however from 12th November 2021 they will be required to show vaccination status/exemption.

7.5. Vaccination

7.5.1. The COVID-19 Booster continues to be rolled out in line with the Joint Committee of Vaccinations priority list. Across L&SC identified PCNs, Hospital Hub, Vaccination Centre and Community Pharmacy sites support the delivery of the booster.

7.5.2. The snapshot of data below shows the number of people that are eligible at the end of each week stated and how many of these patients have received the third dose (regardless of whether 3rd primary or booster); note this does not necessarily reflect the week in which patients were physically vaccinated.

| Central Lancashire ICP | | | |
|---|---|---|---|
| | **20/09/21** | **27/09/21** | **04/10/21** |
| Eligible | 23,334 | 12,296 | 13,148 |
| Vaccinated | 14,341 | 5,879 | 2,332 |
| Not Vaccinated | 8,992 | 6,471 | 10,816 |
| % Vaccinated | 61% | 48% | 18% |

| F&W CCG | | | |
|---|---|---|---|
| | **20/09/21** | **27/09/21** | **04/10/21** |
| Eligible | 22,573 | 14,009 | 15,230 |
| Vaccinated | 12,901 | 6,175 | 2,069 |
| Not Vaccinated | 9,672 | 7,834 | 13,161 |
| % Vaccinated | 57% | 48% | 14% |

| MB CCG | | | |
|---|---|---|---|
| | **20/09/21** | **27/09/21** | **04/10/21** |
| Eligible | 28,237 | 13,949 | 12,630 |
| Vaccinated | 17,336 | 5,291 | 2,666 |
| Not Vaccinated | 10,901 | 8,658 | 10,364 |
| % Vaccinated | 61% | 38% | 18% |

| Pennine Lancashire ICP | | | |
|---|---|---|---|
| | **20/09/21** | **27/09/21** | **04/10/21** |
| Eligible | 32,611 | 13,043 | 12,491 |
| Vaccinated | 17,832 | 5,950 | 2,430 |
| Not Vaccinated | 14,779 | 7,093 | 10,061 |
| % Vaccinated | 55% | 46% | 19% |

| WL CCG | | | |
|---|---|---|---|
| | **20/09/21** | **27/09/21** | **04/10/21** |
| Eligible | 32,611 | 13,043 | 12,491 |
| Vaccinated | 17,832 | 5,950 | 2,430 |
| Not Vaccinated | 14,779 | 7,093 | 10,061 |
| % Vaccinated | 55% | 46% | 19% |

Ongoing communication to increase uptake of the COVID-19 Booster continues.

## 8. Individual Patient Activity and Continuing Healthcare

8.1. Introduction

8.1.1. The ICS IPA Activity section is a month end activity snapshot at 30th September 2021 for L&SC CCGs regarding CHC services. It must be noted that whilst the majority of services are commissioned from MLCSU and B CCG some services are commissioned with other providers.

8.1.2. The section is aimed at highlighting trends in activity for the CCGs on a combined L&SC footprint and not provider performance. Further detailed performance for individual CCGs/ICPs is available if required.

8.1.3. B CCG data in is only partly included in the majority of this report, it is being received (4 months data currently received) but cannot currently be compared against 2019/20 data, more detail will be included in future reports. Trends/themes highlighted in this report do include data/input from B CCG.

8.2. Executive Summary

Referrals

8.2.1. Discharge to assess (D2A) – numbers received across the system continue to remain higher than those received prior to the COVID pandemic – 6 month average ↑ 62%.

8.2.2. Fast Tracks - numbers received across the system continue to remain higher than those received prior to the COVID pandemic - 6 month average ↑ 24%. A review is being undertaken for the reason behind the increase, more focus is being given to EL CCG as they receive a high proportion of the total of Fast Tracks received.

8.2.3. Incomplete Referrals (ICRs) – there are 100 ICRs (as at 30th September 2021) in the system. These are being monitored in weekly reports against a trajectory that was submitted to NHSE/I. ↓ 125 case increase from the end of June 2021. An additional 5 staff have been retained from the 'recovery project' to support the service whilst recruitment is underway for the new ICS funded posts, this and a thorough data quality cleanse has led to a decrease in September 2021.

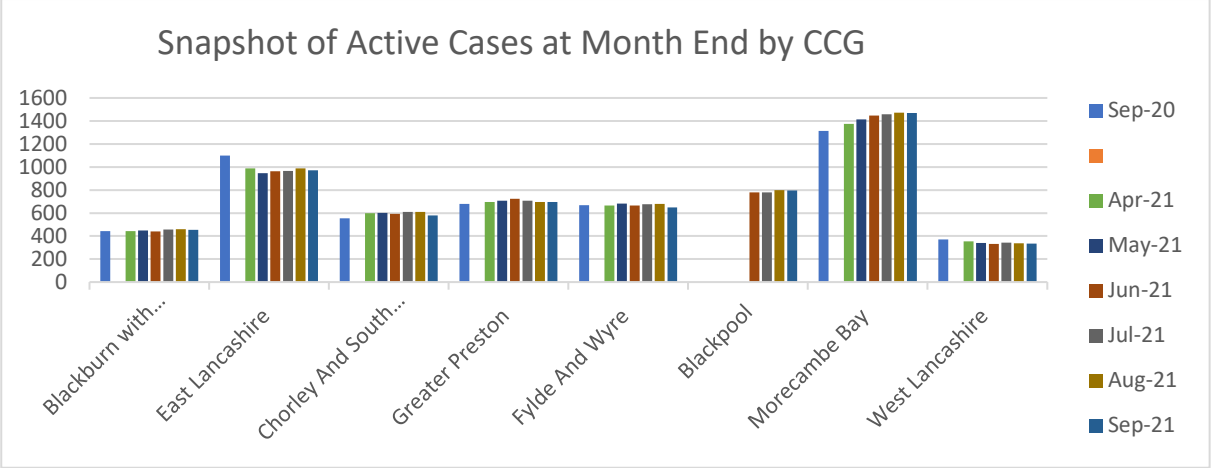
8.2.4. Quality Premium - All CCGs apart from Blackpool are falling short of the Quality Premium Target of completing over 80% of eligibility decisions within 28 days of the referral being made. A trajectory has been submitted to NHSE/I in line with ICR trajectory with a target of

all CCGs meeting the Quality Premium by the end of Q4 2021/22. Currently 5 of the 8 CCGs are behind trajectory and have had to complete an assurance plan.

8.2.5. Overdue Reviews - As a system we are currently operating on a shortfall of around 380 reviews per month. (this number would fluctuate more when we have completed all the overdue reviews and we have the workforce to plan and manage all reviews). The ICS has agreed funding for CHS to undertake c300 ODRs, the cases for review have been identified and the work is ready to commence. Further updates will be given in the weekly and monthly reports.

8.3. Patients with Active Packages of Care at Month End by CCG

| CCG | Sep-20 | | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | | 1 Month Movement | | | 12 Month Movement | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Blackburn with Darwen | 444 | | 442 | 447 | 440 | 456 | 459 | 454 | | -1.1% | -5 | | 2.3% | 10 |
| East Lancashire | 1100 | | 988 | 947 | 963 | 965 | 989 | 972 | | -1.7% | -17 | | -11.6% | -128 |
| Chorley And South Ribble | 555 | | 600 | 601 | 593 | 611 | 610 | 579 | | -5.1% | -31 | | 4.3% | 24 |
| Greater Preston | 679 | | 696 | 706 | 723 | 708 | 697 | 695 | | -0.3% | -2 | | 2.4% | 16 |
| Fylde And Wyre | 668 | | 665 | 683 | 665 | 676 | 679 | 650 | | -4.3% | -29 | | -2.7% | -18 |
| Blackpool | n/a | | n/a | n/a | 779 | 779 | 798 | 796 | | -0.3% | -2 | | n/a | n/a |
| Morecambe Bay | 1313 | | 1374 | 1414 | 1446 | 1459 | 1471 | 1468 | | -0.2% | -3 | | 11.8% | 155 |
| West Lancashire | 371 | | 355 | 340 | 332 | 343 | 338 | 333 | | -1.5% | -5 | | -10.2% | -38 |
| ICS Total (exc Blackpool) | 5130 | | 5120 | 5138 | 5162 | 5218 | 5243 | 5151 | | -1.8% | -92 | | 0.4% | 21 |




8.3.1. The table above shows a snapshot of the number of patients across all IPA, with Active Packages of Care at the end of each month.

8.3.2. There is a slight fluctuation month by month, with the total for the ICS increasing by approximately 0.4% in the last 12 months. September 2020 activity was still being impacted by the COVID emergency period even though the CHC Framework had been reinstated. EL CCG and WL CCG are the only 2 CCGs to report a year on year reduction in packages.

8.3.3. September 2021 is the 1st month to have a month on month decrease in the number or packages, with the total number at its lowest since May 2021. This decrease was seen in all 8 CCGs.

8.3.4. B CCG figures are included from June 2021 but are not included in the totals or 12 month comparisons.

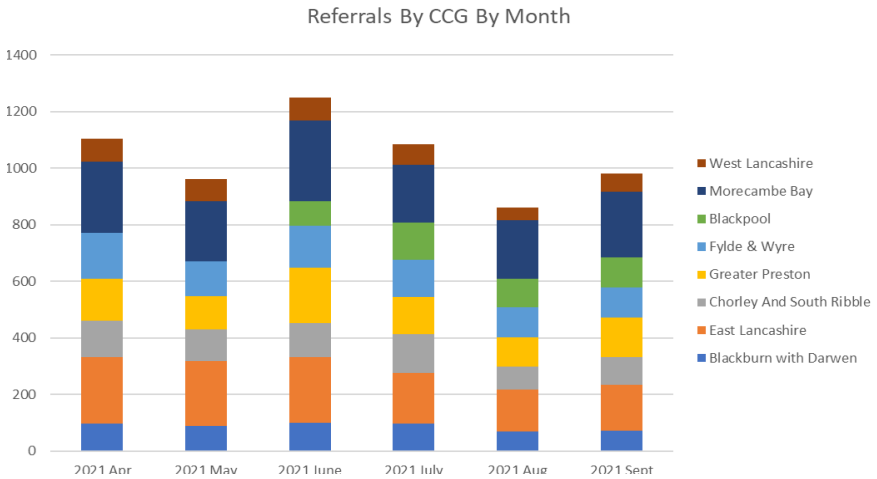
8.3.5. Review on the exceptions noted above will be investigated and provided in future reports.

## 8.4. Referrals Received

| CCG | 2021 Apr | 2021 May | 2021 June | 2021 July | 2021 Aug | 2021 Sept | 6 Month Average | 2019-20 Monthly Average | Monthly Movement | |
|---|---|---|---|---|---|---|---|---|---|---|
| BwD | 97 | 89 | 99 | 98 | 70 | 71 | 87 | 54 | 1 | 1% |
| EL | 235 | 230 | 234 | 178 | 147 | 162 | 198 | 146 | 15 | 10% |
| CSR | 128 | 110 | 120 | 138 | 82 | 99 | 113 | 89 | 17 | 21% |
| GP | 150 | 117 | 195 | 130 | 104 | 141 | 140 | 111 | 37 | 36% |
| F&W | 162 | 125 | 148 | 133 | 105 | 104 | 130 | 111 | -1 | -1% |
| B | n/a | n/a | 86 | 129 | 101 | 107 | 106 | n/a | 6 | 6% |
| MB | 250 | 211 | 287 | 204 | 206 | 232 | 232 | 171 | 26 | 13% |
| WL | 83 | 78 | 81 | 73 | 46 | 65 | 71 | 54 | 19 | 41% |
| **ICS Total** | **1105** | **960** | **1164** | **954** | **760** | **874** | **970** | **734** | **114** | **15%** |

| Referral Type | 2021 Apr | 2021 May | 2021 June | 2021 July | 2021 Aug | 2021 Sept | 6 Month Average | 2019-20 Monthly Average | Monthly Movement | |
|---|---|---|---|---|---|---|---|---|---|---|
| Checklist | 96 | 77 | 87 | 60 | 89 | 84 | 82 | 167 | -5 | -6% |
| Initial DST | 177 | 140 | 172 | 101 | 74 | 97 | 127 | 36 | 23 | 31% |
| Fast Track | 370 | 341 | 361 | 361 | 336 | 396 | 361 | 292 | 60 | 18% |
| D2A | 99 | 59 | 86 | 66 | 70 | 73 | 76 | 47 | 3 | 4% |
| FNC Referral | 1 | 8 | 7 | 7 | 3 | 8 | 6 | 28 | 5 | 167% |
| Funding Request Form | 362 | 335 | 451 | 355 | 177 | 189 | 312 | 158 | 12 | 7% |
| CYP Checklist | | | | 4 | 11 | 27 | 14 | 0 | 16 | 145% |
| **Total** | **1105** | **960** | **1164** | **954** | **760** | **874** | **970** | **734** | **114** | **15%** |

ICS total and referral type breakdown above both exclude Blackpool




8.4.1. The average number of referrals over the last 6 months is 32% higher than the 2019-20 average, with significant increases in Fast Track (24%), Discharge to Assess (62%), Funding Requests and DST referrals. Changes in process have led to increase in Initial DST referrals and decrease in checklist referrals (linked to D2A recording process). The increase is evenly split across the 7 CCGs.

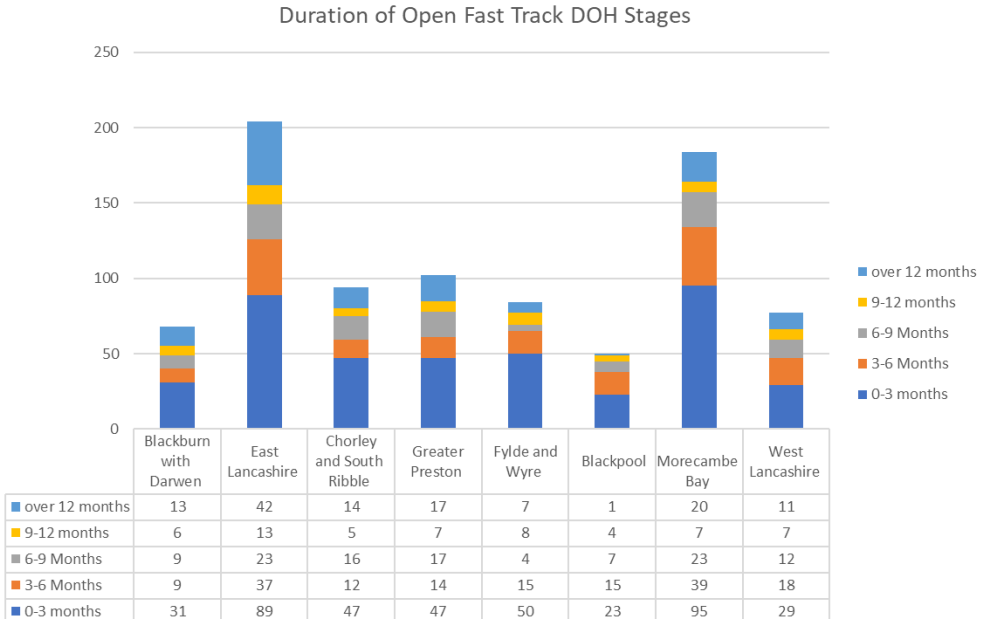
8.4.2. N.B. Data for Month 3 of the Quarter (June 2021) includes a balance for late entered data for the previous 2 months, to allow consistency in line with Quarterly NHS submissions, so month 3 will tend to be higher than months 1 & 2.

8.4.3. Review on the exceptions noted above will be investigated and provided in future reports.

8.5. Fast Track Data – Including Referrals and Reviews by Time band

| Month | Number of Referrals | Snapshot of Patients | % Fast Tracks Stage > 3 months |
|---|---|---|---|
| Apr-21 | 370 | 762 | 43% |
| May-21 | 341 | 774 | 48% |
| Jun-21[3] | 395 | 876 | 49% |
| Jul-21 | 403 | 909 | 49% |
| Aug-21 | 360 | 822 | 55% |
| Sep-21 | 429 | 735 | 52% |

| CCG | 0-3 months | 3-6 Months | 6-9 Months | 9-12 months | over 12 months | Grand Total | % FT over 3 months |
|---|---|---|---|---|---|---|---|
| BwD | 31 | 9 | 9 | 6 | 13 | 68 | 54% |
| EL | 89 | 37 | 23 | 13 | 42 | 204 | 56% |
| CSR | 47 | 12 | 16 | 5 | 14 | 94 | 50% |
| GP | 47 | 14 | 17 | 7 | 17 | 102 | 54% |
| F&W | 50 | 15 | 4 | 8 | 7 | 84 | 40% |
| B | 23 | 15 | 7 | 4 | 1 | 50 | 54% |
| MB | 95 | 39 | 23 | 7 | 20 | 184 | 48% |
| WL | 29 | 18 | 12 | 7 | 11 | 77 | 62% |
| **Grand Total** | **411** | **159** | **111** | **57** | **125** | **863** | **52%** |




[3] NB Blackpool data only provided from June 2021 onwards

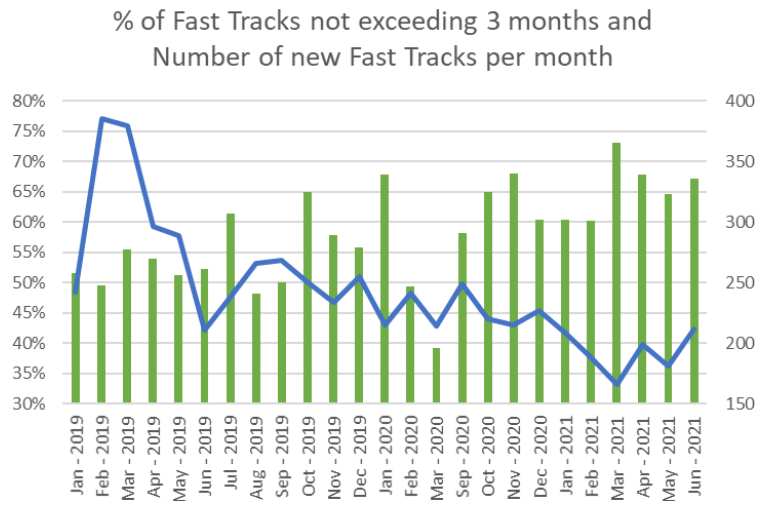
8.5.1. Section 8.4.1 shows a 24% increase in the 6 month average of Fast Track referrals (361) compared to 2019-20 (292).

8.5.2. The percentage of Fast Track patients with a package > 3 months continues to remain high (52%), until the 3 months reviews are completed it is hard to determine if this is because the referrals should not have been Fast Track referrals, quality review of a sample of Fast Track referrals is being undertaken.

8.5.3. EL CCG has the largest number of patients with a stage > 12 months (42 patients, 21%).

8.6. Fast Track Data – Including Referrals and Reviews by Time band

| | 0-3 months | 3-6 Months | 6-9 Months | 9-12 months | over 12 months | Number of new Fast Track |
|---|---|---|---|---|---|---|
| Jan - 2019 | 48% | 4% | 2% | 2% | 45% | 258 |
| Feb - 2019 | 77% | 5% | 1% | 0% | 17% | 248 |
| Mar - 2019 | 76% | 3% | 1% | 1% | 19% | 277 |
| Apr - 2019 | 59% | 4% | 2% | 0% | 35% | 270 |
| May - 2019 | 58% | 1% | 3% | 1% | 38% | 256 |
| Jun - 2019 | 42% | 5% | 1% | 1% | 51% | 261 |
| Jul - 2019 | 48% | 3% | 1% | 0% | 48% | 307 |
| Aug - 2019 | 53% | 2% | 0% | 0% | 44% | 241 |
| Sep - 2019 | 54% | 5% | 1% | 0% | 40% | 250 |
| Oct - 2019 | 50% | 3% | 1% | 0% | 46% | 325 |
| Nov - 2019 | 47% | 3% | 1% | 1% | 48% | 289 |
| Dec - 2019 | 51% | 5% | 0% | 0% | 44% | 279 |
| Jan - 2020 | 43% | 4% | 2% | 0% | 50% | 339 |
| Feb - 2020 | 48% | 2% | 0% | 2% | 48% | 247 |
| Mar - 2020 | 43% | 4% | 3% | 1% | 51% | 196 |
| Sep - 2020 | 50% | 2% | 1% | 1% | 47% | 291 |
| Oct - 2020 | 44% | 2% | 1% | 53% | 0% | 325 |
| Nov - 2020 | 43% | 3% | 1% | 53% | 0% | 340 |
| Dec - 2020 | 45% | 2% | 1% | 51% | 0% | 302 |
| Jan - 2021 | 42% | 4% | 55% | 0% | 0% | 302 |
| Feb - 2021 | 38% | 5% | 57% | 0% | 0% | 301 |
| Mar - 2021 | 33% | 2% | 65% | 0% | 0% | 365 |
| Apr - 2021 | 40% | 57% | 3% | 0% | 0% | 339 |
| May - 2021 | 36% | 64% | 0% | 0% | 0% | 323 |
| Jun - 2021 | 42% | 58% | 0% | 0% | 0% | 336 |



8.6.1. Since the reintroduction of the CHC Framework in September 2020 there has been a 23% increase in the monthly number of new Fast Track cases recorded, compared with the 12 months prior to the pandemic, from an average of 292 cases per month to 360 (as noted on the last slide this matches the 6 month average increase).

8.6.2. The table and graph above detail the number of Fast Tracks received each month from January 2019 – June 2021, breaking down how long the Fast Track package was/is open as a percentage of the total received each month. This information highlights that throughout the system the majority of patients with a Fast Track referral that do not RIP within the first 3 months of the referral will not RIP within 12 months of a Fast Track Referral. To help explain this and using January 2019 as an example:- 258 Fast Track referrals were submitted, 48% were RIP within 3 months an 45% still had a package of care after 12 months.

8.7. Quality Premiums

8.7.1. Less than 15% of all NHS CHC assessments take place in Acute Hospital Setting

N.B. Data for Month 3 of the Quarter (September 2021) includes a balance for late entered data for the previous 2 months, to allow consistency in line with Quarterly NHS submissions.

| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|
| Initial DST Assessments | 287 | 217 | 243 | 94 | 161 | 152 |
| Initial DST Assessments carried out in Acute Settings | 2 | 0 | 1 | 2 | 1 | 1 |
| Quality Premium % | **1%** | **0%** | **0%** | **2%** | **1%** | **1%** |

8.7.2. In July 2021, a total of 94 DSTs were completed (inc B CCG). Of these two were completed in Acute setting meaning the QP was met for an ICS as a whole as well as each of the individual 8 CCGs. As the table to the above shows this QP has now been met for each CCG for the last 6 months.

8.7.3. This QP has significantly increased from 19/20 where on average 14% of DSTs were completed in Acute setting, with at least 1 L&SC CCG not meeting the QP each month.

8.7.4. 80% of all NHS CHC assessments are to be completed within 28 days.

| CCG | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 |
|---|---|---|---|---|---|---|
| BwD | 29% | 48% | 41% | 33% | 23% | 33% |
| EL | 23% | 26% | 22% | 5% | 29% | 25% |
| CSR | 25% | 23% | 22% | 10% | 36% | 27% |
| GP | 22% | 25% | 16% | 36% | 27% | 53% |
| F&W | 53% | 44% | 66% | 45% | 52% | 50% |
| B | 84% | 87% | 85% | 85% | 77% | 83% |
| MB | 51% | 57% | 64% | 64% | 65% | 79% |
| WL | 30% | 17% | 14% | 29% | 30% | 75% |
| **ICS Total** | **41%** | **45%** | **49%** | **50%** | **40%** | **61%** |

eligibility data not provided for Blackpool

8.7.5. B CCG continue to meet the QP, however over the last four months the percentage is in the mid 80's. The remaining 7 CCGs are falling l short of the QP target of completing over 80% of eligibility decisions within 28 days of the referral being made.

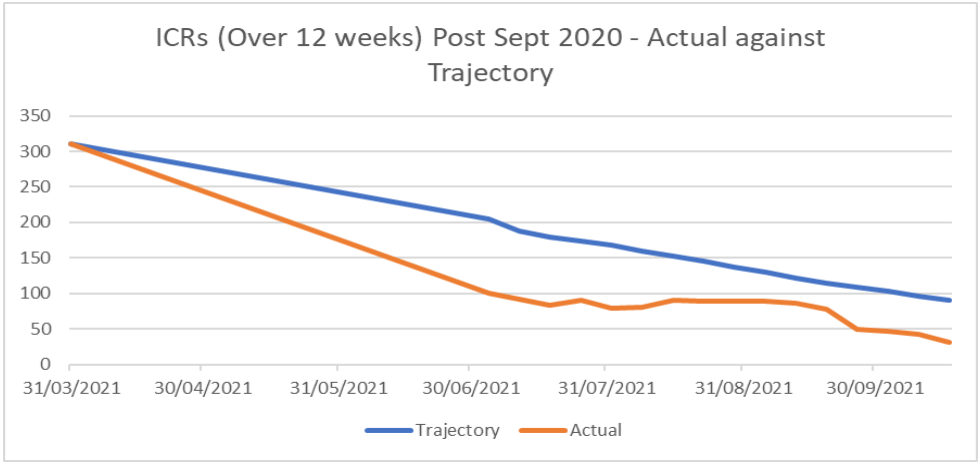
8.7.6. Whilst failure to meet this requirement was commonplace in 2019-20, the performance has been significantly impacted by the current Incomplete Referrals Project, further detail provided in section 8.8, which in turn has meant that five CCGs have fallen behind the 28 day trajectory, as shown below.

8.7.7. The numbers are however consistent with those reported in 2019/20.

| | CCG | NHS Blackburn with Darwen CCG | NHS East Lancashire CCG | NHS Blackpool CCG | NHS Fylde & Wyre CCG | NHS Chorley and South Ribble CCG | NHS Greater Preston CCG | NHS Morecambe Bay CCG | NHS West Lancashire CCG |
|---|---|---|---|---|---|---|---|---|---|
| Q4 20/21 | Actual | 49 | 27 | 88 | 60 | 49 | 50 | 65 | 40 |
| Q1 21/22 | Trajectory | ≥30% to 39.9% | ≥20% to 29.9% | >80% | ≥50% to 59.9% | ≥30% to 39.9% | ≥30% to 39.9% | ≥50% to 59.9% | ≥30% to 39.9% |
| | Actual | 39 | 24 | 85 | 54 | 23 | 21 | 59 | 20 |
| | Comparison | | | | | | | | |
| Q2 21/22 | Trajectory | ≥40% to 49.9% | ≥30% to 39.9% | >80% | ≥60% to 64.9% | ≥40% to 49.9% | ≥40% to 49.9% | ≥65% to 69.9% | ≥40% to 49.9% |
| | Actual | 30 | 20 | 82 | 49 | 24 | 39 | 69 | 44 |
| | Comparison | | | | | | | | |

8.8. Incomplete Referrals over 28 days (data from w/c 17th October 2021)

| Incomplete Referrals over 28 days | Up to 2 weeks | 2 - 4 weeks | 4 - 12 weeks | 12 - 26 weeks | Over 26 weeks | Sub-total |
|---|---|---|---|---|---|---|
| Blackburn with Darwen | 0 | 1 | 0 | 2 | 0 | 3 |
| East Lancashire | 4 | 3 | 2 | 7 | 2 | 18 |
| Chorley and South Ribble | 4 | 0 | 4 | 1 | 0 | 9 |
| Greater Preston | 6 | 0 | 5 | 3 | 1 | 15 |
| Blackpool | 7 | 4 | 4 | 1 | 0 | 16 |
| Fylde and Wyre | 2 | 2 | 5 | 1 | 2 | 12 |
| Morecambe Bay | 7 | 1 | 10 | 7 | 1 | 26 |
| West Lancashire | 2 | 0 | 2 | 3 | 0 | 7 |
| **Total** | **32** | **11** | **32** | **25** | **6** | **106** |




8.8.1. The ICR Project, targeted at clearing all incomplete referrals received prior to March 2020, is close to completion with single figure numbers now awaiting eligibility decisions.

8.8.2. The focus is now on CHC referrals received post September 2020. There is currently a backlog of 106 ICRs in the system that have breached 28 days, this is broken down by CCG in the table to the right. This is a reduction from the 225 that was reported in the August 2021 report this is due mainly to a full data cleanse which identified a number of patients that had multiple referrals, a Fast Track package prior to the referral or data input entry. More staff have been available to complete assessments and some of the more complex cases have now had decisions made on them, this has resulted in the continued decrease in the numbers of ICRs.

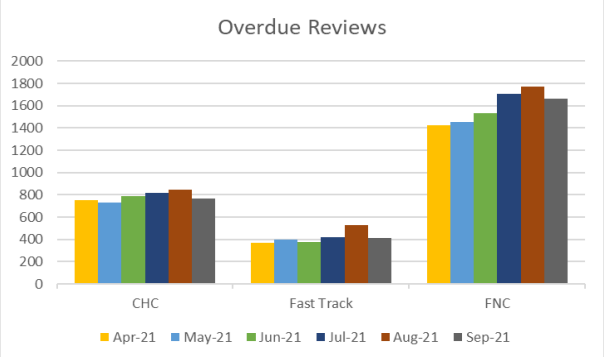
8.8.3. In June 2021 a trajectory for 21/22 was submitted to NHSE/I of the predicted number of referrals breaching 28 days (per quarter) and the predicted Quality Premium – DSTs completed within 28 days. Throughout July 2021, 5 clinicians have been retained from the Covid Deferred Assessments Recovery Team, they have supported the BAU working solely on ICRs built up from 1st September 2020. To help monitor this, detailed weekly reports are being submitted to the system, this will enable the ICS Leadership to act if the trajectory is not being met.

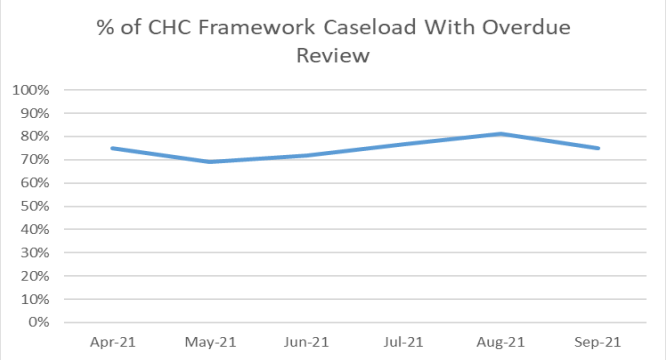
8.8.4. The trajectory to NHSE/I was based on ICRs that have already breached the 28 day period by 12 weeks. The graph highlights that we are ahead of trajectory as an ICS with 31 ICRs over 12 weeks. This has again reduced significantly from the 80 reported in August 2021 report.

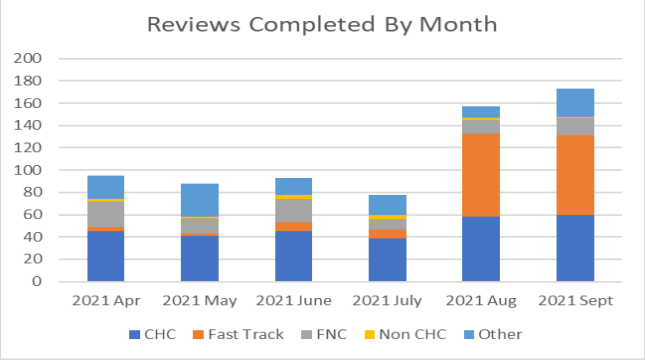
8.9. CHC Framework Overdue Reviews

| | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Monthly Movement | % Change |
|---|---|---|---|---|---|---|---|---|
| CHC | 750 | 730 | 792 | 821 | 850 | 766 | -84 | -9.9% |
| Fast Track | 367 | 395 | 379 | 423 | 530 | 411 | -119 | -22.5% |
| FNC | 1422 | 1451 | 1530 | 1703 | 1768 | 1666 | -102 | -5.8% |
| **Total** | **2539** | **2576** | **2701** | **2947** | **3148** | **2843** | -305 | -9.7% |
| **% of CHC Framework Review Caseload** | **75%** | **69%** | **72%** | **77%** | **81%** | **75%** | | |

NB All Tables Excluding Blackpool



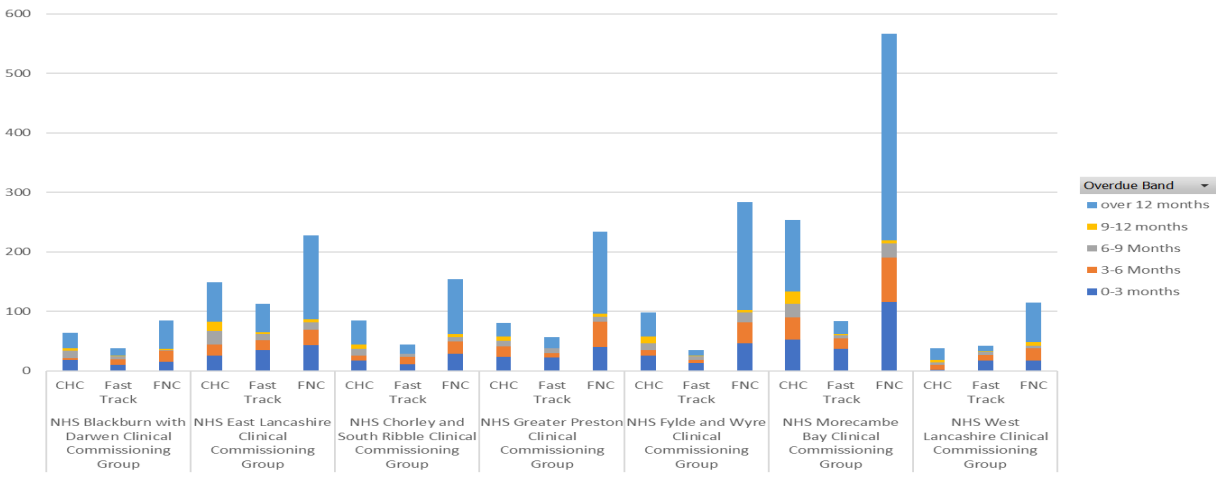

8.9.1. There has been a monthly decrease in the number of CHC Framework reviews that are overdue. This percentage will rise again in the coming months as clearing the backlog of ICRs has led to an increase in the number of CHC and FNC packages that will require their 3 month reviews become due as the resource is not currently in place to handle the workload, with on average around 100 reviews per month currently being recorded. A recent change in

process has resulted in a larger number of Fast Track reviews being reported in August 2021 and September 2021. It should be noted that the reviews have always been completed but had previously been counted as amendments to Fast Track packages.

8.9.2. There are currently circa IPA 6000 patients with packages, these include CHC, FNC, Fast Track, Joint Funded and CYP across L&SC, which equates to around 500 reviews required to be completed per month. As a system we are currently operating on a shortfall of around 380 reviews per month (This number would fluctuate more when we have completed all the overdue reviews and we have the workforce to plan and manage all reviews). The ICS has agreed funding for CHS to undertake c500 ODRs and the work is currently being scoped to commence this project.

8.10. <u>CHC Framework Overdue Reviews</u>

| | 0-3 months | 3-6 Months | 6-9 Months | 9-12 months | over 12 months | Grand Total |
|---|---|---|---|---|---|---|
| CHC | 162 | 104 | 95 | 70 | 335 | 766 |
| Fast Track | 145 | 76 | 47 | 8 | 135 | 411 |
| FNC | 306 | 237 | 74 | 34 | 1015 | 1666 |
| **Grand Total** | **613** | **417** | **216** | **112** | **1485** | **2843** |




8.10.1. The pattern is the same across all CCGs with almost 2/3 of overdue reviews being more than 12 months past the review due date, particularly FNC patients.

8.10.2. The larger CCGs of MB and EL also show particularly high levels of CHC patients with overdue reviews.

8.11. <u>CHC Appeals and Retrospective Reviews (not inc Blackpool)</u>

Total number of CHC Appeals received

| | BwD CCG | CSR CCG | EL CCG | F&W CCG | GP CCG | MB CCG | WL CCG |
|---|---|---|---|---|---|---|---|
| Oct-20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Nov-20 | 0 | 0 | 0 | 0 | 1 | 2 | 0 |
| Dec-20 | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| Jan-21 | 1 | 0 | 0 | 0 | 0 | 1 | 1 |
| Feb-21 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Mar-21 | 0 | 0 | 0 | 0 | 1 | 1 | 1 |
| Apr-21 | 1 | 0 | 2 | 3 | 0 | 0 | 0 |
| May-21 | 1 | 0 | 3 | 0 | 1 | 4 | 1 |

| | BwD CCG | CSR CCG | EL CCG | F&W CCG | GP CCG | MB CCG | WL CCG |
|---|---|---|---|---|---|---|---|
| Jun-21 | 1 | 0 | 3 | 1 | 2 | 3 | 2 |
| Jul-21 | 0 | 1 | 2 | 2 | 2 | 5 | 0 |
| Aug-21 | 0 | 3 | 1 | 3 | 0 | 1 | 1 |
| Sep-21 | 0 | 1 | 2 | 0 | 1 | 1 | 1 |
| **Total** | **4** | **5** | **15** | **9** | **8** | **19** | **7** |

8.11.1. A total of 31 CHC Appeals are currently in process for the Lancashire CCGs. 67 CHC Appeals have been received since October 2020. The table above breaks down the 82 by CCG.

Total number of CHC Appeals Closed

| | BwD CCG | CSR CCG | EL CCG | F&W CCG | GP CCG | MB CCG | WL CCG |
|---|---|---|---|---|---|---|---|
| Oct-20 | 0 | 1 | 0 | 1 | 0 | 2 | 0 |
| Nov-20 | 0 | 0 | 1 | 1 | 0 | 2 | 1 |
| Dec-20 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| Jan-21 | 1 | 0 | 1 | 0 | 2 | 4 | 0 |
| Feb-21 | 0 | 2 | 0 | 3 | 1 | 2 | 1 |
| Mar-21 | 0 | 0 | 1 | 0 | 0 | 1 | 1 |
| Apr-21 | 0 | 1 | 2 | 3 | 1 | 2 | 2 |
| May-21 | 1 | 1 | 2 | 1 | 1 | 2 | 1 |
| Jun-21 | 2 | 0 | 2 | 3 | 4 | 1 | 1 |
| Jul-21 | 0 | 0 | 0 | 0 | 0 | 2 | 0 |
| Aug-21 | 0 | 0 | 1 | 2 | 0 | 4 | 1 |
| Sep-21 | 0 | 0 | 1 | 4 | 0 | 3 | 0 |
| **Total** | **4** | **5** | **11** | **18** | **10** | **26** | **8** |

8.11.2. A total of 82 appeals have been closed across the 7 CCGs since October 2020 (see above), 11 of these have been found eligible:-

- EL CCG – 4 – est. cost £111,280
- F&W CCG – 2 - est. cost £55,640
- GP CCG – 2 - est. cost £55,640
- MB CCG – 2 - est. cost £55,640
- WL CCG – 1 - est. cost £27,820

NB – est. cost based on average CHC cost £535 per week

8.12. <u>CHC Appeals and Retrospective Reviews (not inc Blackpool)</u>

Total number of CHC RRV received

| | BwD CCG | CSR CCG | EL CCG | F&W CCG | GP CCG | MB CCG | WL CCG |
|---|---|---|---|---|---|---|---|
| Oct-20 | 0 | 1 | 0 | 1 | 1 | 0 | 1 |
| Nov-20 | 0 | 0 | 2 | 1 | 0 | 1 | 1 |
| Dec-20 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| Jan-21 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |
| Feb-21 | 0 | 0 | 0 | 2 | 0 | 1 | 1 |
| Mar-21 | 2 | 1 | 0 | 0 | 0 | 1 | 0 |
| Apr-21 | 0 | 0 | 0 | 0 | 0 | 1 | 0 |

| | BwD CCG | CSR CCG | EL CCG | F&W CCG | GP CCG | MB CCG | WL CCG |
|---|---|---|---|---|---|---|---|
| May-21 | 0 | 1 | 1 | 1 | 0 | 0 | 0 |
| Jun-21 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| Jul-21 | 0 | 1 | 0 | 1 | 0 | 0 | 0 |
| Aug-21 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Sep-21 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **3** | **6** | **4** | **8** | **1** | **5** | **3** |

8.12.1. A total 32 CHC Retrospective Reviews have been received to the 7 CCGs since October 2020.

8.12.2. The table above breaks down this number by CCG.

Total number of CHC RRV Closed

| | BwD CCG | CSR CCG | EL CCG | F&W CCG | GP CCG | MB CCG | WL CCG |
|---|---|---|---|---|---|---|---|
| Oct-20 | 0 | 0 | 3 | 1 | 2 | 0 | 1 |
| Nov-20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dec-20 | 0 | 1 | 2 | 2 | 0 | 2 | 0 |
| Jan-21 | 0 | 1 | 0 | 0 | 1 | 3 | 0 |
| Feb-21 | 0 | 0 | 0 | 0 | 1 | 0 | 0 |
| Mar-21 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| Apr-21 | 1 | 0 | 1 | 0 | 2 | 1 | 0 |
| May-21 | 2 | 0 | 2 | 1 | 0 | 2 | 0 |
| Jun-21 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| Jul-21 | 1 | 2 | 0 | 0 | 1 | 0 | 2 |
| Aug-21 | 0 | 0 | 1 | 0 | 0 | 1 | 0 |
| Sep-21 | 0 | 1 | 4 | 1 | 1 | 1 | 0 |
| **Total** | **4** | **6** | **15** | **5** | **9** | **10** | **4** |

8.12.3. A total of 53 Cases have been closed across the CCGs since October 2020 (see above). 24 of these cases have been found eligible: -

- BwD CCG – 2 - est. cost £16,585
- CSR CCG – 3 – est. cost £23,005
- EL CCG – 8 – est. cost £235,858.57
- F&W CCG – 2 - est. cost £5,350
- GP CCG – 1 - est. cost £8,712.86
- MB CCG – 6 - est. cost £61,938.57
- WL CCG – 2 - est. cost £3,592.14

NB – est. cost based on average CHC cost £535 per week

## 9. Safeguarding

9.1. Items to be escalated to the SCC

9.1.1. Safeguarding is currently completing a due diligence exercise; this will conclude in December 2021. As previously reported, there are gaps in Designate professional capacity per head of population requirements (as per intercollegiate requirements) and though skill mix is being applied to mitigate, Children Designate cannot be replaced by a safeguarding practitioner.

9.1.2. During COVID Safeguarding professionals have flexed roles to cover pandemic emergency responses and quality issue. It is evident that most professionals continue to support considerable CCG on call commitment and CCG Quality activity. This is diluting capacity of the Safeguarding Designate professional to fulfil their designate role and function.

9.1.3. There are a number of CCGs whose performance for Mandatory training and Looked After Children initial assessments is below standard, also safeguarding professionals are not consistently being consulted during service redesign or review, a role which seeks to ensure statutory safeguarding requirements are met.

9.1.4. Additionally, Designate professional must have protected time to undertake Serious Case Reviews, and take a lead role in ensuring robust processes are in place across health care services and the system to learn lessons. Operationally the Designate network of professionals cover each other to ensure Designate professional leadership regards SCRs, however many individuals continue to work over and above contracted hours to deliver this statutory duty. Health and Wellbeing of the Designate Professionals will also form part of the due diligence exercise, professionals must consistently access supervision in view of the often distressing and complex nature of the role undertaken.

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

9.2.1. Designate Professionals are linking with Providers (MH, Acute, General Practice, and Regulated Care) to gain assurances in regard to fulfilling statutory safeguarding functions, delivery of organisational safeguarding training and team availability for support and advice in view of some reporting safeguarding team workforce pressures.

9.3. Current area of focus

9.3.1. Core activity remains across complex case strategy management, Child Serious Case Reviews, Adult Serious Incident Reviews, supporting partner agencies with strategy meetings, Domestic Homicide and suicide contagion responses.

9.3.2. Regulated care quality issues, closure planning alongside statutory partner (Local Authority).

9.4. Successes

9.4.1. Phase 1 of the national Child Protection Information system is complete across L&SC. Phase 2 mandate is to complete by March 2023 which will further expands information sharing capability of children and families at risk. Designates will ensure linkage with the share care record programme.

9.4.2. A Police led Operation for young people at a risk of criminal exploitation in East Lancashire has been awarded a Lancashire Constabulary Problem Solving Award. This was a multi-agency operation which resulted in the reduction in antisocial behaviour and the effective safeguarding of children and young people.

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

CYP eating disorder routine waiting time – post pandemic has seen a huge increase in referrals and presentations for CYP with an eating disorder. This has been recognised nationally with access to specialist beds reported as an issue. Actions taken:

- Investment into eating disorder service within LSCFT
- Pathway review underway
- Weekly escalation meeting now in place

## 11. Adult Mental Health

Mental Health – key areas of risk

11.1. IAPT access – IAPT access remain an issue across the ICS and nationally. An ICS group is in place to discuss issues and agree actions to be taken to support the delivery of the ambition. There are several issues relating to referral numbers into the service and communication plans are underway to ensure that people are aware of the service. Actions taken to date:

- Prevalence numbers have been agreed with each provider and each provider has an action plan to support delivery.
- Monthly monitoring in place
- IAPT trainee numbers in line with NHSE/HEE recommended figures have been supported in 2021/2022.
- National NHSE lead attending monthly delivery meeting in November to support ongoing delivery discussions

11.2. Out of Area Placements – whilst nationally the OAP has remained relatively stable several factors have led to an increase in OAP within L&SC. COVID-19 IPC issues led to a review of dormitory provision and closure of beds, an external review which recognised that L&SC does not have enough in patient capacity to support the needs of the population along with an increase in demand and acuity of the patients because of the pandemic. The LTP ambition is to have zero OAP by 21/22 however this ambition will not be achieved within L&SC until building and renovation works are completed. Actions taken

- In patient capacity modelling complete and expansion underway within LSCFT
- Right to reside meetings in place to support timely discharge of patients
- Transformation projects underway within LSCFT to provide alternatives to admission, crisis support, liaison provision on each acute site
- Improvement Board now in place to monitor progress against delivery

11.3. Physical Health Checks for people with severe mental illness – this remains problematic nationally and support to support delivery is in place. Actions taken

- Cleansing and review of data
- Monthly data now produced
- Digital offer under trial
- Monthly task and finish group developed to support a focus on ICP / practice-based issues

## 12. Learning Disability & Autism – key areas of risk

12.1. Inpatient Metrics

Table 1: Number of L&SC Adult inpatients versus trajectory

| | No of Inpatients | Q3 Trajectory | Variance against Q3 Trajectory |
|---|---|---|---|
| CCG In-Patients | 59 | 49 | +10 |
| Secure In-Patients | 38 | 39 | -1 |
| Total | **97** | **88** | +9 |

12.1.1. The position as at the 15th October 2021 is that there are currently 59 CCG inpatients, against a Q3 trajectory of 49 (+10). 30 of these inpatients are placed outside of L&SC. There have been no secure inpatient admissions or discharges and there are 38 secure inpatients, against a Q3 of 39 (-1).

Table 2: Admissions of L&SC Adult inpatients since Q1 2020

| Admissions | Q1 2020 | Q2 2020 | Q3 2020 | Q4 2020 | Q1 2021 | Q2 2021 |
|---|---|---|---|---|---|---|
| CCG Inpatients | 5 | 8 | 14 | 11 | 18 | 18 |
| Secure Inpatients | 1 | 4 | 2 | 1 | 0 | 0 |

12.1.2. There have been 18 people with a Learning Disability and/or Autism admitted into a LSCFT inpatient bed during Q2. 17 were admitted to mental health beds due to their primary mental health need and 1 person into a learning disability bed outside of the North West. This is an increase against the previous quarter. There have been no admissions to a secure bed since Q4 2020.

Table 3: Discharges of Lancashire and South Cumbria Adult inpatients since Q1 2020

| Discharges | Q1 2020 | Q2 2020 | Q3 2020 | Q4 2020 | Q1 2021 | Q2 2021 |
|---|---|---|---|---|---|---|
| CCG Inpatients | 16 | 8 | 11 | 16 | 11 | 10 |
| Secure Inpatients | 1 | 2 | 6 | 3 | 6 | 0 |

12.1.3. There have been 10 CCG patients with a Learning Disability and/or Autism discharged into the community during Q2, and no secure inpatients discharged.

12.1.4. Whilst admissions have seen an increase since Q3 2020 discharges have remained under trajectory across the sector. Actions taken:

- An aligned Health and Social Care Discharge Coordination Team is now established with defined health and social care team functions.
- A Discharge Team Standard Operating Procedure has been developed and all inpatients have been allocated a named health and social care discharge co-ordinator.
- The ICS has developed an ICS Care and Accommodation plan for current and future in patients.
- A detailed Learning Disability and Autism Care and Accommodation Delivery plan will be developed, prioritising groups with greatest complexity and by estimated discharge date.
- Engagement with housing and provider markets will also take place.
- The LDA Improvement Board will monitor progress monthly

12.2. The Five Eyes Review Process: Ensuring the safety and wellbeing of autistic children, young people and adults and those with a learning disability

12.2.1. The learnings from the recent Norfolk Safeguarding Adult Board review report, the National Unit of Concerns work and impact of the COVID 19 Pandemic have identified that current quality oversight processes, is not always robust enough to identify poor standards of care, especially in relation to people's physical wellbeing and quality of life (such as daily activities). Hence the need for a national review, swift and at a point in time, to have absolute clarity that people are being properly cared for; to take immediate remedial action if a review shows that they are not and to identify any key themes that emerge. Actions taken:

12.2.2. The process is made up of two phases:

**Phase 1 – Implement the undertaking of the reviews**
The review template is in its final draft and has been shared with CCG Commissioners. The reviews are being scheduled to take place before the 31st January 2022. A prioritisation process is in place to review hospitals with an inadequate or requires improvement rating.

**Phase 2 – Assurance and Challenge of review findings**
Following completion of the review an oversight panel to scrutinise the reviews has been established at an ICS level. These have been arranged on a weekly basis and the frequency will be reviewed at the end of December and additional sessions arranged as required. Members of the panel include the learning disability and autism senior responsible officer, an expert by experience and a senior clinician with expertise in learning disability and autism.

12.2.3. The scope of the ICS oversight panel is to ensure:

- all individuals from L&SC have had a review and assure themselves that the individuals are safe and well.
- any additional quality assurance intelligence available regarding the commissioned service such as host commissioner reports and safeguarding information is considered.
- ownership of any actions that may need to happen as the result of a review are taken.
- any findings are shared with the NHSE/I regional teams.
- a summary report is provided to the Regional Team detailing the findings, themes, and actions to be taken from the reviews.
- escalation to the regional team on any issues that cannot be addressed on an ICS footprint is provided. Evidence how findings of the review's feeds into the ICS delivery plan.
- all panel members are compliant with local information governance procedures.

## 13. Population Health and Health Inequalities

13.1. Context

13.1.1. This section provides an update to the SCC on the work of the Population Health workstream in tackling Health Inequalities, the actions identified and next steps, and outlines the emerging framework for action for the health and care system to address unfair and avoidable differences in health outcomes.

13.1.2. Our overarching Population Health Operating Model (See Population Health Operating Model & Development Programme summary) has already been discussed and agreed at SLE, and is to be ratified at SCC next month (22nd November 2022), however it is clear that this is reliant on investment and prioritisation.

13.2. Introduction

13.2.1. Health outcomes for people living in L&SC are significantly worse compared to the national average. There are also significant health inequalities between most and least deprived areas within L&SC. Worryingly, the pace of improvement has slowed down with life expectancy going backwards in many areas. Significant action is required to reduce health inequalities and to tackle the major causes of ill-health and premature mortality.

13.2.2. We know that existing deep rooted health inequalities have been further exacerbated by the COVID-19 pandemic with further challenges to outcomes likely given the longer-term economic impact the pandemic will have, and a radical shift in the way care is provided is the only solution; driven by data, focused on prevention and intervention earlier in the progression of illness, set within the context of peoples' lives in their communities.

13.2.3. The outline proposals for legislative change for ICSs, clearly outline a direction of travel for ICSs as vehicles for addressing health inequalities and improving health outcomes, with a particular proposal to introduce a "triple aim" duty on NHS organisations and this will become a key focus in future assurance frameworks. A number of regional and national guidance documents have been published that, between them, set out clear expectations for how the NHS in particular should take steps to address inequalities.

13.2.4. Although we face a significant financial deficit and need to ensure the restoration of our services, without an embedded and consistent population health approach to inform the design and delivery of care and services across the entire L&SC Health and Care Partnership, our challenges will only increase with further risk to financial sustainability and our ability to deliver against the Long-Term Plan and requirements for System Integration.

13.2.5. Our population health development programme is designed to build more robust foundations within our ICS, within our 5 ICPs and within our 41 PCNs upon which to further develop our approach to population health. It responds to the NHS "asks" around population health and health inequalities and importantly builds on our collaborative learning pre COVID-19 from the accelerated learning programme for population health and the resulting programme of work that emerged.

13.3. Key Progress/Issues

13.3.1. We have taken steps to ensure we are responding to the requirements set out in the five key priorities outlined in the 2021/22 NHS Operational Planning Guidance and have also begun to consider how we can work differently to ensure that addressing inequalities becomes a key focus in everything it does aligning to the new ask of Core20Plus5 (see below). This is underpinned by the development of L&SC Health Inequalities Dashboard, work with Elective Recovery and Cancer.

13.3.2. As a system, we have agreed to develop a cohesive and robust plan for mobilising health and care organisations to address health inequalities and improve population health and this plan aims to show tangible actions across all levels of delivery from System, to Place, to Neighbourhood and person. This is set out in our Population Health Operating Model and Development Programme and emerging health inequalities action plan. There is a £21m commitment of investment for this work.

13.3.3. L&SC has launched a Health Equalities Commission chaired by Sir Michael Marmot. Our Commission will be a catalyst for health equalities transformation, helping to develop responses and actions arising, providing independent expert opinion, evidence and guidance as L&SCs communities, places and economy reshapes. Our HEC will provide expertise,

challenge, and support to lead the way, regionally and nationally in recognising and responding to the Equalities that traditionally exist and emerge from the pandemic.

13.3.4. We have received positive feedback from NHSE/I on our approach to embedding action on health inequalities and we received a “green” rating as having made good progress on delivering against the Phase 3 Urgent Actions on Inequalities, but we recognise we have much still to do. We are actively involved with the North West Health Inequalities Delivery Oversight Cell, sharing our good practice with others from across the region and also learning from colleagues to enhance our local approaches.

13.3.5. The Key issues pertaining to the actions required on Health Inequalities are set out in the attached briefing paper on Health Inequalities.

13.4. Conclusion

13.4.1. The fact that Health Inequalities are present within L&SC is not a new concept, with areas of significant deprivation, poor housing, high levels of long-term conditions and poor mental health clearly recognised by all public sector partners. However, Covid-19 has highlighted and worsened the health inequalities that exist within society and in particular, the North West, like never before.

13.4.2. The economic shockwave that will ripple beyond the waves of the pandemic will, by all accounts, drive up poverty and deprivation to levels not seen in a generation. With no uncertainty, this will increase demands for health and care services, physical, mental and social, long after COVID vaccines are deployed. We have an opportunity now to build on the common purpose we forged through our COVID response, to take action with our local authorities, VCFSE partners and residents to support our communities through this shockwave and go beyond this to addresses these inequalities, to address the causes of ill health and prevent further detrimental outcomes.

13.5. Summary of Next Steps

13.5.1. Assurance: Assurance that organisations/systems are responding to the requirements set out in the five key priorities outlined in the 2021/22 NHS Operational Planning Guidance to address health inequalities

13.5.2. Investment: The ICS must also continue to prioritise the investment in and continued development of the Population Health programme.

13.5.3. Agreed Approach: Agree a systematic approach to achieve real benefit from our work that embeds a focus on addressing inequalities throughout all our processes, from project planning, inequalities impact assessments to funding formula and commissioning for improved outcomes.

13.5.4. Data & Dashboard: Development of Health Inequalities Improvement Dashboard

13.5.5. Health Equality commission: Delivery of L&SC HEC in order to establish a catalyst for action on health inequalities

13.5.6. Formulation of Health Inequalities Action Plan

## 14. Health Inequalities Background Paper

14.1. The Challenge

14.1.1. Health outcomes for people living in L&SC are significantly worse compared to the national average. There are also significant health inequalities between most and least deprived areas within L&SC. Worryingly, the pace of improvement has slowed down with life expectancy going backwards in many areas. Significant action is required to reduce health inequalities and to tackle the major causes of ill-health and premature mortality.

14.1.2. Nearly a third of our residents across L&SC live in some of the most deprived areas across England. The percentage of people living in fuel poverty and unable to afford to heat their homes, is higher than the national average: 13% for L&SC, the national average is 10.6%. A significant proportion of children experience adverse living conditions including child poverty leading to significant variation in their development and school readiness. The percentage of children living in poverty ranges from a low of 12% to as high as 38% in L&SC, the national average is 30%.

14.1.3. Life expectancy in L&SC is lower than the national average, but there is a significant level of unwarranted variation in the number of years people can expect to live a healthy life across L&SC. Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of 68 years for children born today. In some neighbourhoods, healthy life expectancy is 46.5 years.

14.1.4. We know that existing deep rooted health inequalities have been further exacerbated by the COVID-19 pandemic with further challenges to outcomes likely given the longer-term economic impact the pandemic will have, and a radical shift in the way care is provided is the only solution; driven by data, focused on prevention and intervention earlier in the progression of illness, set within the context of peoples' lives in their communities.

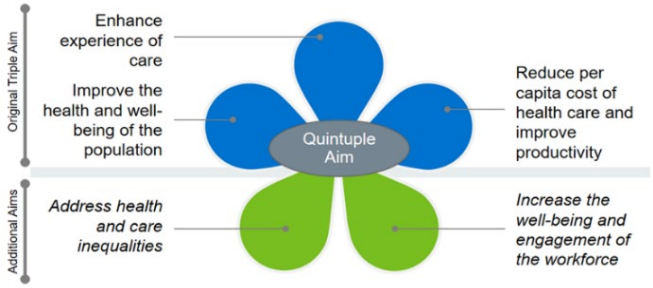
14.1.5. Although we face a significant financial deficit and need to ensure the restoration of our services, without an embedded and consistent population health approach to inform the design and delivery of care and services across the entire L&SC HCP, our challenges will only increase with further risk to financial sustainability and our ability to deliver against the Long-Term Plan and requirements for System Integration.

14.2. The Vision, Goal & Approach

14.2.1. The **vision** is to reduce inequalities and achieve a radical improvement in health outcomes by focusing on population health at place and neighbourhood level.

14.2.2. The **goal** is to improve the health and wellbeing of our population THROUGH the reduction in inequalities in the short, medium and long term.

14.2.3. Our **aims** in L&SC are consistent with the quintuple aims of population health as outlined at National level:



14.2.4. Our vision, goal and aims will be achieved through upscaling and embedding a population health management approach, driven by a more systematic and appropriately scaled use of linked data and qualitative insight to inform actionable interventions at system, place and neighbourhood level. We will take our learning from our work pre COVID-19 and during COVID-19, root causing elements that have blocked or enabled collaborative progress towards a consistent population health management 'way of working'.

14.3. Our Ambition – population health

14.3.1. Our population health development programme is designed to build more robust foundations within our ICS, within our 5 ICPs and within our 41 PCNs upon which to further develop our approach to population health. As such it is focussed on achieving closer alignment between the work within the NHS and with our partners in local Government. It responds to the NHS "asks" around population health and health inequalities and importantly builds on our collaborative learning pre COVID-19 from the accelerated learning programme for population health and the resulting programme of work that emerged. It has taken the learning from COVID-19 and associated tools such as the NW Community Risk Reduction Framework and the work from NHSE/I Equity and Health Inequalities Unit on health inequalities and COVID-19.

14.3.2. It builds on priorities previously identified which were informed by a range of data sources, along with insight and learning gained from working with a broad range of communities across L&SC. As a System, a strategy for population health is needed and will be shaped by the recommendations of the Health Inequalities Commission chaired by Professor Michael Marmot. Embedding this operating model of population health and tackling health inequalities at scale is a substantial piece of the jigsaw to our ambition of reducing health inequalities and will complement the broader programmes of work within our Clinical Networks, our Health and Wellbeing Boards, our own respective organisations and more. It will grow local approaches for understanding and quantifying the impact of different disease combinations on service utilisation to enable ICPs and their constituent partners to target resources more effectively.

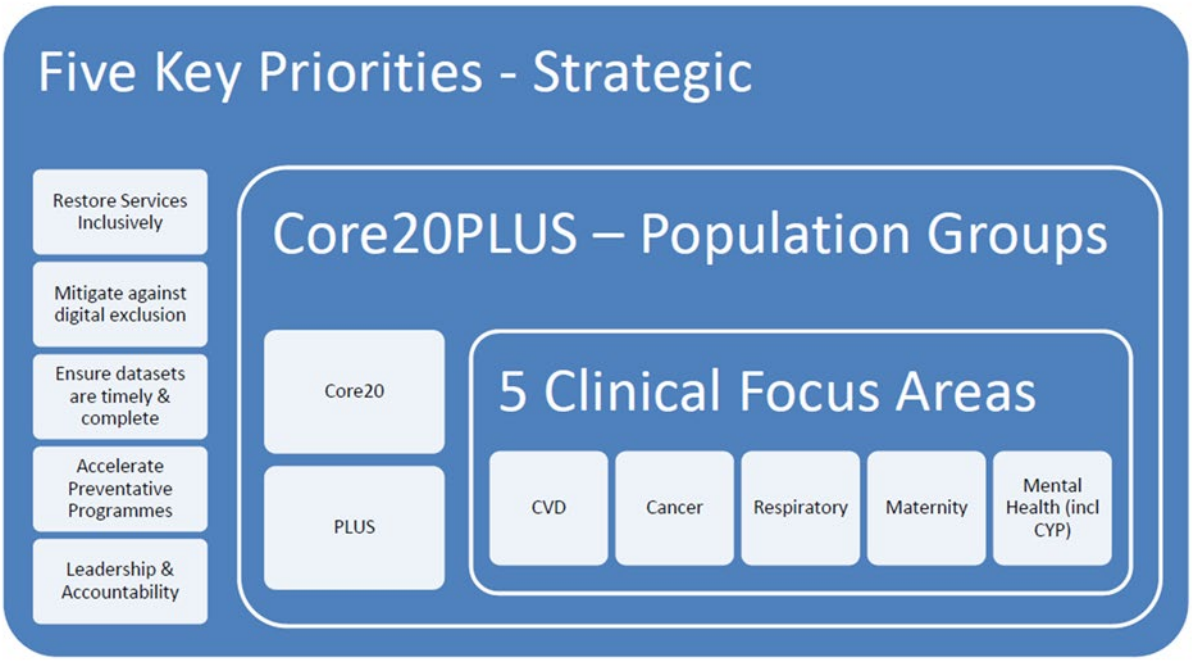
14.3.3. We have been on a journey in L&SC on population health with our most recent engagement and participation in the population health management accelerated learning programme prior to COVID-19. There was positive learning from this, learning that has been developed further within each ICP since. However, whilst there are pockets of good practice across the L&SC HCP, this way of working is not fully embedded, and it requires a cultural leadership shift at scale to support it along with additional investment at neighbourhood level to enable the capacity to be utilised in a way that allows for a more radical upscale of a population health approach. Currently there is no ICP across L&SC that has taken a systematic and sustainable approach to how we risk stratify, use insight and intelligence to segment the population for mobilising appropriately scaled actionable interventions.

14.3.4. We have therefore proposed an approach that sets out population health target operating model and development programme to address this at neighbourhood, PCN, ICP and L&SC levels driven by six key strands of work.

14.4. Embedding Action on Health Inequalities

14.4.1. The outline proposals for legislative change for ICSs, clearly outline a direction of travel for ICBs as vehicles for addressing health inequalities and improving health outcomes, with a particular proposal to introduce a "triple aim" duty on NHS organisations and this will become a key focus in future assurance frameworks. A number of regional and national guidance documents have been published that, between them, set out clear expectations for how the NHS in particular should take steps to address inequalities.

14.5. 2021/22 priorities for systems and providers: Health Inequalities Improvement programme (Core20PLUS5)




14.6. Key progress to date – health inequalities

14.6.1. We have taken steps to ensure we are responding to the requirements set out in the five key priorities outlined in the 2021/22 NHS Operational Planning Guidance and have also begun to consider how we can work differently to ensure that addressing inequalities becomes a key focus in everything it does aligning to Core20Plus5 (core 20 referring to the 20% most deprived wards).

14.6.2. Prevention activity is driven forward by the Cardiac, Respiratory network, Cancer Alliance, Mental Health Cell and Maternity Prevention Board. The system population health team will systematically support these networks to address inequalities in their work.

14.6.3. The Population Health Operating Model and Development Programme provides the blueprint for us to direct action to the most deprived wards to address in equalities and has weighted investment and activity at a local level to do this. This has been seed funded this year to start to lay the foundations for this approach going forward. Work with Elective Recovery and has started to reduce the impact of health inequalities on outcomes.

14.6.4. We have received positive feedback from NHSE/I on our approach to embedding action on health inequalities and we received a “green” rating as having made good progress on delivering against the Phase 3 Urgent Actions on Inequalities, but we recognise we have much still to do. We are actively involved with the North West Health Inequalities Delivery Oversight Cell, sharing our good practice with others from across the region and also learning from colleagues to enhance our local approaches. Our progress in delivering the entirety of the Phase 3 ask has been hampered by the significant and enduring presence of COVID-19, which has hit our residents and our services harder than other areas of the country. However, our approach has been to focus on small, yet tangible actions, that we could collectively deliver throughout the horizons of Covid to attempt to mitigate the impact and severity and avoid further worsening of inequalities.

14.7. Tackling Health Inequalities – Making Sense of the ask

14.7.1. We have agreed, as an ICS to undertake key actions to embed a focus on addressing health inequalities throughout everything we do. We have agreed:

- Develop a health inequalities action plan that embeds a focus on addressing inequalities throughout all our processes and strategies, this action plan will be developed through the hosting of our Health Inequalities Commission for Lancashire which will drive deep listening with our communities to understand needs and requirements for change. This will be developed in partnership with our local authorities, health and wellbeing boards and VCFSE.
- Continued assurance that the system is meeting the requirements set out in the five key priorities outlined in the 2021/22 NHS Operational Planning Guidance and has also begun to consider how it can work differently to ensure that addressing inequalities becomes a key focus in everything it does aligning to Core20Plus5. This will be underpinned by the development of a health inequalities dashboard (due to go live Nov 21) and the newly developed NHSE/I Health Inequalities Improvement Dashboard.
- To support the continued development of population health management across our system, underpinned by a Community Call to Action approach to mobilise community assets
- To work with our system networks to reduce inequalities in outcomes, starting with cancer and electives.

14.8. Health Inequalities Action Plan

14.8.1. Our HIAP is being developed to address the following key lines of enquiry as set out by NHSE/I for addressing inequalities in L&SC:

| KLOE | Action Plan |
|---|---|
| How are we ensuring that we have the right system leadership in place for Health Inequalities and that they have input to their planning and decision making that is representative of the communities they serve? | Delivery of the HEC<br><br>System leaders and DsPH for population health collaboration<br><br>Use existing engagement with communities, key stakeholders and experts to ensure programmes deliver meaningful change |
| How are we reviewing and updating our HI plans in place pre-COVID-19, with changes & learning since COVID-19 and adopting a risk-based approach to health inequalities in light of COVID-19 | Review existing local NHS Long Term Plan published metrics and monitor against delivery and ensure consideration is given to impact on groups most impacted by the virus and make changes to operational delivery as appropriate and feedback any issues to regional teams as appropriate to influence/refine policy decisions. |
| Are there Equality Health Impact Assessments in place for service changes? | Health Inequalities (considerations/impact (through Equality Health Impact Assessments) in context of Place based systems and risk-based approach taking Covid-19 impact and recovery. |

| KLOE | Action Plan |
|---|---|
| How are system boards across LSC using Population Health Management Business Intelligence to support board decisions on HI? | Develop action plans, with identified interventions and measurable impact and outcomes governance oversight arrangements with clear accountability<br><br>Working with ERF and Cancer Alliance to re-prioritise waiting lists and formulate HIE Action Plans |
| How are our system plans identifying what interventions on key clinical/non -clinical areas they are going to focus on and how are these interventions being measured/metrics for impact and outcomes? | Use key data to identify priority areas and priority groups using existing/new tools and resources such as the PHE PBA tools, the Right Care Pack and other tools being developed centrally |
| How will LSC use additional funding i.e. CCG Health inequalities adjustment to target interventions and outcomes for key groups – people in deprived areas, inclusion health groups and BAME/protected groups? | Roll out population health management in PCNs and neighbourhoods supported by the population health operating model<br><br>Initiate and monitor programmes ensure they are co designed with communities and VSFCE sector and are SMART<br><br>Evaluate monitor, identify areas for further review/research unmet needs<br><br>Take forward actions described in the Ethnic minority inequalities group initiated under LRF |
| Have we identified specific evidence –based actions for their most vulnerable populations/communities disproportionately impacted by COVID -19? | Take forward actions described in the Ethnic minority inequalities group initiated under LRF<br><br>Roll out population health management in PCNs and neighbourhoods supported by the population health operating model |
| Given the disproportionate impact of COVID – 19 on certain communities, how are these communities being prioritised | Prioritise target areas key groups BAME, people in deprived areas and inclusion health groups (keep this flexible as there may be other groups identified from Hi risk based approach) |

14.9. Health Equality Commission

14.9.1. L&SC ICS, ICP Execs and CCGs Chairs agreed to form a regional HEC to improve health equalities and make a step change in people's health.

14.9.2. L&SC HEC was proposed to support and influence health equalities work across L&SC and to shape and inform the regions renewal following COVID-19.

14.9.3. The HEC, chaired by Sir Michael Marmot, will bring L&SC up to date, following the pandemic, by using evidence to demonstrate where our biggest health equalities are, what works and make clear how best to govern for health, invest and take priority actions in the short, medium and long term. The HEC is formed of mix of independent experts and key influencers and have a sustained role in the monitoring of its recommendations. Our Commission will be a catalyst for health equalities transformation, helping to develop responses and actions arising, providing independent expert opinion, evidence and guidance as L&SCs communities, places and economy reshapes. Our HEC will provide

expertise, challenge, and support to lead the way, regionally and nationally in recognising and responding to the Equalities that traditionally exist and emerge from the pandemic.

| Forward Plan | |
|---|---|
| Introducing HEC event | 20th September |
| Formation of HEC Panel | 20th Sept – mid Oct |
| 'Ask' local partners to identify needs/evidence/priorities | 20th Sept – end Nov |
| Place based partners present to HEC | Nov – Dec |
| Analysis of partners needs/evidence/priorities by IHE | Dec – end Jan |
| Review analysis & recommendation of HEC panel | Dec – Mar '22 |
| Regional Health Equity Summit | April '22 - date tbc |

14.10. Next Steps

14.10.1. The system must continue to prioritise the investment in and continued development of the Population Health Management programme and Call to Action, as both of these approaches deliver on a number of the actions required. In the longer term, to achieve real benefit from our work, a systematic approach will be needed that embeds a focus on addressing inequalities throughout all our processes, from project planning, inequalities impact assessments to funding formula and commissioning for improved outcomes.

14.10.2. We need to quickly establish common ground with our local authorities on health inequalities, to coordinate our efforts jointly and link into wider partnerships, such as the Lancashire Enterprise Partnership and Greater Lancashire Plan.

14.10.3. In order to establish a catalyst for action on health inequalities, initial discussions have generated the concept of conducting a deep dive on inequalities during 2021/22, to understand the true impact Covid has had and ensure actions are taken by each part of our infrastructure. The establishment and delivery of the L&SC HEC, will take an independent, cross-sector view on the tangible things that can and need to be done to drive improvement, with recommendations being drawn, and delivery against the recommendations will be monitored by the Commission and the ICS Board. These will be fed into the emerging health inequalities action plan.

14.11. Programme enablers and support from other workstreams

14.11.1. Significant progress has been made to create the conditions and environment to establish population health management and this development programme enhances our current plans. Progression has been made to align the population health workstream with the out of hospital workstream and primary care, to ensure that neighbourhood and place are the central focus, and this is underpinned by our digital health roadmap. We are also working with the other workstreams to ensure that there is a common population health agenda which will span a whole number of prevention agendas for the pathways across the ICS.

14.11.2. We have acknowledged that place is a key organising principle for population health systems, and through the lessons learnt from our Vanguards in particular, and the development of our PCNs, we will focus on place based teams of health and care professionals to develop a population health approach to improving outcomes and reducing demand. This gives us the best opportunity to measure and improve population health at a

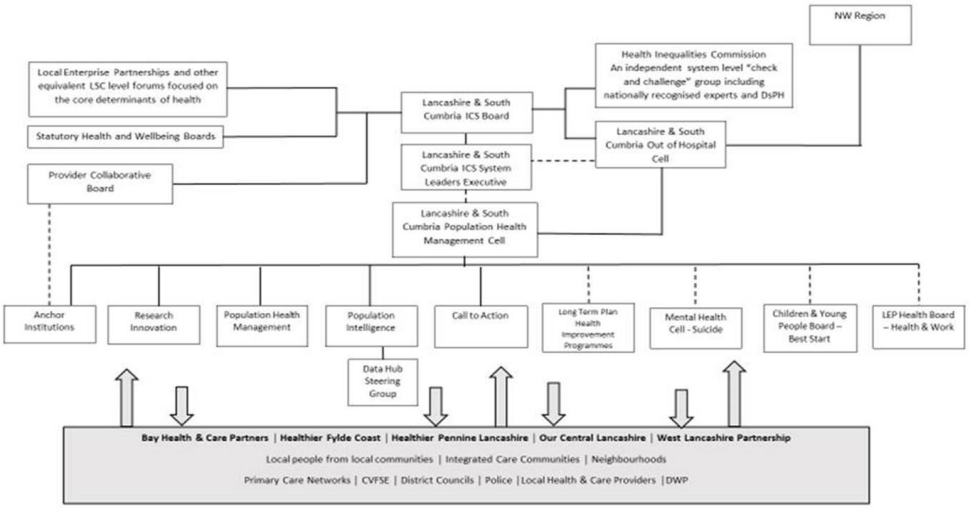
neighbourhood / locality level across our system, whilst continuing to improve health in other settings such as hospital and care homes.

14.12. Risks and Issues

| Risk | Potential Impact | Mitigation |
|---|---|---|
| Resource and capacity | Not having the capacity to develop and delivery prevention and population health plans. | The Population Health Operating Model identifies resources for both the ICS and Place Based Partnerships to support the aims and vision. Recruitment to a number of these posts is taking place during the week commencing 18th October and unfilled posts will then be advertised externally. |
| Investment | Unable to meet the aims and vision of Population Health approach to address inequalities across L&SC | The PHOM identifies £20.8m to support the development of a population health approach. The model has been supported by SLE and is to be tabled at the SSC in November for financial approval. The investment profile for this (unknown at present) will determine the level of mitigation |
| IG restrictions | Unable to stratify and segment population to ensure meaningful analysis and delay in availability of linked patient level data and associated insight. | The ongoing recruitment to the ICS and PBP will enable the use of patient level linked data from other geographies and help develop local expertise and insight, in the first instance, to address these issues.<br><br>COVID-19 data governance rules are applied |

14.13. Governance

A Population health board has been started and is overseeing the work.



## 15. Complaints, MP Letters and PALS

15.1. Introduction

15.1.1. The L&SC ICS/ICB will have a statutory duty to handle complaints from 1st April 2022. This will extend to some MP correspondence where it is handled as a complaint; other MP letters are dealt with outside the legislation but will still require a formal response. The PALS service is not a statutory requirement but is a well-known and used service and is integrated into the complaints handling approach.

15.1.2. The table below outlines the current position for each CCG against the delivery of the function:

Complaints, MP Letters and PALS Service 2021/22

| CCG | Complaints | MP Letters | PALS |
|---|---|---|---|
| Blackburn with Darwen | MLCSU | MLCSU | MLCSU |
| East Lancashire | MLCSU | MLCSU | MLCSU |
| Greater Preston | CCG[4] | CCG | CCG |
| Chorley and South Ribble | CCG | CCG | CCG |
| West Lancashire | MLCSU | MLCSU[5] | MLCSU |
| Fylde and Wyre | MLCSU | CCG | MLCSU |
| Blackpool | MLCSU | CCG | MLCSU |
| Morecambe Bay | MLCSU | MLCSU | MLCSU |

It should be noted that the delivery of the function has evolved over time with Blackpool CCG dealing with complaints internally from January 2021 and Morecambe Bay CCG transferring MP letters to MLCSU during 2019/20. It should also be noted that Central CCG Complaints team also deal with Freedom of Information and Subject Access Requests. Whilst the current Complaints/Patient Experience function in MLCSU currently sits under the Corporate Governance function discussions are underway as to the most appropriate portfolio for the function to sit within at ICB.

15.1.3. To begin preparing for the closedown of CCGs and designing the new function an initial meeting of a Task and Finish group was convened in July 2021 including representation from all CCGs, MLCSU and NHSE/I. This initial meeting was productive and quickly agreed some principles for future delivery. A second meeting took place on 20 October 2021; this report explains the current position and identifies the challenges involved in establishing the new service. The group agreed to monthly meetings between November 2021 and March 2022 and a separate session(s) to work through options for a case management system and mapping current and future business processes.

15.1.4. It should be noted that none of the ICS/ICB national guidance to date makes any reference to complaints, therefore our plans are based on the best assumptions we can make on the limited information available. Significantly, there is no clarity about how those primary care complaints, which are currently handled by NHSE/I teams, will be incorporated into the

[4] Central CCGs have a Customer Care Team which has a broader remit including complaints, MP letters and PALS

[5] Currently, there is a hybrid model for West Lancashire CCG where the CCG are more extensively involved. This is mostly because of extremely high volumes.

ICS/ICB; we await national policy and guidance but in the meantime the ability to plan is limited.

15.1.5. The ICS/ICB will also have a broader role overseeing complaints and patient experience across the system. A benchmarking exercise concluded in 2020 which demonstrated the variation in complaints management across the Lancashire and South Cumbria NHS footprint and made recommendations for harmonising how complaints are handled including standardising KPIs and targets. Furthermore, there are significant opportunities to analyse how the learning from complaints influences service improvements and outcomes for our citizens.

15.2. Agreed Principles for Delivering the New ICS/ICB Service

The Task and Finish group looking at the transition to a new set of arrangements adopted a set of principles for the design of the new service. They are to have one:

- Team/Service
- Process – including sign off arrangements
- Policy
- Case Management System
- Target Timescale
- Quality Standards Framework

15.2.1. It was agreed that the scope of the service would be complaints, MP letters and PALS.

15.2.2. CCG Closedown

Closedown will be worked through systematically based on the best information we have. Again, there is a currently no national guidance or policy about how the transition is expected to work, and we understand there is unlikely to be any legislation. The biggest single piece of work will be data transfer, retention, access and sharing. There are thousands of records held on different systems all with a retention period of ten years. This pre-dates the existence of CCGs therefore a scoping exercise is underway to consider how this exercise can be completed.

15.2.3. Volumes and Likely Demand

This is the area of greatest concern. Demand for current services is high and growing, recruitment and retention of staff has become a problem, the relative numbers of complaint types has also changed (see below) and this has impacted our ability to resolve them quickly and efficiently.

15.2.3.1. The table below outlines a summary of volumes for 2019/20, 2020/21 and 2021/22 year to 15 October 2021 with a then projection to the end of 2021/22 (combination of data held by MLCSU, Central CCGs and Fylde Coast CCGs).

Existing and Projected Volumes[6]

| Case Type | 2019/20 | 2020/21 | 2021/22 Year to Date | 2021/22 Full Year Projected |
|---|---|---|---|---|
| Complaint | 356 | 397 | 299 | 537 |
| MP Letter | 268 | 454 | 250 | 461 |
| PALS | 772 | 1461 | 1174 | 2164 |
| **Total** | 1396 | 2254 | 1723 | 3162 |
| **Units**[7] | 881 | 1340 | 940 | 1719 |

It is clear from this data that we are likely to need a function which can handle somewhere around 1000 complaints and MP letters and around 2000 PALS enquiries annually. This would represent a 94% increase in the 2 years from 2019/20 to 2021/22. Though the figures are not a completely accurate like-for-like comparison they are a useful guide. If current trajectories are maintained this could be higher and the new service could inherit a backlog. There may be some additional correspondence generated solely because new commissioning arrangements are launched.

15.2.3.2. These headline figures mask some of the trends and themes which are highlighted in existing quarterly reports provided to CCGs. The table below outlines a summary of comparative volumes for 2021/22 broken down by CCG. Cases we currently handle are divided into three overall categories. Firstly, those made about actions or omissions of the CCGs, secondly about Continuing Healthcare/Individual Patient Activity and thirdly, about commissioned providers. A detailed analysis of the themes and trends will be provided in the next iteration of the report.

2021/22 Year to 15th October 2021 - Volumes by CCG

| CCGs | Complaints | MP Letters | PALS | 'Units' |
|---|---|---|---|---|
| MBCCG | 58 | 38 | 145 | 144 |
| West | 37 | 84 | 126 | 163 |
| Central[8] | 119 | 60 | 632[9] | 390 |
| Pennine | 61 | 20 | 213 | 152 |
| Fylde Coast | 24 | 48 | 58 | 91 |
| **Total** | **299** | **250** | **1174** | **940** |

15.2.3.3. Further scrutiny of the MLCSU data reveals provider activity accounts for 78% of all contact during 2021/22; this has increased from 69% in 2019/20. These are difficult to address as we are reliant on those organisations investigating and responding at a time they face significant challenges. This will only represent a small fraction of the overall complaint activity in each of these provider organisations and the ICS/ICB could eventually consider conducting further work (in the medium term) to analyse complaints and patient experience activity across the whole Lancashire and South Cumbria NHS to ensure a holistic approach and maximise learning to improve outcomes.

[6] This is based on data collected from the MLCSU complaints service, CSR/GP Customer Care and Fylde Coast CCGs. There are some variations over the time covered by this as MLCSU took on the Blackpool service and some MBCCG MP letters during this period. This does not impact the 2021/22 activity or projections.
[7] Units is a measure used by MLCSU to allow comparisons between different types of activity. It is 1 unit = 1 complaint = 1 MP letter = 3 PALS.
[8] Data extracted on 19 October
[9] Categorised as 'PALS and General Enquiries'

15.2.4. Links to Other Functions

Our discussions highlighted links to other areas of activity currently taking place as we transition to the ICS/ICB. These are summarised below, and we have ascribed responsibility to task and finish group members to make links with these functions or workstreams and report back to our next meeting.

15.2.4.1. Communication and Engagement – especially in relation to how MP enquiries are handled and information about the service
15.2.4.2. Other governance and corporate functions – FoI, SARS, reception, front door
15.2.4.3. Clinical Quality, Patient Safety, Serious Incidents
15.2.4.4. Provider complaints and wider patient experience
15.2.4.5. Continuing Healthcare/Individual Patient Activity

15.3. Next Steps

The Task and Finish Group will continue to design the new function, work on the closedown of CCGs and plan the transition.

15.4. Recommendations

The SCC is requested to:

15.4.1. To note the work undertaken to prepare for the transfer of this function and the future actions identified.
15.4.2. To make representations to NHSE/I for clarity in relation to primary care complaints.
15.4.3. Agree to receive a progress report at the meeting of 3rd February 2022.

**16. 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 | ICB | Integrated Commissioning Board |
| AEDB | A&E Delivery Boards | ICP | Integrated Care Partnership |
| AHP | Allied Health Professional | ICR | Incomplete Referrals |
| AMHP | Approved Mental Health Professional | ICS | Integrated Care System |
| ASD | Autism Spectrum Disorder | IPA | Individual Patient Activity |
| B CCG | Blackpool Clinical Commissioning Group | IPC | Infection Prevention and Control |
| BGH | Burnley General Hospital | L&SC | Lancashire and South Cumbria |
| BI | Business Intelligence | LeDeR | Learning Disabilities Mortality Review |
| BTHT | Blackpool Teaching Hospitals Trust | LOS | Length of Stay |
| BVH | Blackpool Victoria Hospital | LSCFT | Lancashire South Cumbria Foundation Trust |
| BwD | Blackburn with Darwen | LTHT | Lancashire Teaching Hospital Trust |
| C&M | Cheshire and Mersey | MAS | Memory Assessment Service |
| CAMHS | Children and Adolescent Mental Health Service | MB CCG | Morecambe Bay Clinical Commissioning Group |
| CBT | Cognitive Behavioural Therapy | MCFT | Mersey Care Foundation Trust |
| CCG | Clinical Commissioning Group | MDT | Multidisciplinary Team |
| CHC | Continuing Health Care | MH | Mental Health |
| CHR | Clinical harm review | MHLT | Mental Health Liaison Team |
| CoP | Court of Protection | MLCSU | Midlands and Lancashire Commissioning Support Unit |
| CPA | Care Programme Approach | MRI | Magnetic Resonance Imaging |
| CRG | Clinical Reference Groups | MSK | Musculoskeletal |
| CSR | Chorley and South Ribble | NHSE | National Health Service England |
| CT | Computerized Tomography scan | NHSI | National Health Service Improvement |
| CTR | Care and Treatment Review | NW | North West |
| CYP | Children and Young People | NWAS | North West Ambulance Service |
| D2A | Discharge to assess | OAP | Out of Area Placement |
| DA | Domestic Abuse | PALS | Patient Advice and Liaison Service |
| DCA | Double-crewed Ambulance | PCN | Primary Care Network |
| DH&SC | Department of Health and Social Care | PHE | Public Health England |
| DNA | Did not attend | PHOM | Population Health Operating Model |
| DTA | Decision to Admit | PICU | Psychiatric Intensive Care Unit |
| ECDS | Emergency Care Dataset | PPE | Personal Protective Equipment |
| ECRG | Elective Care Recovery Group | QP | Quality Premium |
| ED | Emergency Department | Q&P | Quality and Performance |
| EDi | Eating Disorders | RBH | Royal Blackburn Hospital |
| EIP | Early Intervention Psychosis | RDC | Rapid Diagnostic Centre |
| EL | East Lancashire | RLI | Royal Lancaster Hospital |
| ELCAS | East Lancashire Child and Adolescent Services | RPH | Royal Preston Hospital |
| ELHT | East Lancashire Hospitals Trust | RTT | Referral to Treatment |
| ERF | Elective Recovery Fund | S136 | Section 136 |
| F&W | Fylde and Wyre | SARs | Subject Access Requests |
| FDS | Faster Diagnostic Standard – is a new policy in which patients should have cancer ruled out or diagnosed within 28 days of referral | SCC | Strategic Commissioning Committee |

| | | | |
|---|---|---|---|
| FGH | Furness General Hospital | SCRs | Serious Case Reviews |
| FoI | Freedom of Information | 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. |
| G&A | General and Acute | UCC | Urgent Care Centre |
| GP | Greater Preston | UEC | Urgent and Emergency Care |
| GM | Greater Manchester | UECN | Urgent and Emergency Care Network |
| HCP | Health and Care Partnership | UHMB | University Hospitals of Morecambe Bay |
| HEC | Health Equality commission | US | Ultrasound |
| HEE | Health Education England | VCFSE | Voluntary, Community, Faith and Social Enterprise |
| HIAP | health inequalities action plan | WL | West Lancashire |
| HLSC | Healthier Lancashire and South Cumbria | WLIs | Waiting List Initiatives |
| IAPT | Improving Access to Psychological Therapies | | |

**Appendix 1 D codes for Endoscopy**
**Waiting list prioritisation**

D1 Potentially life threatening or time critical conditions e.g. cardiac failure, significant bleeding, chest pain, renal failure, vision loss. Patients who are an emergency would fit into this category

D2 Potential to cause severe disability or severe reduction of quality of life e.g., intractable pain. Urgent patients, including 2ww, would fit within this category

D3 Chronic complaints that impact on quality of life and may result in mild or moderate disability. Routine patients who would normally be seen within the next 4-6 weeks

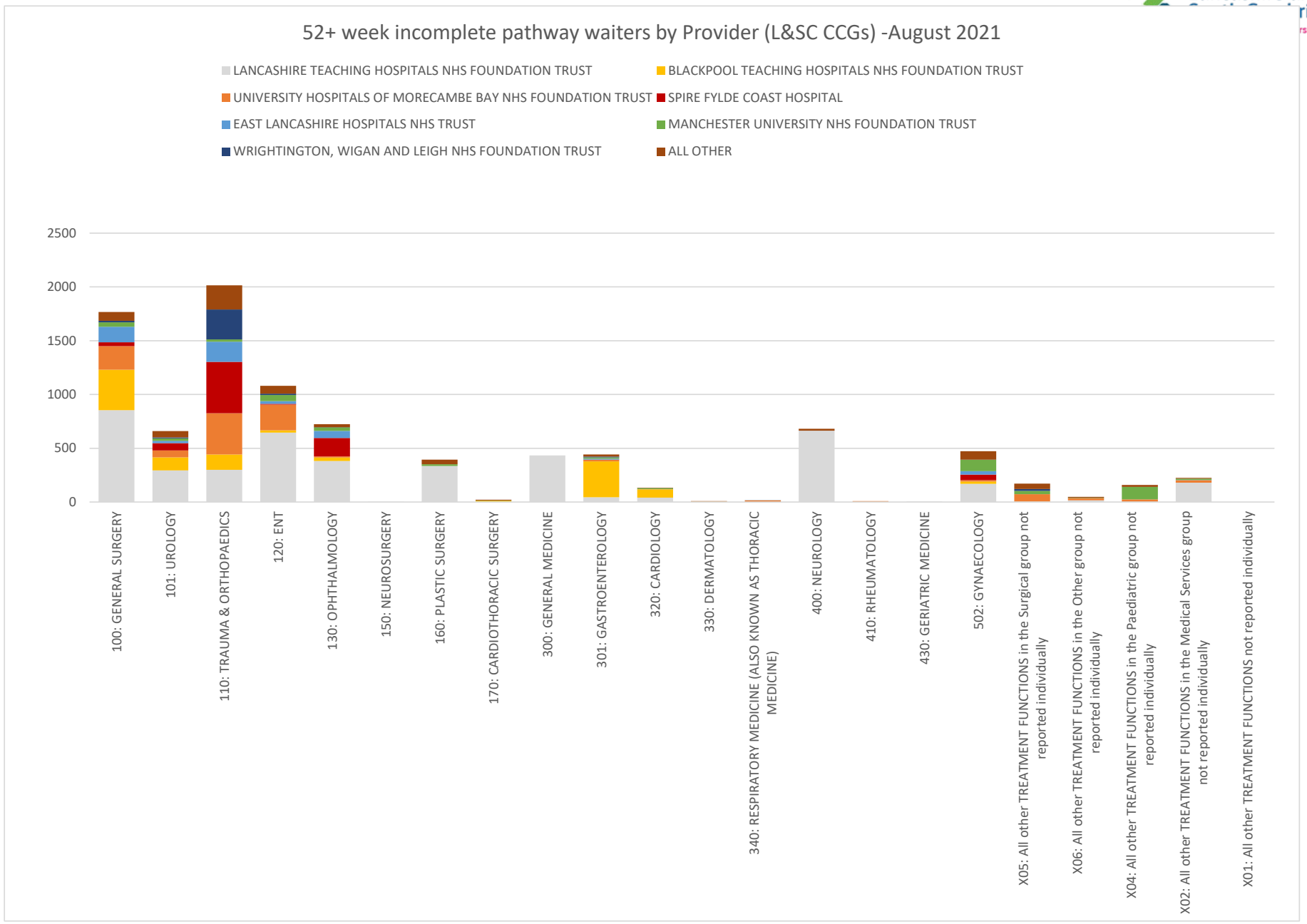
D4 Chronic complaints that impact on quality of life and may result in mild or moderate disability Routine patients who would normally be seen within the next 6-12 weeks

D5 Patient wishes to postpone procedure because of COVID-19 concerns

D6 Patient wishes to postpone procedure due to non-COVID-19 concerns

## Appendix 2: Over 52 week waiters for L&SC CCGs split by Specialty and Provider (August 2021)

| Specialty | LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | UNIVERSITY HOSPITALS OF MORECAMBE BAY 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 | 854 | 376 | 219 | 36 | 145 | 41 | 13 | 83 | 1767 | 18.7% |
| 101: UROLOGY | 295 | 120 | 64 | 69 | 21 | 23 | 9 | 58 | 659 | 7.0% |
| 110: TRAUMA & ORTHOPAEDICS | 299 | 143 | 384 | 478 | 186 | 21 | 279 | 224 | 2014 | 21.3% |
| 120: ENT | 645 | 22 | 238 | 8 | 25 | 56 | 14 | 72 | 1080 | 11.4% |
| 130: OPHTHALMOLOGY | 382 | 32 | 10 | 172 | 66 | 33 | 1 | 28 | 724 | 7.6% |
| 150: NEUROSURGERY | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0.0% |
| 160: PLASTIC SURGERY | 336 | 0 | 0 | 0 | 0 | 15 | 0 | 44 | 395 | 4.2% |
| 170: CARDIOTHORACIC SURGERY | 0 | 13 | 0 | 0 | 0 | 2 | 0 | 6 | 21 | 0.2% |
| 300: GENERAL MEDICINE | 434 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 434 | 4.6% |
| 301: GASTROENTEROLOGY | 45 | 333 | 15 | 1 | 9 | 12 | 7 | 20 | 442 | 4.7% |
| 320: CARDIOLOGY | 41 | 77 | 1 | 0 | 0 | 11 | 0 | 4 | 134 | 1.4% |
| 330: DERMATOLOGY | 1 | 2 | 3 | 0 | 0 | 0 | 0 | 4 | 10 | 0.1% |
| 340: RESPIRATORY MEDICINE (ALSO KNOWN AS THORACIC MEDICINE) | 0 | 1 | 16 | 0 | 1 | 0 | 0 | 0 | 18 | 0.2% |
| 400: NEUROLOGY | 664 | 0 | 0 | 0 | 0 | 0 | 0 | 17 | 681 | 7.2% |
| 410: RHEUMATOLOGY | 0 | 2 | 7 | 0 | 0 | 0 | 0 | 0 | 9 | 0.1% |
| 430: GERIATRIC MEDICINE | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 0.0% |
| 502: GYNAECOLOGY | 170 | 21 | 12 | 52 | 32 | 106 | 2 | 77 | 472 | 5.0% |
| X05: All other TREATMENT FUNCTIONS in the Surgical group not reported individual | 0 | 3 | 70 | 0 | 0 | 30 | 18 | 50 | 171 | 1.8% |
| X06: All other TREATMENT FUNCTIONS in the Other group not reported individually | 17 | 0 | 19 | 0 | 0 | 3 | 0 | 9 | 48 | 0.5% |
| X04: All other TREATMENT FUNCTIONS in the Paediatric group not reported individu | 0 | 2 | 23 | 0 | 0 | 116 | 0 | 18 | 159 | 1.7% |
| X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported i | 181 | 0 | 23 | 0 | 1 | 12 | 0 | 8 | 225 | 2.4% |
| X01: All other TREATMENT FUNCTIONS not reported individually | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **Grand Total** | **4368** | **1147** | **1104** | **816** | **486** | **481** | **343** | **722** | **9467** | **100.0%** |
| % TOTAL | 46.1% | 12.1% | 11.7% | 8.6% | 5.1% | 5.1% | 3.6% | 7.6% | **100.0%** | |


52+ week incomplete pathway waiters by Provider (L&SC CCGs) -August 2021
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF MORECAMBE BAY 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 3: Over 52 week waiters for L&SC Providers split by Specialty (August 2021)

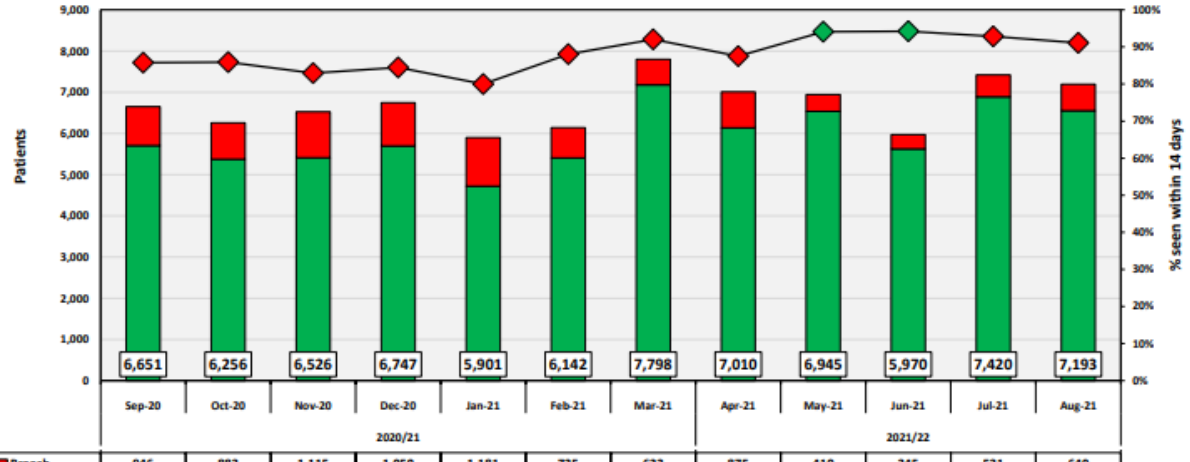
| Treatment Function | LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST | UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST | BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST | EAST LANCASHIRE HOSPITALS NHS TRUST | TOTAL | % TOTAL |
|---|---|---|---|---|---|---|
| Oral Surgery Service | 1770 | 28 | 15 | 192 | 2005 | 20.2% |
| General Surgery Service | 906 | 227 | 381 | 150 | 1664 | 16.8% |
| Trauma and Orthopaedic Service | 339 | 403 | 145 | 188 | 1075 | 10.8% |
| Ear Nose and Throat Service | 676 | 245 | 22 | 25 | 968 | 9.8% |
| Neurology Service | 683 | 0 | 0 | 0 | 683 | 6.9% |
| Urology Service | 313 | 69 | 124 | 22 | 528 | 5.3% |
| Ophthalmology Service | 390 | 11 | 32 | 66 | 499 | 5.0% |
| Neurosurgical Service | 485 | 0 | 0 | 0 | 485 | 4.9% |
| General Internal Medicine Service | 456 | 0 | 0 | 0 | 456 | 4.6% |
| Gastroenterology Service | 45 | 15 | 335 | 9 | 404 | 4.1% |
| Plastic Surgery Service | 351 | 0 | 0 | 0 | 351 | 3.5% |
| Gynaecology Service | 183 | 13 | 21 | 32 | 249 | 2.5% |
| Other - Medical Services | 199 | 23 | 0 | 1 | 223 | 2.2% |
| Cardiology Service | 43 | 1 | 85 | 0 | 129 | 1.3% |
| Other - Surgical Services | 0 | 81 | 3 | 0 | 84 | 0.8% |
| Other - Other Services | 17 | 19 | 0 | 0 | 36 | 0.4% |
| Other - Paediatric Services | 0 | 24 | 2 | 0 | 26 | 0.3% |
| Respiratory Medicine Service | 0 | 19 | 1 | 1 | 21 | 0.2% |
| Cardiothoracic Surgery Service | 0 | 0 | 13 | 0 | 13 | 0.1% |
| Rheumatology Service | 0 | 7 | 3 | 0 | 10 | 0.1% |
| Dermatology Service | 1 | 3 | 2 | 0 | 6 | 0.1% |
| Elderly Medicine Service | 3 | 0 | 0 | 0 | 3 | 0.0% |
| Other - Mental Health Services | 0 | 0 | 0 | 0 | 0 | 0.0% |
| **TOTAL** | **6860** | **1188** | **1184** | **686** | **9918** | **100.0%** |
| % TOTAL | 69.2% | 12.0% | 11.9% | 6.9% | **100.0%** | |

| | |
|---|---|
| VERY HIGH [>1000] | 1000 |
| HIGH [>500] | 500 |
| ELEVATED [>100] | 100 |
| TRACK | |

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

## 2 Week Wait Referrals (93% Standard)

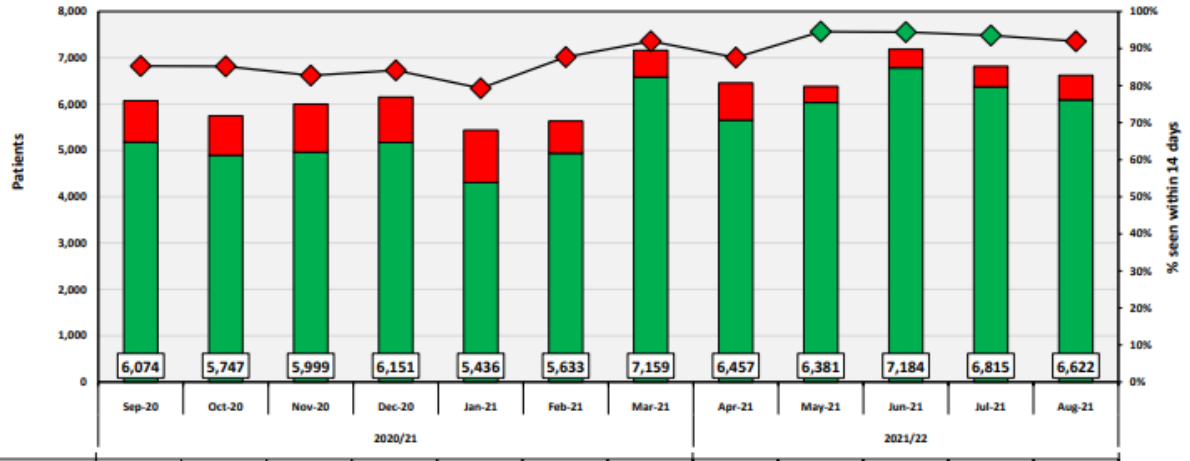
### Cancer Alliance CCGs (Sep-20 to Aug-21)




| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 946 | 883 | 1,115 | 1,050 | 1,181 | 735 | 622 | 875 | 410 | 345 | 531 | 640 |
| Within 14 Days | 5,705 | 5,373 | 5,411 | 5,697 | 4,720 | 5,407 | 7,176 | 6,135 | 6,535 | 5,625 | 6,889 | 6,553 |
| Seen | 6,651 | 6,256 | 6,526 | 6,747 | 5,901 | 6,142 | 7,798 | 7,010 | 6,945 | 5,970 | 7,420 | 7,193 |
| Performance | 85.78% | 85.89% | 82.91% | 84.44% | 79.99% | 88.03% | 92.02% | 87.52% | 94.10% | 94.22% | 92.84% | 91.10% |

| CCG | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BwDCCG | 579 | 67 | 88.43% | 5,414 | 361 | 93.33% |
| BCCG | 689 | 58 | 91.58% | 7,806 | 451 | 94.22% |
| CSRCCG | 764 | 51 | 93.32% | 8,766 | 938 | 89.30% |
| ELCCG | 1,367 | 127 | 90.71% | 14,032 | 883 | 93.71% |
| FWCCG | 922 | 62 | 93.28% | 10,886 | 786 | 92.78% |
| GPCCG | 954 | 59 | 93.82% | 11,021 | 1,198 | 89.13% |
| MBCCG | 1,372 | 113 | 91.76% | 16,397 | 3,923 | 76.07% |
| WLCCG | 546 | 103 | 81.14% | 6,237 | 793 | 87.29% |
| CA CCGs | 7,193 | 640 | 91.10% | 80,559 | 9,333 | 88.41% |

### Cancer Alliance Providers (Sep-20 to Aug-21)



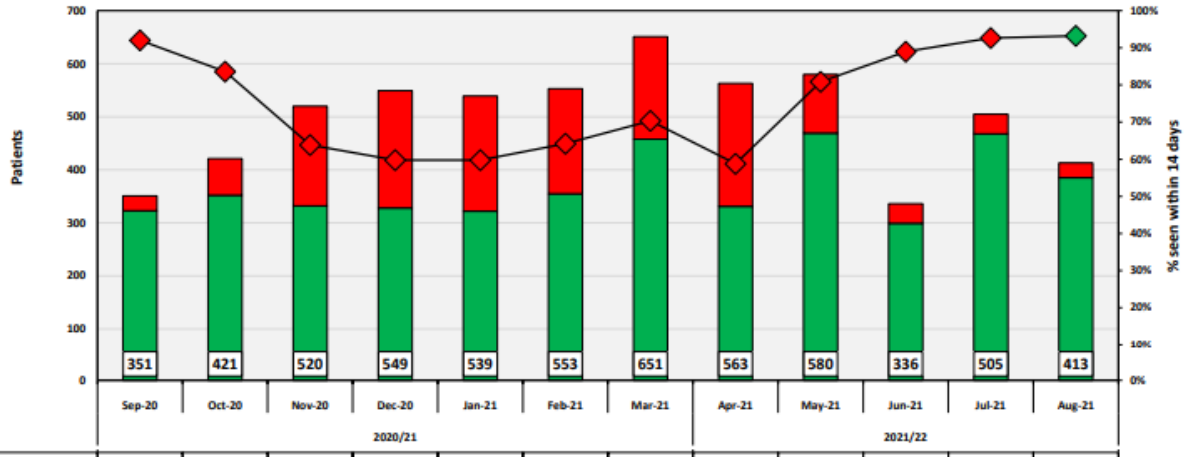

| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 895 | 850 | 1,036 | 978 | 1,127 | 693 | 575 | 803 | 348 | 401 | 442 | 533 |
| Within 14 Days | 5,179 | 4,897 | 4,963 | 5,173 | 4,309 | 4,940 | 6,584 | 5,654 | 6,033 | 6,783 | 6,373 | 6,089 |
| Seen | 6,074 | 5,747 | 5,999 | 6,151 | 5,436 | 5,633 | 7,159 | 6,457 | 6,381 | 7,184 | 6,815 | 6,622 |
| Performance | 85.27% | 85.21% | 82.73% | 84.10% | 79.27% | 87.70% | 91.97% | 87.56% | 94.55% | 94.42% | 93.51% | 91.95% |

| Provider | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BTH | 1,398 | 105 | 92.49% | 16,627 | 898 | 94.60% |
| ELHT | 1,867 | 185 | 90.09% | 20,145 | 1,231 | 93.89% |
| LTH | 1,880 | 121 | 93.56% | 21,402 | 2,347 | 89.03% |
| UHMB | 1,477 | 122 | 91.74% | 17,484 | 4,205 | 75.95% |
| CA Providers | 6,622 | 533 | 91.95% | 75,658 | 8,681 | 88.53% |

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

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

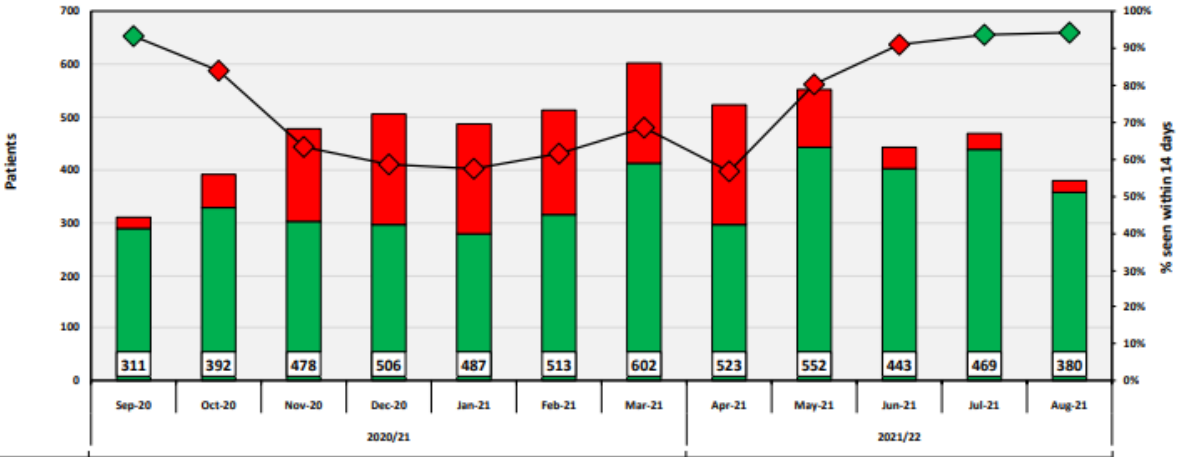
### Cancer Alliance CCGs (Sep-20 to Aug-21)




| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 28 | 69 | 188 | 221 | 217 | 198 | 193 | 232 | 111 | 37 | 37 | 28 |
| Within 14 Days | 323 | 352 | 332 | 328 | 322 | 355 | 458 | 331 | 469 | 299 | 468 | 385 |
| Seen | 351 | 421 | 520 | 549 | 539 | 553 | 651 | 563 | 580 | 336 | 505 | 413 |
| Performance | 92.02% | 83.61% | 63.85% | 59.74% | 59.74% | 64.20% | 70.35% | 58.79% | 80.86% | 88.99% | 92.67% | 93.22% |

| CCG | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BwDCCG | 49 | 2 | 95.92% | 624 | 50 | 91.99% |
| BCCG | 35 | 0 | 100.00% | 745 | 128 | 82.82% |
| CSRCCG | 51 | 4 | 92.16% | 697 | 284 | 59.25% |
| ELCCG | 96 | 3 | 96.88% | 1,382 | 109 | 92.11% |
| FWCCG | 43 | 2 | 95.35% | 633 | 137 | 78.36% |
| GPCCG | 45 | 5 | 88.89% | 776 | 330 | 57.47% |
| MBCCG | 64 | 9 | 85.94% | 776 | 465 | 40.08% |
| WLCCG | 30 | 3 | 90.00% | 348 | 56 | 83.91% |
| CA CCGs | 413 | 28 | 93.22% | 5,981 | 1,559 | 73.93% |

### Cancer Alliance Providers (Sep-20 to Aug-21)



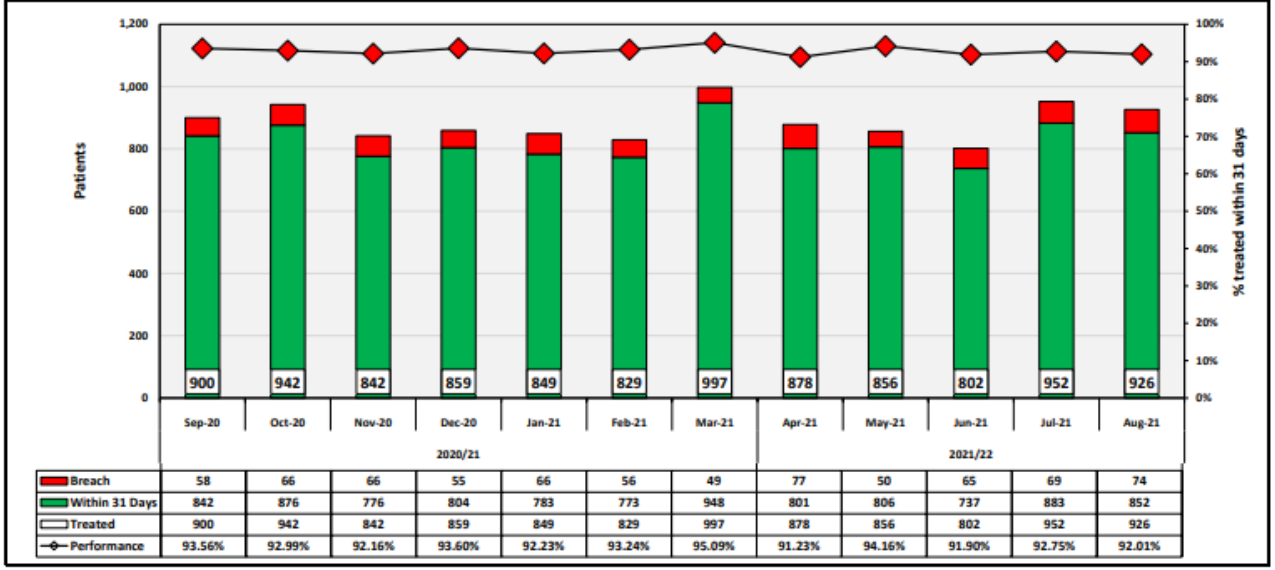

| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 21 | 63 | 175 | 209 | 207 | 197 | 189 | 226 | 109 | 40 | 30 | 22 |
| Within 14 Days | 290 | 329 | 303 | 297 | 280 | 316 | 413 | 297 | 443 | 403 | 439 | 358 |
| Seen | 311 | 392 | 478 | 506 | 487 | 513 | 602 | 523 | 552 | 443 | 469 | 380 |
| Performance | 93.25% | 83.93% | 63.39% | 58.70% | 57.49% | 61.60% | 68.60% | 56.79% | 80.25% | 90.97% | 93.60% | 94.21% |

| Provider | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Seen | Breach | Performance | Seen | Breach | Performance |
| BTH | 72 | 2 | 97.22% | 1,290 | 212 | 83.57% |
| ELHT | 143 | 4 | 97.20% | 2,026 | 132 | 93.48% |
| LTH | 96 | 7 | 92.71% | 1,513 | 637 | 57.90% |
| UHMB | 69 | 9 | 86.96% | 827 | 507 | 38.69% |
| CA Providers | 380 | 22 | 94.21% | 5,656 | 1,488 | 73.69% |

# % 31 Day Cancer – Definitive Treatment – August 21

## 31 Day First Treatment (96% Standard)

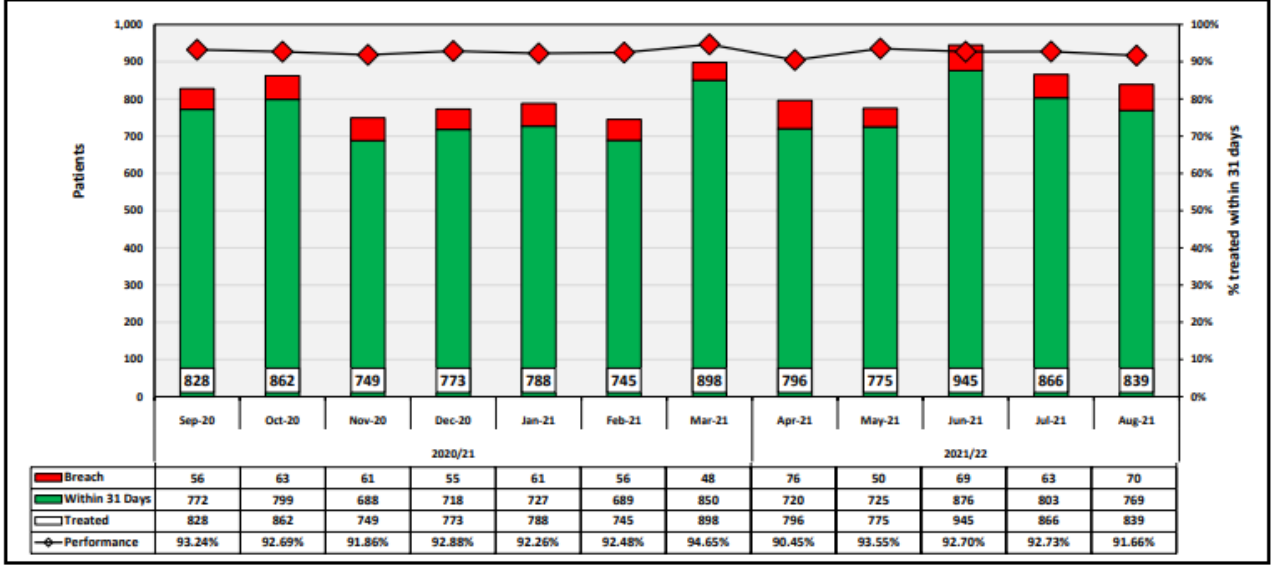
### Cancer Alliance CCGs (Sep-20 to Aug-21)




| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 58 | 66 | 66 | 55 | 66 | 56 | 49 | 77 | 50 | 65 | 69 | 74 |
| Within 31 Days | 842 | 876 | 776 | 804 | 783 | 773 | 948 | 801 | 806 | 737 | 883 | 852 |
| Treated | 900 | 942 | 842 | 859 | 849 | 829 | 997 | 878 | 856 | 802 | 952 | 926 |
| Performance | 93.56% | 92.99% | 92.16% | 93.60% | 92.23% | 93.24% | 95.09% | 91.23% | 94.16% | 91.90% | 92.75% | 92.01% |

| CCG | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BwDCCG | 54 | 7 | 87.04% | 702 | 47 | 93.30% |
| BCCG | 102 | 8 | 92.16% | 1,220 | 67 | 94.51% |
| CSRCCG | 115 | 10 | 91.30% | 1,162 | 105 | 90.96% |
| ELCCG | 157 | 10 | 93.63% | 1,919 | 119 | 93.80% |
| FWCCG | 158 | 8 | 94.94% | 1,590 | 96 | 93.96% |
| GPCCG | 91 | 12 | 86.81% | 1,072 | 107 | 90.02% |
| MBCCG | 179 | 17 | 90.50% | 2,214 | 189 | 91.46% |
| WLCCG | 70 | 2 | 97.14% | 753 | 21 | 97.21% |
| CA CCGs | 926 | 74 | 92.01% | 10,632 | 751 | 92.94% |

### Cancer Alliance Providers (Sep-20 to Aug-21)



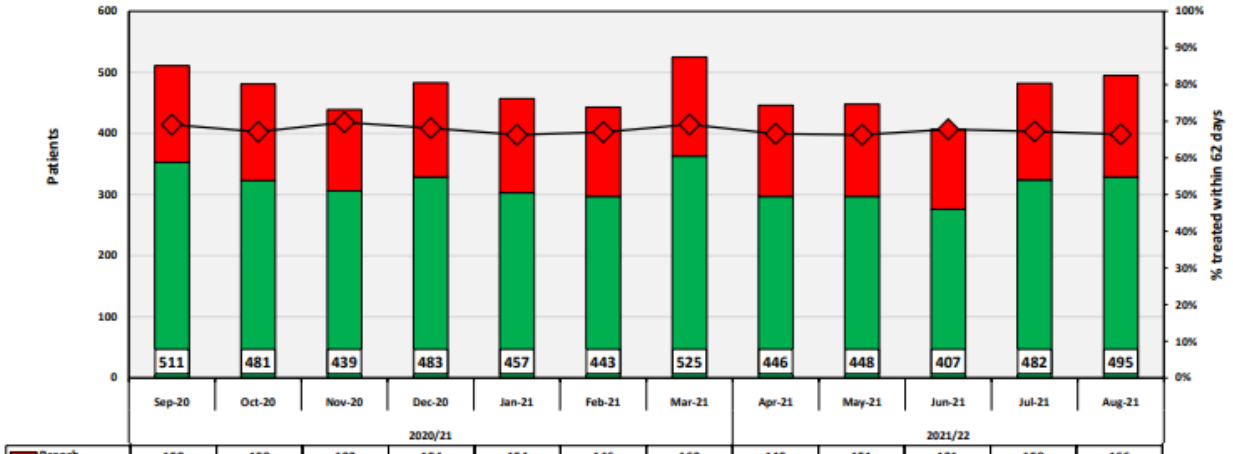

| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 56 | 63 | 61 | 55 | 61 | 56 | 48 | 76 | 50 | 69 | 63 | 70 |
| Within 31 Days | 772 | 799 | 688 | 718 | 727 | 689 | 850 | 720 | 725 | 876 | 803 | 769 |
| Treated | 828 | 862 | 749 | 773 | 788 | 745 | 898 | 796 | 775 | 945 | 866 | 839 |
| Performance | 93.24% | 92.69% | 91.86% | 92.88% | 92.26% | 92.48% | 94.65% | 90.45% | 93.55% | 92.70% | 92.73% | 91.66% |

| Provider | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BTH | 206 | 2 | 99.03% | 2,324 | 46 | 98.02% |
| ELHT | 171 | 10 | 94.15% | 2,382 | 121 | 94.92% |
| LTH | 313 | 43 | 86.26% | 3,322 | 442 | 86.69% |
| UHMB | 149 | 15 | 89.93% | 1,836 | 119 | 93.52% |
| CA Providers | 839 | 70 | 91.66% | 9,864 | 728 | 92.62% |

# % 62 Day Cancer – August 21

## 62 Day Classic Performance (85% Standard)

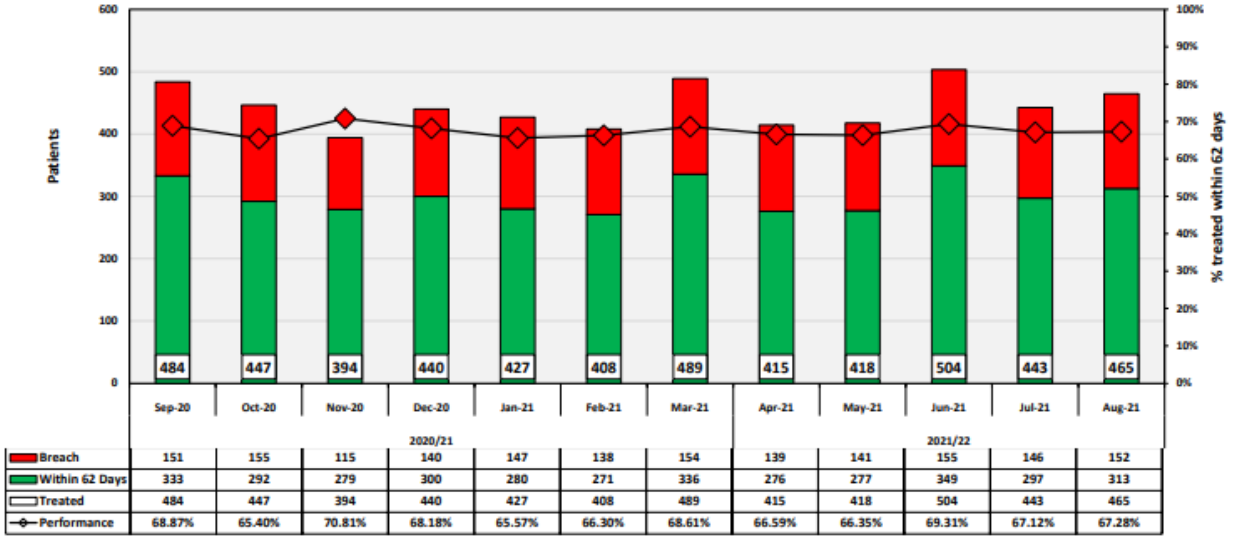
### Cancer Alliance CCGs (Sep-20 to Aug-21)




| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 158 | 158 | 133 | 154 | 154 | 146 | 162 | 149 | 151 | 131 | 158 | 166 |
| Within 62 Days | 353 | 323 | 306 | 329 | 303 | 297 | 363 | 297 | 297 | 276 | 324 | 329 |
| Treated | 511 | 481 | 439 | 483 | 457 | 443 | 525 | 446 | 448 | 407 | 482 | 495 |
| Performance | 69.08% | 67.15% | 69.70% | 68.12% | 66.30% | 67.04% | 69.14% | 66.59% | 66.29% | 67.81% | 67.22% | 66.46% |

| CCG | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BwDCCG | 30.0 | 11.0 | 63.33% | 350.0 | 98.0 | 72.00% |
| BCCG | 55.0 | 18.0 | 67.27% | 604.0 | 180.0 | 70.20% |
| CSRCCG | 69.0 | 24.0 | 65.22% | 665.0 | 229.0 | 65.56% |
| ELCCG | 91.0 | 21.0 | 76.92% | 996.0 | 276.0 | 72.29% |
| FWCCG | 79.0 | 18.0 | 77.22% | 870.0 | 229.0 | 73.68% |
| GPCCG | 49.0 | 20.0 | 59.18% | 598.0 | 223.0 | 62.71% |
| MBCCG | 94.0 | 39.0 | 58.51% | 1,161.0 | 470.0 | 59.52% |
| WLCCG | 28.0 | 15.0 | 46.43% | 373.0 | 115.0 | 69.17% |
| CA CCGs | 495.0 | 166.0 | 66.46% | 5,617.0 | 1,820.0 | 67.60% |

### Cancer Alliance Providers (Sep-20 to Aug-21)




| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Breach | 151 | 155 | 115 | 140 | 147 | 138 | 154 | 139 | 141 | 155 | 146 | 152 |
| Within 62 Days | 333 | 292 | 279 | 300 | 280 | 271 | 336 | 276 | 277 | 349 | 297 | 313 |
| Treated | 484 | 447 | 394 | 440 | 427 | 408 | 489 | 415 | 418 | 504 | 443 | 465 |
| Performance | 68.87% | 65.40% | 70.81% | 68.18% | 65.57% | 66.30% | 68.61% | 66.59% | 66.35% | 69.31% | 67.12% | 67.28% |

| Provider | Aug-21 | | | Sep-20 to Aug-21 | | |
|---|---|---|---|---|---|---|
| | Treated | Breach | Performance | Treated | Breach | Performance |
| BTH | 121.0 | 27.5 | 77.27% | 1,320.0 | 319.0 | 75.83% |
| ELHT | 108.5 | 28.0 | 74.19% | 1,325.0 | 352.0 | 73.43% |
| LTH | 141.5 | 58.5 | 58.66% | 1,570.0 | 629.5 | 59.90% |
| UHMB | 93.5 | 38.0 | 59.36% | 1,115.5 | 428.5 | 61.59% |
| CA Providers | 464.5 | 152.0 | 67.28% | 5,330.5 | 1,729.0 | 67.56% |

# % 6 Week Diagnostic Waiters –August 21

## ICS Level: Lancashire & South Cumbria

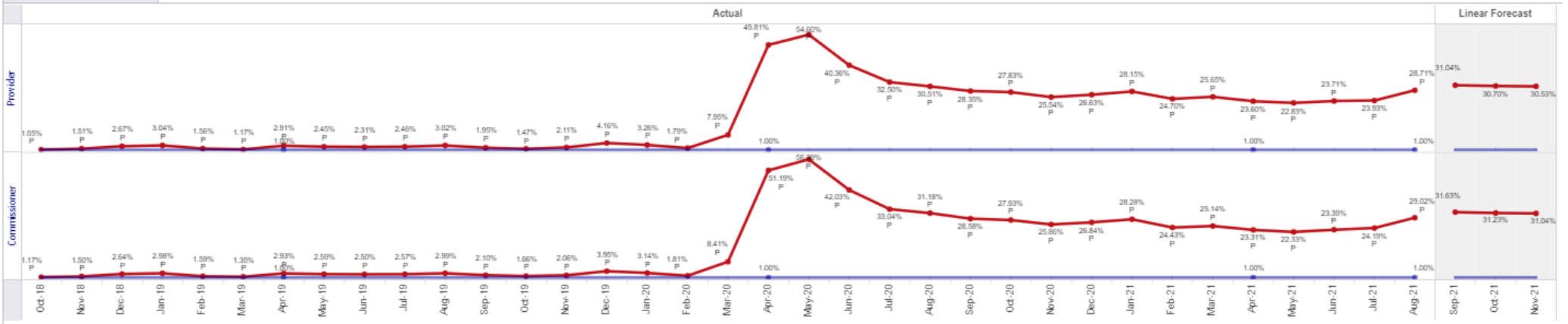
% of patients waiting 6 weeks or more for a diagnostic test

| | Provider | | YTD |
|---|---|---|---|
| Value | Aug-21 | 28.71% | 24.57% |
| Target | Aug-21 | 1.00% | 1.00% |
| Forecast | Sep-21 | 31.04% | 24.57% |

| | Commissioner | | YTD |
|---|---|---|---|
| Value | Aug-21 | 29.02% | 23.75% |
| Target | Aug-21 | 1.00% | 1.00% |
| Forecast | Sep-21 | 31.63% | 23.75% |

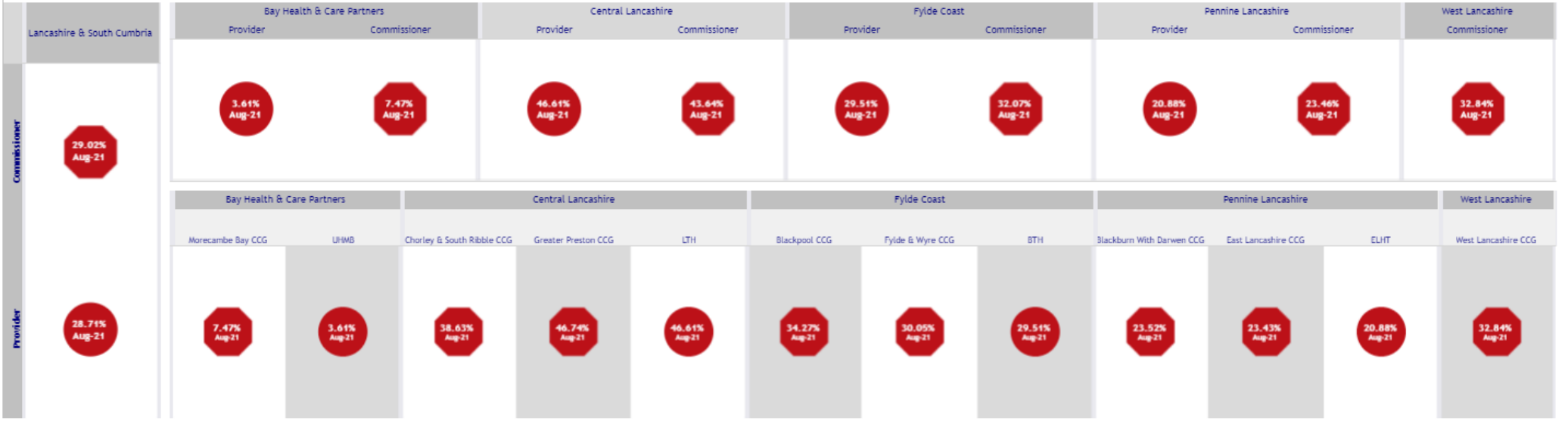
% Waiters 6 Wks Diagnostics

Organisation




ICS

Integrated Care Partnerships \ Integrated Care Organisations



# % Incomplete 18 weeks RTT – August 21

## ICS Level: Lancashire & South Cumbria

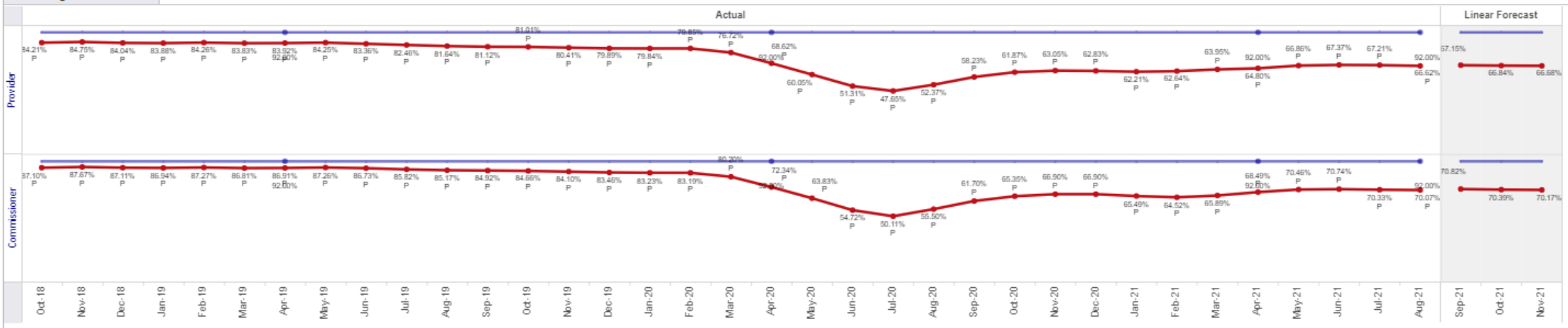
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

| | Provider | | YTD |
|---|---|---|---|
| Value | Aug-21 | 66.62% | 66.59% |
| Target | Aug-21 | 92.00% | 92.00% |
| Forecast | Sep-21 | 67.15% | 66.59% |

| | Commissioner | | YTD |
|---|---|---|---|
| Value | Aug-21 | 70.07% | 69.94% |
| Target | Aug-21 | 92.00% | 92.00% |
| Forecast | Sep-21 | 70.82% | 69.94% |

**% Incomplete 18 Wks RTT**

Organisation




ICS | Integrated Care Partnerships \ Integrated Care Organisations

# Total number of Incompletes RTT –August 21

## ICS Level: Lancashire & South Cumbria

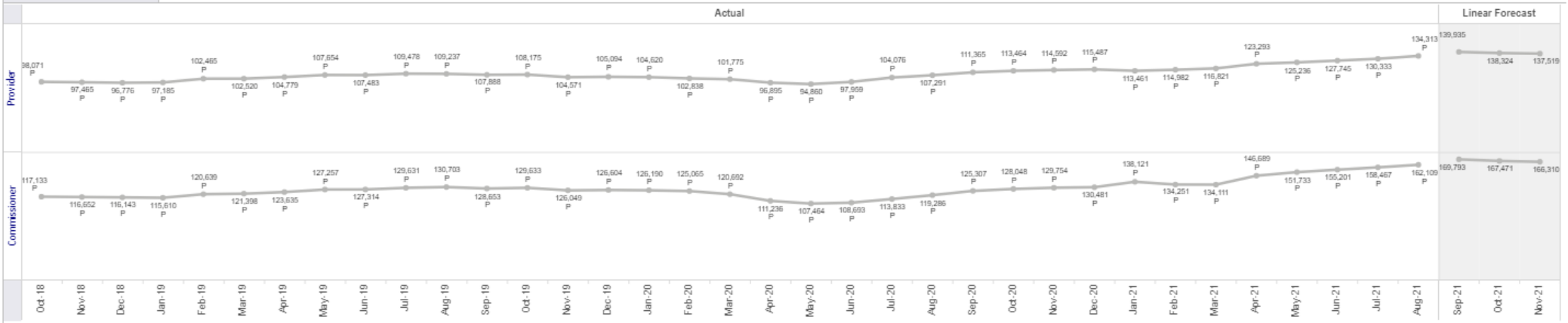
### Total Number of Incompletes under and above 18 weeks RTT

| Provider | | |
|---|---|---|
| Value | Aug-21 | 134,313 |
| Target | Aug-21 | |
| Forecast | Sep-21 | 139,935 |

| Commissioner | | |
|---|---|---|
| Value | Aug-21 | 162,109 |
| Target | Aug-21 | |
| Forecast | Sep-21 | 169,793 |

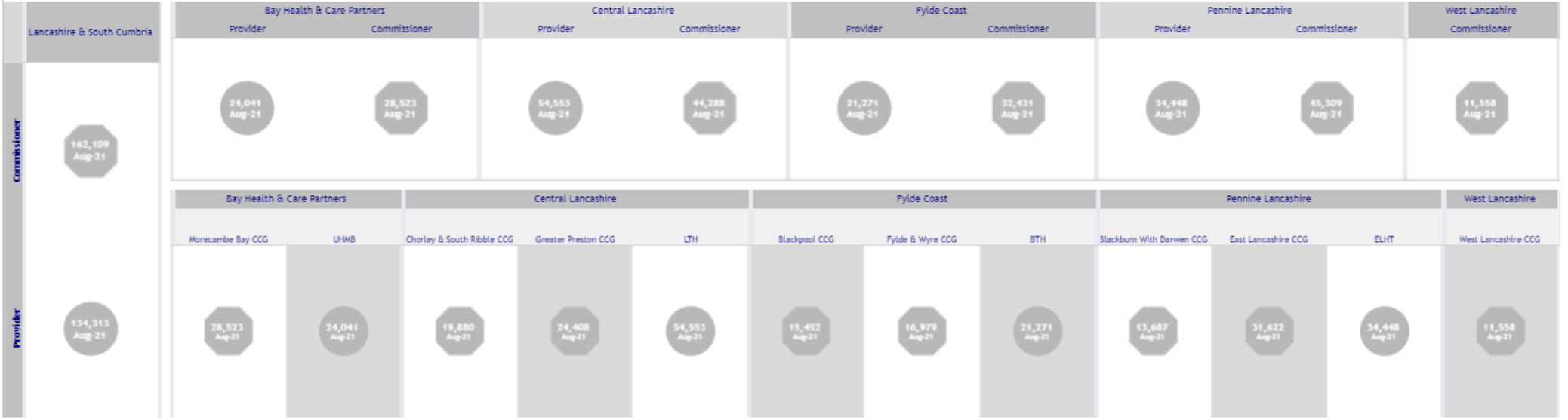
Total no. of Incompletes RTT

Organisation

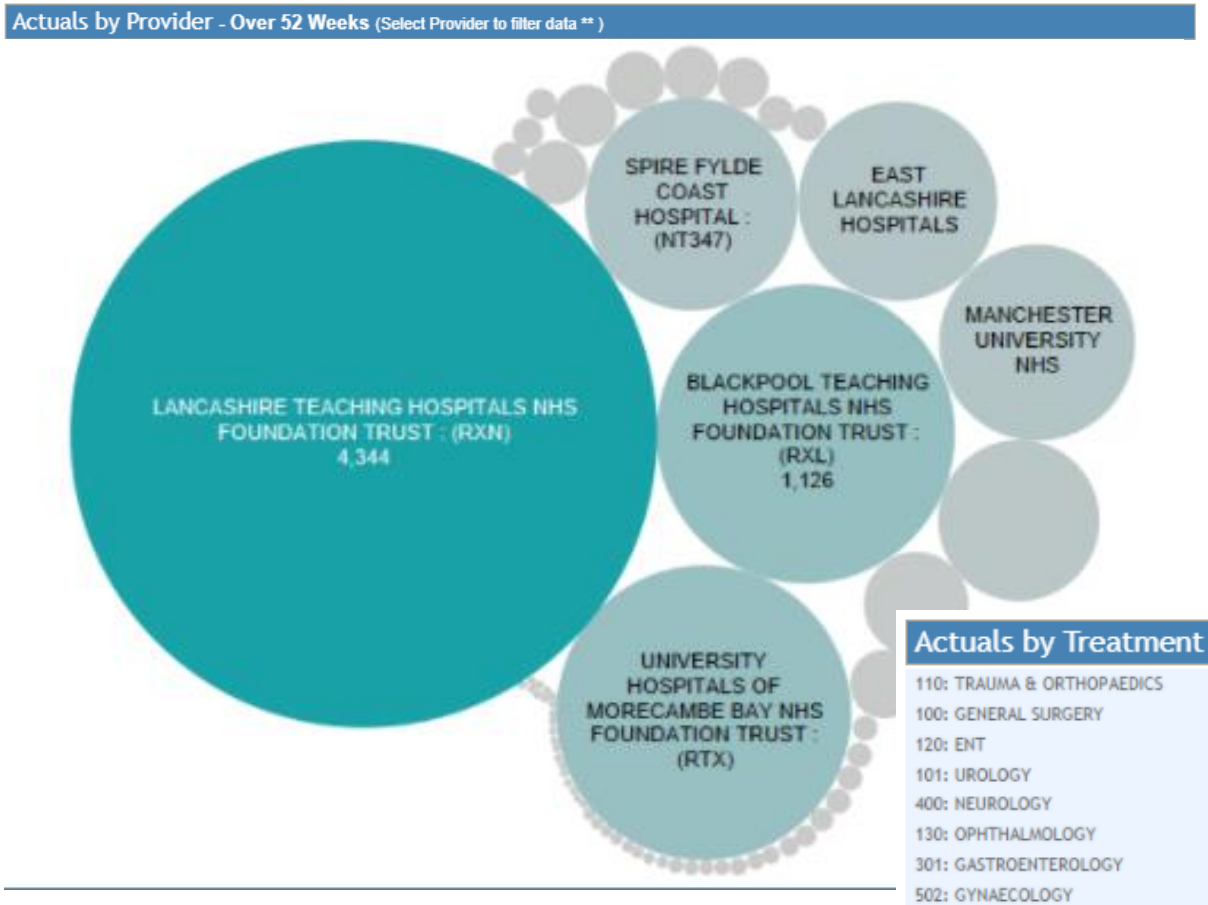


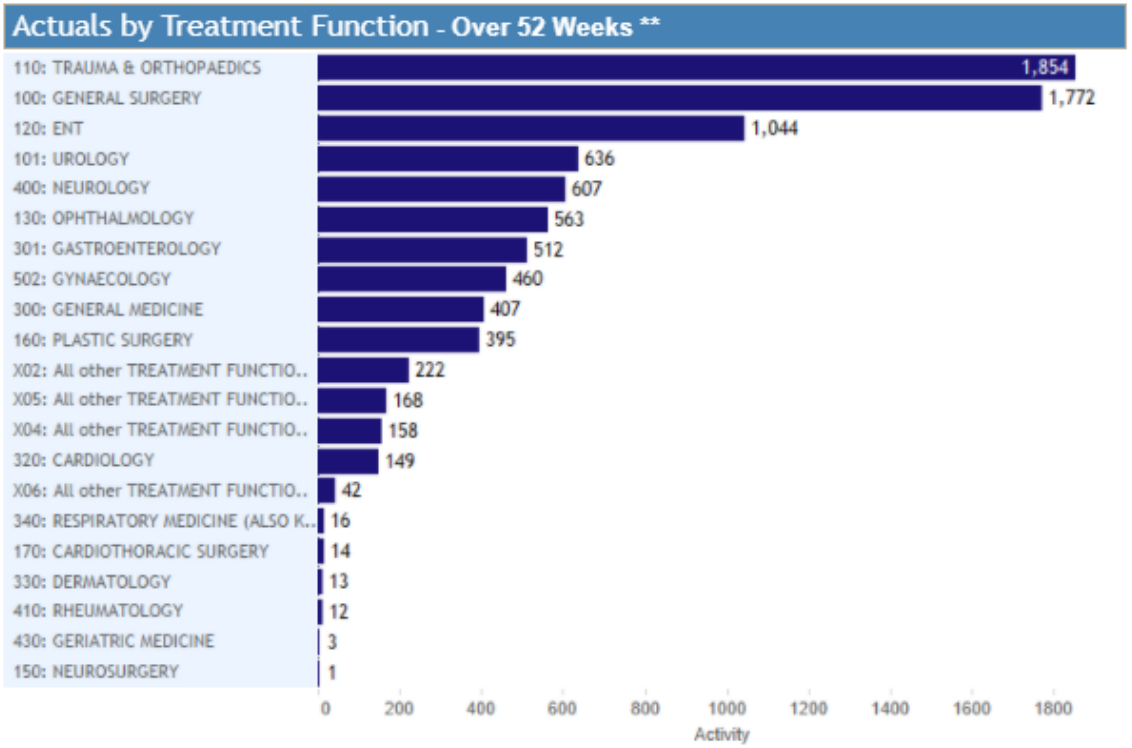

ICS

Integrated Care Partnerships \ Integrated Care Organisations



# Over 52 week waiters – August 21



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

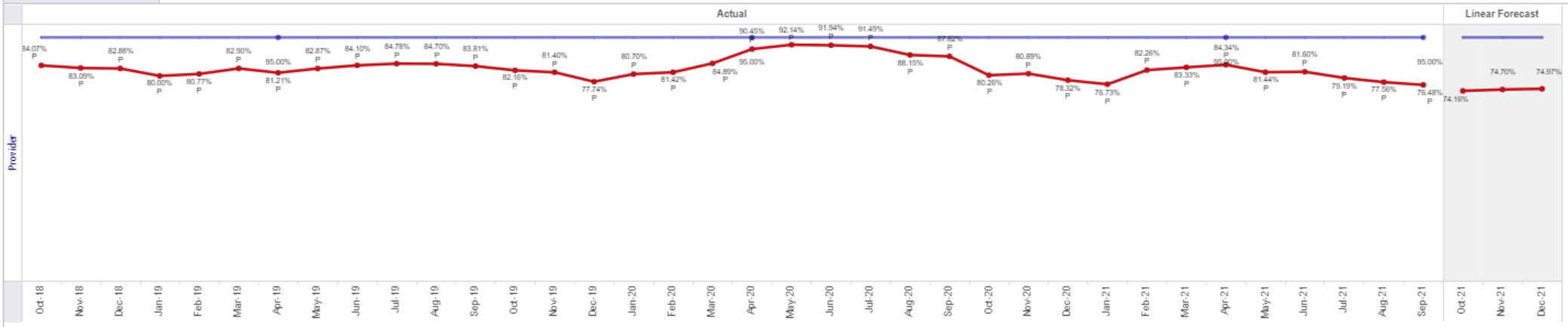
ICS Level: Lancashire & South Cumbria

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

| | Provider | | YTD |
|---|---|---|---|
| Value | Sep-21 | 76.48% | 80.05% |
| Target | Sep-21 | 95.00% | 95.00% |
| Forecast | Oct-21 | 74.16% | 80.05% |

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

Organisation




ICS

Integrated Care Partnerships \ Integrated Care Organisations

Lancashire & South Cumbria

Provider

76.48% Sep-21

| Bay Health & Care Partners | Central Lancashire | Fylde Coast | Pennine Lancashire |
|---|---|---|---|
| Provider | Provider | Provider | Provider |
| 78.42% Sep-21 | 77.84% Sep-21 | 79.30% Sep-21 | 71.18% Sep-21 |
| UHMB | LTH | BTH | ELHT |
| 78.42% Sep-21 | 77.84% Sep-21 | 79.30% Sep-21 | 71.18% Sep-21 |

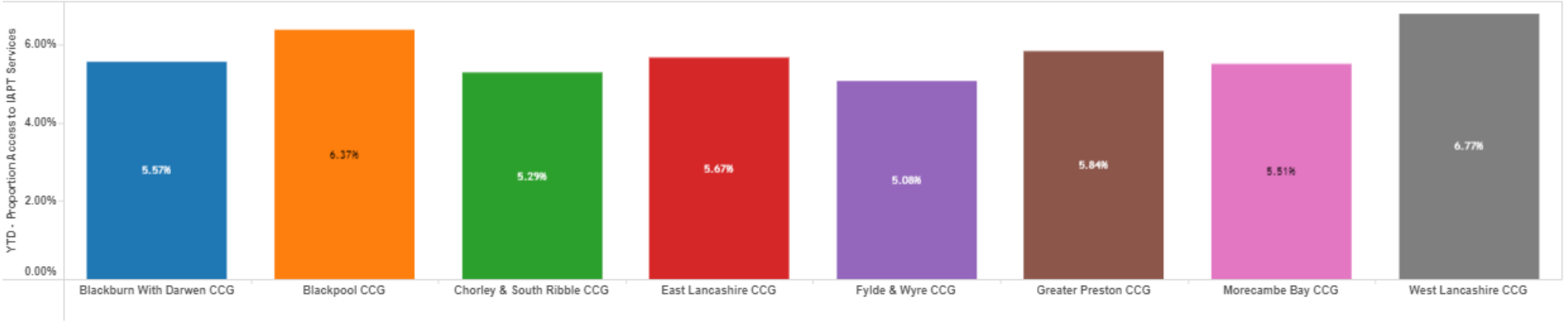
IAPT Access – July 21

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

Midlands and Lancashire Commissioning Support Unit

| Area | Financial Year | Select data by |
|---|---|---|
| Lancashire | 2021-22 | Proportion Access to IAPT services % |

**Selected Area: Lancashire**
**Financial Year: 2021-22**
**The graph shows year to date figures for Proportion Access to IAPT services %. To filter for a particular month, click on the month name in the table below.**




## Data from NHS Digital Monthly Extracts

| CCG Name | April | May | June | July |
|---|---|---|---|---|
| Blackburn With Darwen CCG | 1.32 | 1.27 | 1.44 | 1.54 |
| Blackpool CCG | 1.70 | 1.79 | 1.44 | 1.44 |
| Chorley & South Ribble CCG | 1.22 | 1.41 | 1.24 | 1.43 |
| East Lancashire CCG | 1.53 | 1.22 | 1.51 | 1.40 |
| Fylde & Wyre CCG | 1.17 | 1.15 | 1.32 | 1.44 |
| Greater Preston CCG | 1.51 | 1.34 | 1.61 | 1.38 |
| Morecambe Bay CCG | 1.37 | 1.31 | 1.48 | 1.34 |
| West Lancashire CCG | 1.97 | 1.52 | 1.69 | 1.59 |

## Data from NHS Digital Quarterly Extracts

| CCG Name | Q1 |
|---|---|
| Blackburn With Darwen CCG | 4.03 |
| Blackpool CCG | 4.93 |
| Chorley & South Ribble CCG | 3.86 |
| East Lancashire CCG | 4.17 |
| Fylde & Wyre CCG | 3.62 |
| Greater Preston CCG | 4.46 |
| Morecambe Bay CCG | 4.15 |
| West Lancashire CCG | 5.18 |

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **11th November 2021** |
| **Title of paper** | **Population Health Operating Model & Development Programme** |
| **Presented by** | **Dr Julie Higgins**<br>ICS SRO Population Health Management and Health Inequalities<br>**Dr Andy Knox**<br>ICS Clinical Director Population Health Management |
| **Author** | **Dr Julie Higgins** |
| **Agenda item** | **9** |
| **Confidential** | **Yes or no** |

## Purpose of the paper

The purpose of the paper is to update SCC on the population health operating model and development programme which has a £20.87 million investment commitment by the Lancashire and South Cumbria Health and Care Partnership.

## Executive summary

This paper 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.

- A detailed section on the operating model and development programme that includes:
  - Each of the six strands of enabling capabilities in detail (referred to as 'Hexagons') including relevant investment proposals and high-level funding requirements. Running cost parameters and existing CCG policies and practice have been considered alongside the remit and cost of roles.
  - Detailed design principles.
  - Aggregated benefits and key measurements across the operating model.
  - Evidence base underpinning the operating model.

The next steps in the project following overwhelming support from the SLE on 20th October 2021 are:

- To establish programme reporting to SLE

- For each Place-Based Partnership to develop local implementation plans of the operating model that reflect local needs in line with H2 funding and future funding arrangements.
- To develop a programme plan for the 'do once' activity at system.
- To continue to work through and manage interdependencies such as primary care, business intelligence, personalised care, action on health inequalities etc

**Recommendations**

Note and approve the population health operating model financial envelope and next steps in developing the implementation programme which will report via the Population Health Board to SLE.

**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? | | | | |

# Lancashire and South Cumbria
# Population Health Operating Model and Development Programme
# Summary Document

**Purpose of paper**

This paper has been developed by members of the Lancashire and South Cumbria Population Health Group, comprised of representatives from all five place-based partnerships (previously known as ICPs) with inputs from a range of contributors across other key workstream areas and subject matter expertise. It draws upon the published evidence base and builds on existing good practice across Lancashire and South Cumbria to set out a draft proposal for the population health operating model and development programme across Lancashire and South Cumbria. It has been shared at key forums within each place-based partnership and at the Lancashire and South Cumbria level as well as with relevant individuals (including a national expert on health inequalities) and has been iterated and refined to take account of key themes that have emerged.

It provides a summary of the finalised population health operating model and development programme that includes:

- The vision, goals and approach.
- Context and key challenges.
- Overview of the population health operating model through the six strands of enabling capability for Lancashire and South Cumbria and the 5 corresponding place-based partnerships.
- High-level overview of impact, interdependencies, funding proposals and next steps.

This paper can be read in conjunction with the following:

- Annex A – A more detailed overview of each of the six strands of enabling capabilities and relevant investment proposals.
- Annex B – Further detail on the benefits, measurements and evidence underpinning the operating model.

The purpose of this paper is to share the finalised operating model for final endorsement and ratification.

Once the model is agreed, further work will be undertaken to plan for implementation with full consideration of any due process in preparation for changes post April 2022.

## 1. The vision, goal and approach

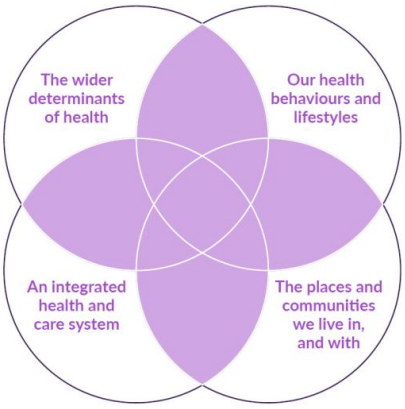
The **vision** is to reduce inequalities and achieve a radical improvement in health outcomes by focusing on population health at place and neighbourhood level.

The **goal** is to improve the health and wellbeing of our population THROUGH the reduction in inequalities in the short, medium and long term.

Our **aims** in Lancashire and South Cumbria are consistent with the quintuple aims of population health as outlined at National level:

- Enhance experience of care.
- Improve the health and well-being of the population.
- Reduce per capita cost of health care and improve productivity.
- Address health and care inequalities.
- Increase the well-being and engagement of the workforce.

The **approach** aligns to the four pillars of a population health system (The King's Fund, 2018):




Our vision, goal and aims will be achieved through upscaling and embedding a population health management (PHM) approach, driven by a more systematic and appropriately scaled use of linked data and qualitative insight to inform actionable interventions at system, place and neighbourhood level. We will take our learning from our work pre COVID-19 and during COVID-19, root causing elements that have blocked or enabled collaborative progress towards a consistent population health management 'way of working'.

Our vision, goal and aims can only be truly achieved by working together, in partnership, across the statutory sector including the breadth of service in Local Government and beyond into the community, voluntary, faith and social enterprise sectors and, for economic prosperity, the business sector. This is why working through our ICPs, Fylde Coast, Pennine Lancashire, Central Lancashire, Morecambe Bay and West Lancashire (referred to within this document as place-based partnerships) is a key design principle, working through them with the rich range of partners to address the wider (or "core") determinants of health, our behaviours and lifestyles and the places and communities we live in and with.

The feedback received from sharing the first iteration of this model served as a reminder that the NHS must approach this work with humility and a recognition that there are others who understand our communities at a far more granular level and have been working on population health approaches for far longer. It is only through working with partners at a local level that we can achieve the vision set out in this paper. This will need to include further consideration of the role local Health and Wellbeing Boards will play. It should be remembered that whilst broader partners have informed this model it has been written by the NHS and is predominantly about how NHS resource is used differently in order to play our part in the collective endeavour that is population health. The NHS has further to go in its learning on how to do this and this through working with partners the model outlined in this document will, as it is mobilised, continue to evolve.

The **design principles** (appendix 1) define how we are going to work to improve population health:

- Nothing about us, without us, is for us.
- An all age, life course approach.

- The higher level in the system (i.e. Lancashire & South Cumbria) should only do what only it can do.
- Distributed leadership must be trusted with investment focussed on Place and Neighbourhood to facilitate actionable intervention that supports local decision-making and priorities, contributing to overarching system objectives.
- Development of realistic capacity within a place-based core team.
- Key elements of the Population Health Budget will be distributed through a formula weighted towards vulnerability and reducing health inequalities.
- Done well, this work is organic by its nature.
- Population health improvement cannot occur unless inequalities are addressed.
- Population health is not the work of a small group; it needs to be embedded in all functions.
- We need to value, develop and grow compassionate leaders/champions in population health at every level and in every field and sector (statutory, Community, Voluntary, Faith and Social Enterprise (CVFSE) sector and business).
- Everyone in the workforce (health and all partners) needs to understand how they can contribute to population health and embed population health across all workstreams and should also develop their understanding of how each other contribute too.
- This requires short and long-term commitment, understanding that some of the associated outcomes cannot be changed within 3year cycles.

## 2. Our Ambition

This population health operating model and development programme is designed to build more robust foundations at every level to further develop our approach to population health. It responds to the NHS "asks" around population health and health inequalities and is focused on achieving closer alignment with all partners to build on our collaborative learning both pre and during the pandemic.

Embedding this population health operating model and development programme and tackling health inequalities at scale is a substantial piece of the jigsaw to our ambition of reducing health inequalities. It will complement the broader programmes of work within our Clinical Networks, Health and Wellbeing Boards, respective organisations and more. It will grow local approaches for understanding and quantifying the impact of different disease combinations on service utilisation to enable place-based partnerships and their constituent partners to target resources more effectively.

As a System, *an overarching strategy for population health is needed* and will be shaped by the recommendations of the Health Equity Commission chaired by Professor Michael Marmot. What is outlined within this operating model and development programme purposefully tried to "raise the bar" in how the NHS is responding to the expectations of it on population health and is embedding a population health approach.

**It is purposely not prescriptive in terms of the detail. The programme will develop the capacity and capability at system, place and neighbourhood level to evolve a more evidence based, systematic and scaled way of working. The design and the detail for local mobilisation and implementation will rest with place-based partnerships, Primary Care Networks (PCNs) and neighbourhoods. This recognises the importance of:**

- **Nurturing local, place-based leadership for population health**
- **Understanding local context, assets, needs and opportunities**
- **Local ownership of the design for longer term sustainability.**

## 3. The Context

We must strike the right balance between responding to the current COVID-19 pandemic and maintaining a focus on our long-term clinical and social priorities to transform into a truly integrated system of care for our citizens and communities across Lancashire and South Cumbria. The pandemic has resulted in significant changes to services and working practices across our system. Throughout what has been an incredibly difficult and challenging period, some of the enforced changes have taken us forward in our goal to modernise, integrate and focus our services on the needs of individuals. Our approach aims to 'lock in' these changes where possible and build on the achievements we have secured to make them scalable and sustainable across our System.

The close partnership working between health, care, voluntary, charitable, faith, social enterprise sectors and local Government, including strong public health leadership, has been essential to our response to the pandemic. These strong relationships must remain the foundation for achieving our vision.

However, COVID-19 has further exposed the staggering health inequalities across Lancashire and South Cumbria. Although we face a significant financial deficit and need to ensure the restoration of our services, without an embedded and consistent population health approach to inform the design and delivery of care and services across the entire Lancashire & South Cumbria Health and Care Partnership, our challenges will only increase with further risk to financial sustainability and our ability to deliver against the national and regional strategic plans (appendix 2) and requirements for System Integration.

Population Health cannot be delivered by just one small team – it must be owned by all teams across health and social care and in partnership with the CVFSE and other critical community stakeholders including our citizens, with governance structures that reflect the need for collaborative working and co-design. The plans outlined in this document assume that services that currently exist remain in place, funded by whichever source currently funds them, which may vary in different parts of Lancashire and South Cumbria. It will also require close alignment and the sharing of resource and pooling of budgets between local government and community-based organisations and all NHS providers and shared, collaborative leadership across these entities. This has been reiterated in the feedback received and will remain a continued area of development for us at both the Lancashire and South Cumbria level and within each of our five place-based partnerships.

## 4. The Challenge

Health outcomes for people living in Lancashire and South Cumbria are significantly worse compared to the national average. There are also significant health inequalities between most and least deprived areas within Lancashire and South Cumbria. Worryingly, the pace of improvement has slowed down with life expectancy going backwards in many areas. Significant action is required to reduce health inequalities and to tackle the major causes of ill-health and premature mortality.

Key drivers include:

- Nearly a third of our residents across Lancashire and South Cumbria live in some of the most deprived areas across England.
- The percentage of people living in fuel poverty and unable to afford to heat their homes, is higher than the national average: 13% for Lancashire and South Cumbria, the national average is 10.6%.
- A significant proportion of children experience adverse living conditions including child poverty leading to significant variation in their development and school readiness.
- The percentage of children living in poverty ranges from a low of 12% to as high as 38% in Lancashire and South Cumbria, the national average is 30%.
- Issues with access with transport being cited as a barrier in several of our communities, rural and urban.

**Life expectancy in Lancashire and South Cumbria is lower than the national average,** but there is a **significant level of unwarranted variation in the number of years people can expect to live a healthy life**. Healthy life expectancy and disability-free life expectancy is predicted to be less than the expected state pension age of 68 years for children born today. In some neighbourhoods, healthy life expectancy is 46.5 years[1]. We know that the COVID-19 pandemic has exacerbated inequalities with further challenges to outcomes likely given the longer-term economic impact the pandemic will have.

Lancashire and South Cumbria has significant financial challenges to address over the coming years as it improves efficiency and productivity in the system. Population health and population health management approaches provide a significant lever to support action on these challenges as its purpose is to intervene early and mobilise the workforce. It is used internationally to improve outcomes and reduce costs.

Further to this, the way we fund inequalities does not fully take into account the level of local challenge. We recognise this and are working with university partners to help us test more equitable funding mechanisms and incentives, including application of a weighted formula.

Currently there is no place-based partnership across Lancashire and South Cumbria that has taken a systematic and sustainable approach to how we risk stratify, use insight and intelligence to segment the population for mobilising appropriately scaled actionable interventions. Whilst there are pockets of good practice across the Lancashire & South Cumbria Health and Care Partnership, this way of working is not fully embedded. It requires a cultural leadership shift at scale to support it along with additional investment at neighbourhood level to enable the capacity to be utilised in a way that allows for a more radical upscale of a population health approach.

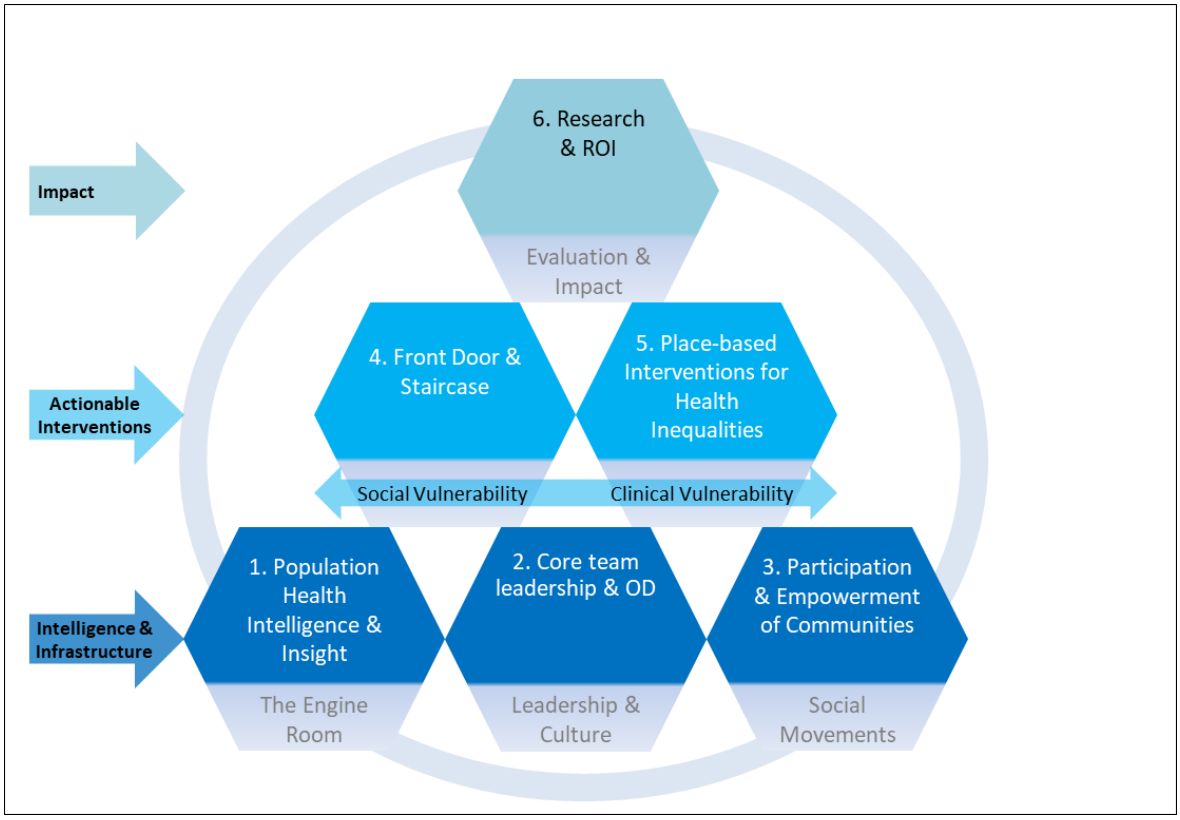
The approach proposed here sets out a population health target operating model and development programme to address this at neighbourhood, PCN, place-based partnership and Lancashire and South Cumbria levels driven by six key strands of work as described in the next section.

## 5. The Operating Model Key Strands

At a system level, action on population health uses data, including actuarial and health economics, to determine priorities and strategies for health. In order to deliver population health in place and at scale, there are six key strands in our operating model that we must develop across the Integrated Care System. These enablers (which we term 'hexagons') will help us focus on the pragmatic actions we must tackle if we are to effectively and sustainably address the health and social inequalities in our neighbourhoods and regions.

The operating model recognises that each of our five place-based partnerships across Lancashire and South Cumbria have a different starting point on each of these hexagons which reflects their pre-existing work to date. The first step will be working with partners, at a local level, to take stock of that 'current state' and scaling up these insights to take a system-wide informed view of what mobilisation across each of these hexagons looks and feels like within each place-based partnership – for discussion and agreement with each of the place-based partnerships.

[1] https://www.healthierlsc.co.uk/Change - figures are currently being refreshed and will be updated when available.




## 5.1 Population Health Intelligence and Insight (The Engine Room)

This is about ensuring we have the best possible data, intelligence and feedback loops available to provide local teams with the information they need about our residents and communities and the knowledge required to generate insights, mobilise the workforce and drive action. It will draw on the published evidence of "what works" based on the insights, utilising data by predictive analytics for risk stratification, population segmentation and forecasting to enable well evidenced cohort selection to derive actionable insight for improving outcomes and addressing inequalities.

These actionable interventions will be delivered both within place and (where appropriate) at scale. This will involve a continuous and systematic feed of data, so we become a truly data informed system. It will provide capacity for identifying opportunities, developing these, socialising and contextualising specific population health schemes where there are improvements to be made.

Key investments include:

- A place-based business/data intelligence function that includes dedicated analytics resource and Population Health Intelligence Advisors, to use data insights, published evidence & tacit knowledge to enable local-level identification of patient/citizen cohorts and inform subsequent design of actionable interventions and service enhancements. This capacity, embedded within local teams will provision intelligence drawn from quantifiable data and qualitative insight into partners, including PCNs and those focussed at neighbourhood level. This data and insight is not just held within the NHS and this capacity will enable us to go further with integrating intelligence.
- A digital intelligence function to build on existing capabilities to deliver insight into population health at system and place through linked data from a range of partners and interactive visualisations. It will enable

new capabilities and data insights into both clinical and social vulnerabilities, supporting action and intervention evaluation alongside the population health activities.

- A data science function that uses machine learning and predictive analytics for risk stratification, population segmentation and forecasting to enable evidence-based cohort selection and impactability modelling.
- Application development support function to develop and maintain a platform and tools for PHM using a scalable, cloud based architecture.
- Cloud consumption and data management.
- Training and support at place level.

It should be noted that these capabilities would be delivered as part of an integrated intelligence function at the Lancashire and South Cumbria level and not via a standalone population health management intelligence function.

## 5.2 Core Team, Leadership and Organisational Development (Leadership and Culture)

This strand will create the right conditions, culture and leadership upon which a population health approach can anchor and grow. It is about ensuring our system and organisations are aligned in ethos as well as development and deployment of resources and capabilities to tackle health inequalities and improve outcomes.

It will enable a core team in each place-based partnership to nurture the right conditions at neighbourhood, PCN, district and place-based partnership level to facilitate radically new ways of working. The place-based partnership core team will grow a culture of shared accountability, compassionate leadership and collaborative working across organisations focused on reducing health inequalities. The place-based partnership core team will work to mobilise the full content of this operating model and development programme and will include:

- Clinical leadership of the place-based partnership programme and team.
- Programme Management capacity, both to manage the local programme and to contribute to the capacity at the Lancashire and South Cumbria level as blended roles.
- Operational management of the Population Health function and approach.
- Programme coordination and support.

It will be supported by a Lancashire and South Cumbria wide function that will:

- Develop a Population Health and Health Inequalities Academy for all partners to benefit from, that compliments existing learning opportunities and training hubs and providers, that delivers shared learning, competency building and best-practice approaches. We will explore opportunities for the learning offered by the Academy to be accredited. The Academy may, in time, develop to include delivery of learning that raises confidence and skills within communities and community leaders directly.
- Provide strategic and clinical leadership and co-ordination of the Lancashire and South Cumbria-wide programme through a blended approach (roles spanning both place-based partnership and Lancashire and South Cumbria Health and Care Partnership and across different functions .ie. primary and community, public health) to deliver a portfolio of personalised care, health inequalities, research/academics, PHM and core determinants.
- Drive the required culture and behaviours through a leadership forum that is accountable for reducing health inequalities. This is intrinsically linked to the culture emerging within each place-based partnership.

Key investments include:

- Each place-based partnership will determine its own core population health function capacity and infrastructure based against a suggested model and taking account of existing capacity. Whilst the composition of the place-based function may vary, key aspects include:

  - Clinical leadership
  - Population Health Leads
  - A small co-ordination function
- Lancashire and South Cumbria Health and Care Partnership core team that includes:
  - Strategic and clinical leadership
  - Programme direction and population health leads that work across both place-based partnerships and Lancashire and South Cumbria Health and Care Partnership.
  - A small co-ordination function
  - Academy development function
- Programme funding that includes developing the Academy and embedding cultures, values and behaviours.

## 5.3 Participation and Empowerment of Communities (Social Movement)

This strand is focussed on drawing on the depth of knowledge, skills, capability and expertise and investing in our colleagues in the CVFSE sector to shape this area of work, to support teams to build their capability for developing genuine conversation and relationships with their local communities and to learn which culturally appropriate approaches/forms of participation are most accepted and work best for different communities. It will also help us to learn how to use the best tools and techniques available to deepen relationships with our communities to build a social movement for population health. This will include deep listening, collaborative conversations, participatory planning and creating a network of anchor institutions[2].

The approach includes:

- Community participation and development of community assets to gain deep insight and intelligence of lived experience of those experiencing health inequalities to support and harness community responses.
- Develop the art of conversation with communities that is continuous and ongoing, to maximise relationships and infrastructure that already exists in communities and connect this to co-produced solutions to deliver positive change. Being purposeful about this and getting it right will contribute towards creating the right culture for population health and neighbourhood development within the place-based partnership.
- Provide the right tools at local level to build on community participation and development of community assets.

Key investments include:

- Investment to develop/enhance a place-based function to build community assets and initiatives. Where this investment is best placed will be for place-based partnership decision but is likely to heavily include the CVFSE.
- A small resource at the Lancashire and South Cumbria level to lead and support participatory approaches.
- Programme funding that includes:
  - Wider participation and capability building in each place-based partnership via art of hosting (or equivalent) approaches.
  - Delivery of poverty truth commissions (or equivalent) in each place-based partnership.
  - Funding for communities to mobilise participatory approaches and participatory budgeting through CVFSE and partners to grow community assets as service providers to support healthier choices.
  - Mobilisation and delivery of system priorities related to community identified issues and community led interventions (all age and includes consideration of Adverse Childhood Experiences).
- Participation tools and licences.

[2] https://cles.org.uk/what-is-community-wealth-building/what-is-an-anchor-institution/ and https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

## 5.4 Nurturing protective behaviours and tackling social and/or multiple vulnerability (Actionable intervention)

This strand focuses on how we build, at place level, rapidly configurable care and support models around the true, real time needs of residents and their community particularly those experiencing social and/or multiple vulnerability. It is focussed on shifting to a more joined up and proactive care model, connecting existing workforce and service provision for a more integrated and comprehensive approach to social and/or multiple vulnerability.

The model is centred on a personalised care approach that gets alongside people to understand and prioritise what matters most to them and to act as a catalyst to unlock longer term, sustainable health gain. The right approach within each place-based partnership will differ and so each place-based partnership will need to decide on the approach to how this is codesigned and mobilised locally but key features should include:

- A single point of contact or "front door" that includes self-referral for those experiencing vulnerability.
- A locally designed assessment of need, assets and opportunities with full understanding of the drivers of vulnerability with involvement from individuals with lived experience of social vulnerability.
- A workforce with a clear understanding of the respective skills and capabilities of different roles arranged across a continuum for supporting different levels of vulnerability. This workforce is likely to be drawn from existing but overlapping roles and aims to harness the collective capacity if organisational barriers are removed and such roles worked as an integrated team.
- Ensures minimum standards and appropriately skilled workforce support by appropriate training.
- Support pro-active "case finding" through trusted partners which will ensure reach to people currently not accessing services and will include innovation for working with people in different ways.
- Deployment of wellbeing coaches that dovetail into local workforce and deliver plans.

Key investments include:

- Seed funding for local co-design and to lay the foundations of what the local model looks like.
- Mobilisation funding to deliver at place-level.
- Commissioning of wellbeing coaches.
- Commissioning and delivery of training that include Making Every Contact Count, health coaching, Patient Activation Measures (PAMs) and care co-ordination.
- Additional behavioural science support.

## 5.5 Place-based Interventions for Health Inequalities (Actionable Intervention)

This will build the capacity and capability to deliver evidence-based, place-based approaches, led by primary care clinicians collaborating with all key partners (including the CVFSE) within their neighbourhoods to tackle health inequalities. As such it will be a key way for local delivery of the national approach to health inequalities CORE20+5 and will further enable Primary Care Networks to deliver the DES. It includes additional investment and resource to enable capacity to develop the local operating model, build competency and skills and deliver actionable interventions.

The approach will be organic in its nature and will be underpinned by a principle of what matters most to people. place-based partnerships are likely to already have good practice examples or delivery vehicles being delivered locally. This workstream offers the opportunity to tailor and/or upscale these interventions as well as taking the learning from across Lancashire and South Cumbria of interventions that may be of benefit for local mobilisation.

This strand also supports a financial enhancement to areas with "priority wards". These deprived wards experience greater than expected non-elective admissions, with significantly more admissions even than might be expected for their deprivation score. This is symptomatic of ward environments least supportive of prevention and pro-active management of health risks, which then present as crisis and emergency. These wards will have an enhanced level of intervention with a particular focus on avoidable attendances and admissions. It should be noted that this will require local work to better understand the drivers within priority wards, the solutions for which may be through tackling social determinants.

This strand also proposes a focus on CVD, which is the biggest cause of preventable death in Lancashire and South Cumbria. It is does not infer a disease "silo" approach and, as local capacity and capability for this work develops, so should a more blended approach to comorbidities that has personalised care at its core. In this starting example, CVD should be considered in the broadest sense.

Key investments include:

- At neighbourhood/PCN level:
    - Health inequalities leads in each PCN, that are in addition to and compliment the PCN DES. It will be for place-based partnership decision on to ensure a blend in leadership reflecting clinical and non-clinical time.
    - Neighbourhood development support*
    - Neighbourhood clinical co-ordinators*
- Programme funding for "priority ward" focussed work.

*For local agreement but investment proposals have been built up based on indicative functions to provide an estimate of total budget to deliver the required capacity. Local co-ordination function at place-based partnership /Neighbourhood level will have a level of autonomy to make adjustments to the process to meet local circumstances.

It is anticipated that some of the funding will be distributed into neighbourhoods on the basis of deprivation (as a proxy for the perceived level of health inequalities) in order to provide neighbourhoods facing more significant challenges with the support and resources to make a real, lasting and continued impact on health and social care inequalities. Options for this are currently being reviewed by an independent expert.

## 5.6 Research and Return on Investment (Evaluation and Impact)

It is clear that an evidence base on the endeavours that we take forward to improve population health is required to prove a return on investment. Population Health has much less research behind it that other aspects of medicine. It is therefore really important to us that we develop research and academic partnership on all aspects of what we are doing, which will also help us understand return on investment.

This strand supports how we will measure and research our outcomes, in partnership with The Centre for Health Futures at Lancaster University and the SEED partnership and key nationally recognised experts, to demonstrate social, clinical, economic and financial returns on investment and rapidly build an evidence base for the approach.

We believe that we should set ourselves some truly audacious goals whilst bearing in mind that these are best done with the help of academic rigor, in collaboration across partner organisations to ensure mutual accountability, involving our communities who are most affected by health inequities and with compassionate leadership towards an already tired workforce.

Key investments include:

- **PHM Tool and data**
  - Data intelligence enabling segmented targeting alongside assessment of impacts against baseline activity levels.

- **Partnership with Lancaster University**
  - From design to evaluation including development of short, medium and long-term goals.
  - Trusted partner in enabling us to learn from mistakes and avoiding unintended consequences
  - Engagement of subject matter experts to advise on evidence of impact, working alongside Lancaster Uni. Example may include time from individuals such as Chris Bentley for health inequalities etc.

- **Academic resources**
  - Funding to support academic research, evaluation, literature review and specialist guidance.

## 6. Overview of the Operating Model in Action

Done well, this work is organic in its nature and will be underpinned by a principle of what matters most to people and not what's the matter with them. The approach provides enhanced resource within neighbourhoods as well as drawing on the capacity and capability from across the development programme as a whole.

It will allow people in a place (with specific regard to PCNs and those in neighbourhoods) to get into true conversation and deepen relationships with local communities and cohorts of their local community to better inform the local approach and to tailor and then deliver actionable interventions.

Funding is described so that it will enable capacity and capability to develop the local operating model, provide programme funding for local activities and provide clinical leadership and backfill for PHM cohort management and community leadership.

At a high-level the approach will operate as follows:

- Developing skills to utilise population health approaches including population health data to identify patients that may experience health inequalities with a focus on socioeconomic characteristics, protected characteristics and membership of vulnerable groups. It uses predictive analytics for risk stratification, population segmentation and forecasting to enable well evidenced cohort selection.
- Collaborating with our colleagues in the CVFSE and local community leaders and developing the skills to utilise participatory and co-production approaches with local communities and/or targeted groups including harnessing the insight drawn from the voice of targeted groups within local communities.
- Identify stakeholders, build assets within local communities and develop and deepen partnerships with local authority, CVFSE partners, local community leaders as well as others with deep roots into local communities, leveraging data, experience and resources to collaborate and address core determinants of heath.
- Nurturing high quality leadership within neighbourhoods/PCNs, Place and System for tackling health inequalities
- A locally designed interface with the work to mobilise a model for addressing social and/or complex vulnerability.
- Local implementation of a cycle of targeted participation, co-production and subsequent targeted interventions with identified groups or a local community.

- Measuring the impact and designing in ongoing evaluation to allow successful approaches to tackling inequality to be scaled across place-based partnerships and the Lancashire & South Cumbria Health and Care Partnership.

## 7. The impact

The population health operating model and development programme, delivered through collaborative joint endeavours will embed a population health approach. It aims to achieve the best health for all, prevent ill health and optimise outcomes at scale. It will better prepare Lancashire and South Cumbria Health and Care Partnership to meet commitments already made and expected of it, including;

- Increasing the years of life that people live in good health and reduce the gap in life expectancy in our most deprived communities.
- Reducing the gap in life expectancy for people with mental health, learning disabilities and autism.
- Reducing health inequalities for children living in households with the lowest incomes.

Work is ongoing with Professor Marmot's team and academic partners to develop a set of sub indicators that will enable us to monitor progress against these high-level outcomes including via logic modelling.

Annex B provides further detail on the development of benefits, measurements and evidence that are being developed to support the proposed operating model.

## 8. The Interdependencies

Effective implementation of what is outlined here is dependent on a number of other key aspects outside of the scope of this programme. This will include:

- The work programmes of key Clinical Networks and programmes such as those for respiratory, child and maternal health, cancer, CVD, mental health (including suicide) and more.
- The continued development of primary care and out of hospital care.
- Considered integration with public health in local Government.
- The development and maturity of Provider Networks.
- The evolution of other key Lancashire & South Cumbria Health and Care Partnership and Integrated Care Board functions; business intelligence, quality, personalised care and more.
- The work of Health and Wellbeing Boards and Partnerships, Local Economic Partnerships and other key forums, particularly for robust action addressing the core determinants of health.
- The Lancashire and South Cumbria Digital Programme is a critical enabler to a population health management approach and therefore alignment between these programmes of work is essential. In particular development of the Lancashire and South Cumbria Health and Care Partnership Data Orchestration Ecosystem and other key related programmes.
- System reform and the design of the Lancashire and South Cumbria Integrated Care Board and place-based partnerships.
- Support to, development of and collaboration with the CVFSE sector.

## 9. Funding

The estimated full year cost of the population health operating model is **c. £20,869,016** with a summary breakdown against each of the six strands of enabling capacity set out in the table below.

| Indicative Funding | Funding |
|---|---|
| 1 - Population Health Intelligence and Insight | £3,410,086 |
| 2 - Core Team, Leadership and Organisational Development | £4,130,224 |
| 3 - Participation and Empowerment of Communities | £3,523,991 |
| 4 – Social and/or multiple vulnerability | £4,131,420 |
| 5 - Interventions for Health Inequalities | £4,673,295 |
| 6 - Research and Return on Investment | £1,000,000 |
| **Total** | **£20,869,016** |

Please note:

- Some elements of funding are anticipated to be from existing funding sources including some within existing establishment. Once the model is agreed, further work will be undertaken to refine the investment proposal in line with any required due process in preparation for April 2022.
- This paper does not articulate the sole "budget" for population health and inequalities. Partners and other work programmes will have their own aligned budgets and resources which will in turn contribute to the population health and inequalities focus. We will progress work to consider options for further alignment of budgets and/or pooled budgets.
- Work continues with other related areas to ensure the population health operating model and development approach

Work on the underpinning detailed finances has included:

- A financial check of investment proposals to ensure comparability and consistency across each strand of work.
- Development of a phased approach to implementation that includes delivery of plans for H1 and H2 funding 2021/22.
- Independent review by a national expert on health inequalities of the weighted formula options to apply. The overall finalised sum remains the same but the allocation between place-based partnerships and PCNs/neighbourhoods for relevant aspects has been split using the formula.

## 10. Next Steps

Following ratification of the model the population health development programme will be mobilised via the establishment of a core Lancashire and South Cumbria population health function and place-based partnership Population Health Leads. A phased approach to implementation will be developed that is based on:

- The current level of maturity of population health in each place-based partnership and at the Lancashire and South Cumbria level.
- Seed funding during the transition phase 2021/22 (linked to use of H1 and H2 funding).
- Further growth / targeted intervention.

The phased approach will also allow for consideration of how the staffing requirements within the model will be fulfilled, where a developmental and phased approach may be necessitated.

The programme will be overseen in terms of delivery via the Lancashire and South Cumbria Population Health Board and will be subject to appropriate governance oversight and a PMO approach.

Appendix 1

**Population Heath in the Lancashire and South Cumbria Health and Care Partnership Core Principles**

**Principles**

The principles laid out here are for honest discussion so we can collectively understand our commitment to population health and improving the health and wellbeing of the 1.8m Lancashire and South Cumbria residents through the reduction in inequalities. Only by having transparency in what we are signing up to can we effectively propel population health forward, anchoring the change for the longer term.

- **Nothing about us without us is for us** – we need our residents and communities to be actively involved with us in achieving our goal. This comes with a shift in power to real people in real communities.
- **An all-age approach across the life course**.
- **Population health improvement cannot occur unless inequalities are addressed**.
- **Relationship building with local residents and communities is vital** to effective population health. These relationships have to have depth to them and for that we need to be consistent and committed to this for the longer term. This will require a shift to community participation and partnership, from communications and engagement.
- **Development of realistic capacity within a place-based core team**, within a culture of joy, without feeling overwhelmed or suffering burnout.
- **Population health is not the work of a small group; it needs to be embedded in all functions** across the Lancashire and South Cumbria Health and Care Partnership and place-based partnerships and partner organisations including the emerging single CCG. Therefore, knowledge about what population health is needs to be widely understood and actively promoted. Our actions and behaviours will look different if we get this right.
- **Be prepared for this to be a bit messy. This work done well is organic by its nature.** It's about understanding what matters most to people and not what the matter with them is. As such, the path to achieve an outcome is often not a straight line.
- **Our actions, priorities, decisions and resource distribution must align with our values around population health**.
- Believe in the established evidence base and **hold our nerve, understanding that some of the associated outcomes cannot be changed within 3year cycles**. In line with this, resource allocations has to be for the longer term.
- **Leaders/champions in population health are needed at every level and in every field**, clinical and managerial, and should be nurtured and supported.
- **Value, develop and grow bold yet compassionate leaders at all levels including within communities,** able to identify the strengths in others and take a balancing approach.
- **Everyone in the workforce (health and all partners) need to understand how they can contribute to population health** in their role, and this should be built into role descriptions and performance systems.
- **All of the Lancashire and South Cumbria Health and Care Partnership and place-based partnership work streams should have at their core a focus on the individual and their community**; however community is defined by the individual, not us.
- **PHM activity is required at System, Place and Neighbourhood**. At a System level, analysis of data including actuarial and health economic intelligence and evaluation will inform strategy and System priorities and co-ordinate functions that make sense to be done once across a Lancashire and South Cumbria footprint (many digital supported self-management approaches, the work of the personalised care hub to train and develop our front-line staff in activation and coaching skills, addressing digital inclusion). At a Place level, analysis of data will inform local priorities and distributed leadership will have a key role in developing capability to integrate PHM into all services and enable implementation as close to the individual and community as possible.
- **Key elements of the Population Health Budget will be disseminated through a formula weighted towards vulnerability and reducing health inequalities** (which is currently being evaluated with the help of The Health

Foundation). The formula has a clear focus on deprivation, aligned to the Marmot principle of proportionality – the most deprived people in our communities suffer the greatest health inequalities. Using the formula will ensure as much resource as possible flows into the localities where it is needed most, with some retained to ensure the delivery of Lancashire and South Cumbria-wide initiatives, where this makes sense.

- The evidence base for population health is robust. **Distributed leadership must be trusted** to work with the communities they serve to meet the overall goal, with appropriate governance and accountability in place in each place-based partnership and to the Lancashire and South Cumbria Health and Care Partnership.
- **Improving Population Health requires both economic development and addressing climate change.**

**Partnerships**

- At neighbourhood level, the **focus should be on creating integrated care communities** (or equivalent term), with key partners relevant to the needs and opportunities within each neighbourhood (and its sub neighbourhoods) being alongside communities to improve population health through the reduction in health inequalities. Primary Care Networks are an essential player and their leadership in this is integral whilst the CVFSE has trust and deep relationships with different groups within communities.
- The relationships represented at a neighbourhood/district level require **support and permission** from their place-based partnership teams in order to succeed, through enabling levers, learning spaces and appropriate resources.
- **Strong partnerships** and broad representation are needed at the place-based partnership level as population health work will be led by the place-based partnerships.
- At the Lancashire and South Cumbria Health and Care Partnership, there will need to be **alignment of vision and resources** with close partnership working between the Lancashire and South Cumbria level NHS representation, Local Government (upper tier and unitaries – including for Public Health, Social Care and beyond), the Voluntary, Community, Faith and Social Enterprise sector (including for supporting its development at scale) and the Local Economic Partnerships as examples.
- **Shared decision-making** will be required at all partnership levels to ensure services, programmes, and strategies are integrated and collaborative, avoiding duplication in the partnership. This decision making should reflect the involvement of those with lived experience of inequalities.

Appendix 2

**Strategic Context:**

**National:**

- **NHS Long Term Plan** setting our increasing focus on population health and partnership working through new Integrated Care Systems supported by triple integration, personalised care and moving from reactive care towards a model embodying population health management.
- **Integration and Innovation** white paper focussed on collaboration, partnership and integration including the need for more sophisticated approaches to population health management and local organisations working together to address the more intractable challenges associated with wider determinants
- **2021/22 Priorities and Operational Planning Guidance** setting out the requirement to take further steps to develop PHM and personalised care approaches that improve health outcomes and address inequalities in access, experience and outcomes through local partnership working.
- **Advancing our health: prevention in the 2020s** green paper signalling the focus on prevention at the centre of all decision-making, role of individuals and communities and shared responsibility to achieve the vision of healthier and happier lives for everyone.

**Lancashire & South Cumbria:**

- **Lancashire & South Cumbria Clinical Strategy** identifies PHM as a priority in delivering the ambition to improve the health and wellbeing of local communities.
- **ICP Common Strategic Narrative** sets out the requirement to move to a preventative, proactive and holistic approach and to build and deliver PHM infrastructure and culture to inform planning, mobilisation of the workforce and to support collaborative decision-making that builds on existing neighbourhood working, community hubs, PCNs and other partners to reduce risk and vulnerability within local populations.
- **ICP Maturity Matrix** identifies current state of maturity specific to PHM for each place-based partnership with the opportunity for evolving strategy outlined in this document to support each place-based partnership's developmental journey to embed a culture of PHM.

# Lancashire and South Cumbria
# Population Health Operating Model and Development Programme
# Summary Document Annex A

The following annex provides further detail on each of the six strands of enabling capabilities (referred to as Hexagon's) and includes relevant investment proposals and high-level funding requirements.

## 1. Hexagon 1 – Population Health Intelligence and Insight

**Overview:**

The Population Health Intelligence workstream aims to ensure sufficient capacity and capability of data and intelligence to embed the use of a population health management approach in utilising data by predictive analytics for risk stratification, population segmentation and forecasting to enable well evidenced cohort selection to derive actionable insight for improving outcomes and addressing inequalities.

The approach will inform and evidence a population health approach and support priorities at system, place, neighbourhood and practice level. It will seek the opportunity to scale up these capabilities at system level to realise efficiencies and ensure 'single source of truth' approach to data interpretation and action.

Key aspects include:

- Leverage the capabilities being delivered through the LSC Digital Strategy; in particular the Data Orchestration Ecosystem which will provide the data storage, validation, transformation and normalisation capabilities required.
- Understanding data, analytical and intelligence capability and capacity across LSC health and care system at place and system level and identify what will be needed going forward to support population health management.
- Develop an operating model for deploying these resources building on current capabilities within the system with due consideration to any Integrated Intelligence function.
- Deliver a phased approach in the development and deployment of the interactive intelligence tools as part of the ongoing LSC digital roadmap noting an options appraisal of digital solutions to support population health management will be undertaken by the Lancashire and South Cumbria Health and Care Partnership Digital Team.
- Understand the data assets (including tacit knowledge at place/grassroots level) within the system that would support a population health management approach and expand the breadth of data underpinning an approach to include flows of data from outside the NHS i.e. local Government, DWP, Blue Light services building strong feedback loops to enable real time evaluation, predictions and prioritisation.
- Identify any current areas of duplication that would allow us to consolidate data capture at scale.
- Define and implement a process for developing and sharing the actionable insights derived to inform place and neighbourhood teams decide where best to focus and support shared learning.
- Build system, place, neighbourhood capability in data driven decision-making, including actuarial and health economics information to predict, shape priorities and incentives and mobilise the workforce.

**Investment Overview:**

The population health management intelligence function whilst providing dedicated resource would be part of any integrated Lancashire and South Cumbria Health and Care Partnership intelligence function established. The underpinning principles being that we need as a system to ensure appropriate economies of scale and skills are realised, we mitigate the risk of a fragmented approach to BI and we avoid unnecessary duplication of function or activity. A hub and spoke model is proposed.

Summary investment:

| Population Health Intelligence Functions | Funding |
|---|---|
| 1. Core Digital Intelligence Function | £819,582 |
| 2. Place Based BI Capacity | £1,171,205 |
| 3. Data Science Support Function | £368,799 |
| 4. Application Development Support Function | £367,884 |
| 5. Cloud Consumption and Data Management | £414,547 |
| 6. Training Support Function | £188,570 |
| 7. IT equipment @ £1,500/person | £79,500 |
| **Total** | **£3,410,086** |

Key functions are described in more detail below:

1a. Core Digital Intelligence Function

This function will lead and oversee development of the existing capabilities within the system to deliver insight into population health through linked data and interactive visualisations. It will enable new capabilities and data insights into both clinical and social vulnerabilities, supporting action and intervention evaluation alongside the population health activities.

It includes senior capacity to provide guidance, specification support and clinical oversight - working as bridge between clinicians and Lancashire and South Cumbria Health and Care Partnership board- creating and overseeing real time dynamic data capabilities in Lancashire and South Cumbria Health and Care Partnership to:

- Mobilise service response.
- Link data to funding/incentives and strategy.
- Translate strategy into priorities, transformation programmes and training.
- Build clinical data management and interpretation capability in workforce.
- Oversee feedback loops and compliance systems.
- Develop actuarial and health economics analysis.
- Includes analytical capacity, IG enablers, data quality at all levels, data warehousing and infrastructure architecture.
- Academic resource to support research, evaluation, literature review and specialist requirements.

1b. Place Based BI Capacity

Place-based Population Health Intelligence capacity will use the data and information available from insight tools, published evidence base and tacit knowledge to identify the interventions and service enhancements needed to improve health outcomes and reduce inequalities in the local population. This capacity, embedded within local

teams will provision intelligence drawn from quantifiable data and qualitative insight into partners, including PCNs and those focussed at neighbourhood level. This data and insight is not just held within the NHS and this capacity will enable us to go further with integrating intelligence.

Key elements of the function include:

- Provide additional capacity to PCNs, those working in neighbourhoods and other key partners at the local level for furthering work on population health including Intelligence Advisors to interpret PHM data in the place's population health management tool of choice, blended with available insight and the published evidence of "what works" and make recommendations on that intelligence into local PCNs, neighbourhoods and/or partners.
- Provide dedicated analytical resource aligned to and embedded within place.
- Additional capacity identifying opportunities for upscaling and embedding proactive models of care including more personalised care.
- Grow local approaches for understanding and quantifying the impact of different disease combinations on service utilisation to enable place-based partnerships and their constituent partners to target resources more effectively.

1c. Data Science Support Function

This function will use machine learning and predictive analytics for risk stratification, population segmentation and forecasting to enable well evidenced cohort selection. It will provide analysis and production of models to assist PCNs in assessing health needs within their organisations, modelling outcomes of interventions and evaluation of workstreams.

Plans include scenario/impactability modelling with a given cohort/intervention combinations, and where interventions are novel or poorly evidenced, use appropriate experimental study designs so that robust evaluation of those interventions can be undertaken by the team.

1d. Application Development Support Function

This function will develop and maintain a platform and tools for PHM using a scalable, cloud based architecture. The tools will be intuitive, with interactive data visualisations, and be a "one stop shop" for all the tools and data required for population health management.

The function will work closely with the end consumers and data science team to ensure the tools are fit for purpose and constantly improved as the programme matures. It will include:

- Oversight of development activities and plans aligned to population health management, linking into Data Science and BI teams to align and priorities developments.
- Creation of intuitive interactive applications and functionality through user engagement and collaboration with the data science/BI teams.
- Additional developer support and career development pathways to build future capacity and succession planning.

1e. Cloud Consumption and Data Management

This function would provide additional support for the ingest and transformation of population health management data, maintaining standards and supporting data egress as required. This will include architecture decisions being

made aligned to the development and delivery of the Data Orchestration Ecosystem, already established in supporting regional shared care record (LPRES), the Person Held record (WellPRES), and the forming Diagnostics programme (HIPRES). To include:

- Ongoing maintenance of the data.
- Development of new data flows from across the system.
- Grow local resource to build future capacity and succession planning.
- Cloud consumption and Infrastructure costs supporting population health management.

1f. Training Support Function

This function will support the training and deployment of the use of the platform and associated population health intelligence tools as these are brought online, ensuring there is a sustainable model in place to support NHS/LA/CVFSE sector staff at place-base partnership level and Lancashire and South Cumbria level to utilise these. Note: It will not cover how to interpret the data and insights provided.

## 2. Hexagon 2 – Core Team, Leadership and Organisational Development

**Overview:**

The aim of the core team, leadership and OD workstream is to create the right conditions for a radically different approach to population health to grow and flourish at PCN and neighbourhood level, within all place-based partnerships and at a Lancashire and South Cumbria Health and Care Partnership level. The place-based partnership core team will work to mobilise the full content of this operating model and development programme and will include:

- Nurturing the infrastructure, culture, behaviours, capacity and skills to enable the population health programme to become embedded and to flourish at every level, recognising that our workforce are our biggest asset, and our ways of working should enable them to be everything they can be.
- Working with partners in other workstreams/programmes at place-based partnership and Lancashire and South Cumbria Health and Care Partnership level to cultivate patient empowerment and self-care, through continuous and meaningful engagement with and participation of the population.

The objectives are to mobilise population health across all levels as set out below:

2a. At a PCN/neighbourhood and place-based partnership level:

To enable each place-based partnership to establish a core team and to nurture the right conditions at neighbourhood, PCN, district and place-based partnership level to facilitate radically new ways of working, link. It includes:

- Establishing core population health functions with the capacity to enable delivery of the Population Health programme in every place-based partnership, including at neighbourhood/PCN level.
- Modelling behaviours which focus on decision-making being as close to people as possible, co-produced with people and collaborative.
- Nurturing and growing leadership qualities for population health across all partners and at all levels and developing a culture of shared accountability, compassionate leadership and collaborative working focussed on reducing health inequalities.

- A comprehensive workforce development plan to empower our workforce to be champions of population health and embedding a quality improvement approach in our work.
- Creating robust and creative partnerships at local level built on strong, deep, trusted relationships.
- Embedding a culture of; making every contact count, personalised care and empathetic understanding of individual and local need that includes social as well as clinical vulnerability within the workforce.
- Change expectations and the way we do business from “doing to” to “empowerment and enablement”.
- Developing and harnessing the power of local partners as anchor institutions.
- Continuous deep listening, engagement with and participation of communities to ensure that patient centred knowledge informs resource requirements and capabilities/OD developments and actions.
- Promoting the use of accredited, evidence-based personalised care approaches, delivering activation, enablement and empowerment, creating increased resilience and independence and reduced call on services.

2b. At a Lancashire and South Cumbria Health and Care Partnership level:

Establishing the right conditions to ensure the same behaviours, culture and qualities as set out above are modelled at Lancashire and South Cumbria Health and Care Partnership level across all services with the additional ambition to:

- Establish a Population Health and Health Inequalities Academy for all partners to benefit from, that compliments existing learning opportunities and training hubs and providers that:
    - Delivers shared learning, competency building and best-practice approaches building competency and skills in population health.
    - Where possible offers accredited learning.
    - Provides a place where place-based partnerships can share skills, knowledge and approaches and learn from each other and from wider national and international approaches.
    - Delivers a vibrant and ambitious catalyst for engagement and participation that supports local action and improves local outcomes by nurturing high-quality leadership for inequalities and population health.
    - In time, develops to include delivery of learning that raises confidence and skills within communities and community leaders directly.
- Provide opportunities to share resources and benefit from economies of scale e.g. training, tools and leadership development.
- Take an overview at the Lancashire and South Cumbria Health and Care Partnership level of all the work within place-based partnerships, providing reports and plans as required.
- Build a senior leadership forum and senior leaders who are passionate about developing the right culture and are accountable for reducing health inequalities in both the Lancashire and South Cumbria Health and Care Partnership and place-based partnerships and models the behaviours and values of compassionate leadership.
- Secure resources on behalf of place-based partnerships and provide complementary population health leadership at a Lancashire and South Cumbria Health and Care Partnership level.
- Upskilling and growing the workforce across our integrated system and establish learner placements to ensure learners are included within the population health culture.

**Investment Overview:**

The following capacity is required to provide leadership and infrastructure and to provide capacity to develop cultures and behaviours for population health across Lancashire and South Cumbria and at place-based partnership level.

| Population Health Intelligence Functions | Funding |
|---|---|
| **Place-Based Partnership Core Teams (x5)**<br>> Clinical Leadership<br>> Senior Population Health Leads (blended role place-based partnership/L&SC HCP)<br>> Programme Management<br>> Population Health Managers<br>> Project and Administrative support | £2,598,706 |
| **L&SC HCP Core Team**<br>> Strategic and clinical leadership<br>> Programme Director<br>> Senior Population Health Leads (blended role place-based partnership/L&SC HCP)<br>> Programme Management and Admin support<br>> Population Health Management (Academy and anchor work) | £654,018 |
| **Programme Funding:**<br>> Academy<br>> Embedding cultures, values and behaviours | £750,000 |
| IT equipment @ £1,500/person | £67,500 |
| Travel costs (L&SC HCP and place-based partnerships) | £60,000 |
| **Total** | **£4,130,224** |

Key aspects of the investment are set out in more detail below:

2c. Place-Based Partnership Core Teams

Each place-based partnership will determine its own core population health function capacity and infrastructure based against a suggested model and taking account of existing capacity. Whilst the composition of the place-based function may vary, funding estimates are supported by evidence from existing patterns of working. Where this capacity is already in place it should be ring fenced within the transition to the new statutory organisation. Key aspects of the place-based partnership core function will include:

- Clinical leadership of the place-based partnership programme and team.
- Programme management capacity, both to manage the local programme and to contribute to the Lancashire and South Cumbria level capacity as senior blended roles.
- Operational management of the population health function and approach.
- Programme coordination and support.
- Administrative support

2d. Lancashire and South Cumbria Level Core Team

Leadership for the Lancashire and South Cumbria Health and Care Partnership-wide population approach will be provided through a blended approach (roles working across Lancashire and South Cumbria and place-based partnerships) and will incorporate:

- Strategic and clinical leadership and co-ordination of the Lancashire and South Cumbria-wide programme.
- Population Health Leads operating blended roles across Lancashire and South Cumbria/ place-based partnerships to deliver against key workstreams including:
    - Personalised care.
    - Health inequalities.
    - Research/academic.
    - Population health management including relationships with primary care.
    - Core determinants.
- Programme management capacity to coordinate workstreams and produce relevant plans, performance management returns etc. at Lancashire and South Cumbria level.
- Capacity to support and enable local workforce/development leads in place-based partnerships to contribute to the population health approach, provide oversight to the Population Health and Health Inequalities Academy.
- Additional development support has been included to mobilise the Lancashire and South Cumbria Health and Care Partnership Population Health and Health Inequalities Academy and support the sharing of practice from across place-based partnerships on population health at place level.

2e. Programme Funding

- Funding to embed work addressing cultures, values and behaviours to support population health across their place-based partnership partner workforce so that every member of the workforce understands how they can contribute in their role (similar to the Wigan development programme for the entire health and care workforce).
- Each place-based partnership will require funding for capacity building, training and development approaches. A nominal sum has been identified for each place-based partnership p.a. using the weighted formula. Use of this funding may vary depending on state of readiness within each place-based partnership and place-based partnerships may be encouraged to use some of this to buy into Lancashire and South Cumbria Health and Care Partnership-wide training and development initiatives.
- Funding to mobilise the Population Health and Health Inequalities Academy which would include funding for activities, speakers and associated costs for the Academy. This would involve provision of monthly learning meetings with all Health Inequalities Leads (clinical and non-clinical and other partners) to explore issues around population health, population health management and health inequalities.

## 3. Hexagon 3 – Participation and Empowerment of Communities

**Overview:**

The role of communities in improving health is receiving increasing, and long-overdue, attention in health policy and practice – the need for this focus has been underlined by experiences during the COVID-19 pandemic. Stronger recognition of the role communities can play and acknowledgement of their greater involvement in efforts to improve health and wellbeing are needed if there is to be a successful move to a population health and population health management driven approach and a reduction in health inequalities. As part of this shift in focus, integrated

care systems need to take the role communities can play in improving and sustaining good health seriously, working at the place and neighbourhood level where the link to communities is strongest (Kings Fund, Communities and Health, May 2021).

The evidence and rationale for a clear focus on participation and empowerment of communities is strong. Examples include:

- The communities that people are born, live, work and socialise in have a significant influence on how healthy they are.
- Under certain circumstances, social isolation and loneliness can be as bad for health as risk factors such as smoking.
- There are many 'assets' within communities, such as skills and knowledge that can be mobilised to promote health and wellbeing.
- Communities have great insight and intelligence on what they need from health services, and on what works in improving health.

Within this content, this area of work is focussed on drawing on the depth of knowledge, skills, capability and expertise and investing in our colleagues in the third sector to shape this area of work. In practice **place-based partnerships will discuss with third sector colleagues locally the best approach to this given their own local context**. As such, what is outlined here are suggestions of the possible areas of work that need developing but refinement of this and **whether these are the right things for each of the five place-based partnerships will be for local decision**. The local approach should look to address;

- Supporting teams to build their capability for developing genuine conversation and relationships with their local communities
- Learning which culturally appropriate approaches/forms of participation are most accepted and work best for different communities.
- Learning how to use the best ~~participation~~ tools and techniques available to ~~work with~~ deepen relationships with our communities to build a social movement for population health. This will include deep listening, collaborative conversations and participatory planning
- Creating a network of anchor institutions[1] including development of and commitment to an anchor charter.

Therefore, there are three suggested key elements to this Hexagon, all of which will need to be considered as part of the local place-based partnership conversation about the right approach to this work in each place:

3a. Community participation and the development of community assets

The focus here is on building a social movement for health and builds on work to date on the "Call to Action". The Call to Action will in turn support the call for evidence for the Health Equity Commission and future Poverty Truth Commissions. This includes the generation of insight into the lived experience of those experiencing health inequalities to support and harness community responses.

Key features include:

- Unleashing the power and resources we have available to us to gain a broader and deeper insight and community intelligence through a range of methodologies and techniques devolved to community level e.g. community participation and participatory budgeting, face-to-face as well as via digital and other channels.

[1] https://cles.org.uk/what-is-community-wealth-building/what-is-an-anchor-institution/ and https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution

- We will look to evidence based and innovative methodologies such as the work of Popay[2] to harness the power of citizen and activist bloggers and journalists where stories are shared with policy makers, the media and others positioned to influence actions.
- Participation in community development by individuals to create confidence and build skills to improve life chances and behaviours for health.
- Provide the opportunity for participation and empowerment to help improve their lives, and the lives of those around them, in their communities, workplaces, and local democratic institutions to co-create opportunities, strengthening community assets to establish better lives for everyone and have a sense of control and agency about themselves and their lives to be able to make healthier choices.
- Generate insight, ideas, and new approaches to tackle health inequalities by listening to and actively involving people.
- Community assets developed will be part of the range of services available to people to help shape their choices for health.

3b. The art of conversation with communities to inform policy makers, including the "art of hosting"

The aim is to maximise the relationships and infrastructure that already exists in communities and connect this to the policy-making process, including within place-based partnerships, by ensuring participation in discussions and putting local people in the driving seat for enabling and delivering change.

A fundamental lynchpin to this whole approach will be developing an ongoing cycle of Poverty Truth Commissions at place level. The purpose of these is to bring people with lived experience and leaders together to shape policy. These will be allocated on a prioritised basis of inequalities.

Based on the successful experience of Commissions elsewhere, these will contribute and support a sustainable change in culture that is required to lead to impactful, lasting change. Underpinning this, we will be working with our third sector colleagues in building capability for community conversations through methods and approaches such as the Art of Hosting and other innovative and effective approaches. These enablers are factored in recurrently as they are critical to developing robust foundations upon which to grow a participatory, empowered culture of improvement.

3c. Having the tools to draw on at the granular level

To build on community participation and the development of community assets and to enhance the art of conversation with communities, we will supply a "toolbox" for dipping into at the local level. Local decision will be important on the right tools for each place, but the following have been costed for;

At the place-based partnership level:

- The resource to engage a specialist community engagement provider (or similar, for local place-based partnership decision) to provide support, training (i.e. train the trainer approach to build capacity in place-based partnerships **and PCNs**), facilitation, tools and methodologies for engagement and co-production. The requirements of such work would be agreed in discussion with key partners and individuals within each place-based partnership.
- Support for local participation and co-production. Use of these funds will be for place-based partnership decision but could pay for release of staff time, support from third sector partners, project management,

[2] For range of publications see http://www.research.lancs.ac.uk/portal/en/people/jennie-popay(b4cf253a-15ad-4df2-8d0d-0cb1c9a0e6a8)/publications.html?page=1&ordering=researchOutputOrderByType

training etc. dependent on the work being undertaken. These funds will be divided to reflect the level of deprivation and need across PCNs using relevant formulas and should be deployed by place-based partnerships to reflect this.

Within PCNs/Neighbourhoods:

- Licences for each PCN to purchase tools to support (online) engagement and co-production. The following have been costed but will again be for by decision in each place-based partnership on the best tools subject to preference of local communities:
    - Miro
    - Mentimeter
    - SurveyMonkey (or equivalents).

**Investment Overview:**

The recurrent investment proposals are set out below:

| Participation and Empowerment of Communities | Funding |
|---|---|
| Dedicated system resource to ensure this is effectively led and supported at system level and supports work across partners and teams in each place-based partnership. This will help to co-ordinate the priorities of population health at Lancashire and South Cumbria, place-based partnership and PCN level. | £87,061 |
| Dedicated place-based function working as a network across the area to support and facilitate the delivery of population health management, build community assets and initiatives working as part of a place-based team, supported by broader participatory expertise within place. | £512,610 |
| Supporting wider participation / building capability in each place-based partnership via art of hosting approach (or equivalent) and facilitating co-production with communities | £250,000 |
| Delivery of Poverty Truth Commissions (or equivalent) in each place-based partnership (phased approach across Lancashire and South Cumbria with additional match funding expected) | £600,000 |
| Support for participation events and related activities and interventions in each place-based partnership (weighted to each place-based partnership) | £50,000 |
| System and place-based partnership level collective resource for materials, videos, case studies, messaging and campaigns around population health management pieces of work. | £60,000 |
| Funding for communities to participatory approaches, participatory budgeting, CVFSE and partners around agreed local decisions and grow community assets as service providers to support healthier choices. | £700,000 |

| | |
|---|---|
| Programme funding that enables mobilisation and delivery of delivery of system priorities related to community identified issues, community led interventions. This is very clearly all age including consideration of ACEs.<br>(Recurrent funding. Investment weighted and focused more in areas of higher deprivation and inequality with funding also committed from CYP, DsPH, Education and mental health longer term). | £1,000,000 |
| Participation tools and licences:<br>• Community engagement specialist support<br>• Miro licences or similar (n=42)<br>• Mentimeter licences or similar (n=42)<br>• Survey Monkey licences or similar (n=42) | <br>£200,000<br>£6,300<br>£4,620<br>£36,900 |
| IT equipment @ £1,500/person | £16,500 |
| **Total** | **£3,523,991** |

It should be noted that the majority of funding within this area is devolved to place-based partnerships. The capacity at the Lancashire and South Cumbria level will work with the behavioural psychology capacity reflected in hex 4, place-based partnership population health leads for local insights and learning and the OD/culture capacity reflected in hex 2 to grow behavioural insight and understanding that will compliment the data of hex 1.

## 4. Hexagon 4 –Nurturing protective behaviours and tackling social and/or multiple vulnerability (Actionable intervention)

**Overview:**

This workstream is focussed on how we build, at place level, rapidly configurable care and support models around the real time needs of residents and their community particularly those experiencing social and/or multiple vulnerability. It is focussed on shifting to a more joined up and proactive care model, connecting existing workforce and service provision e.g. social prescribers, health coaches, community connectors, TAPPs etc. for a more integrated and comprehensive approach to social and/or multiple vulnerability.

This model of care is centred on a Personalised Care approach, consistent with commitments in the Long-Term Plan that gets alongside people to understand and prioritise what is important to them and what matters most to them and to act as a catalyst to unlocking longer term, sustainable health gain. As such, and integral to this work will be local consideration of the interface with (for example) local social prescribing commissions, ARRS roles, work via the CVFSE, Recovery Colleges, local mobilisation of schemes such as *Changing Futures* and more.

The workstream outlines a standardised "target operating model", the detail of which is to be designed and mobilised at place-based partnership level for a more systematic approach to nurturing protective behaviours and tackling social and/or multiple vulnerability. A critical part of this is embedding a place-based approach to citizen/patient activation which in turn must have the voice of lived experience embedded throughout.

The workstream asks place-based partnerships to develop a model that;

- Has a single point of contact for those experiencing vulnerability. This single point or "front door" may or may not be virtual and is for local design via each place-based partnership with consideration of pathways in and through the "front door" including the option for self-referral.

- Once through this "front door", a locally designed assessment of need, assets and opportunity that includes assessment of an individual's vulnerability and, critically, an understanding of the drivers of that vulnerability. This must be done with involvement from individuals with lived experience of social vulnerability.
- Develops the workforce with a clear understanding of the respective skills and capabilities of the different roles arranged across a continuum for supporting different levels of vulnerability, operating as an integrated team with one set of operating principles and underpinning values. The workforce team should understand resources available (appendix 1) across the place-based partnership to enable optimised intervention design based on individual patient/citizen needs and opportunities.
- Ensures appropriately skilled workforce with relevant training available (commissioned at the LSC level) to ensure a consistent accredited approach based on evidence-based practice adhering to minimum training standards.
- Includes provision of proactive "case finding" led by an appropriate, trusted partner, whoever is best placed to build the necessary trust and engagement, and in consultation with relevant local services and social care providers locally, who may have encountered working alongside individuals with low activation. This will help ensure reach to people currently not accessing services and will include innovation for working with people in different ways.
- Takes maximum advantage of using population health intelligence to inform the design and operation of the model (both quantitative data and qualitative, behavioural insight all drawn from a broad range of partners).
- Deploys place-based partnership anchored Wellbeing Coaches for an enhanced focus on supporting healthy lifestyles and behaviour change of individuals. These posts must dovetail into local mobilisation of place-based health inequalities (hex 5).

**Investment Overview:**

The investment to support delivery of the model addressing social and/or multiple social vulnerability is set out below:

| Front Door and Staircase | Funding |
|---|---|
| Phase 1* - Seed fund to "lay the foundations" for the model longer term. It would be for place-based partnership decision on how best this funding would be used to fulfil this phase of work but a plan that supports overarching aims. | £250,000 |
| Phase 2* - Subject to fulfilling phase one criteria, the second phase tranche of funding would be released for mobilisation of the model at place-level (allocation per place-based partnership that is part weighted) | £500,000 |
| Commissioning of Wellbeing Coaches | £999,890 |
| Commissioning and delivery of Making Every Contact Count training | £40,209 |
| Commissioning and delivery of health coaching training:<br>> Recruitment and training of volunteer-based service<br>> Trainers to embed at scale<br>> Trainer accreditation, course resources and train the trainer<br>> Externally commissioned training | <br>£0<br>£120,834<br>£214,400<br>£88,000 |
| Commissioning and delivery of PAMs training | £40,209 |
| Commissioning and delivery of care co-ordination training | £180,000 |
| Coordination and administration of workforce training | £32,250 |

| | |
|---|---|
| PAMs licences | £60,000 |
| Cohort One TAPPs recruited January 2021 Based PCNs (Deemed essential) | £750,000 |
| Cohort Two TAPPS to be recruited January 2022 Based PCNs (Deemed optional) | £548,000 |
| Other Behavioural Psychology/Science Posts | £291,129 |
| IT equipment @ £1,500/person | £16,500 |
| **Total** | **£4,131,420** |

*Further detail in appendix 2

## 5. Hexagon 5 – Place Based Interventions for Health Inequalities

**Overview:**

This workstream focusses on a reduction in inequalities and achieving an ongoing shift in health outcomes (including via more equitable access to services) by focusing on population health at place[1] level through robust local implementation of the strands of the LSC population health operating model and development programme. That is, building the delivery of the operating model by 'doing'.

It focuses on:

- Developing population health capability, with a prime focus on PHM capability at PCN level to use predictive analytics for risk stratification, population segmentation and forecasting to enable well evidenced cohort selection and intervention by enabling clinical leadership and development of actionable interventions (initially with a focus on CVD) and local operating models.
- Building competency and skills in population health, including protected time for participation in the emerging Population Health and Health Inequalities Academy, for delivering on actionable interventions at neighbourhood level.
- Incentivised focus on areas of social deprivation and service use above predicted levels.

Done well, this work is organic in its nature and will be underpinned by a principle of what matters most to people and not what's the matter with them. This strand provisions enhanced resource within neighbourhoods to do population health work and develop and deliver the population health operating model in neighbourhoods. Funding will be provided to enable capacity to develop the local operating model and provide clinical leadership and backfill for population health management cohort management and population health driven participation-with the community.

Place-based partnerships are likely to already have good practice examples being delivered locally. This workstream offers the opportunity to tailor and/or upscale these interventions as well as taking the learning from across LSC of interventions that may be of benefit for local mobilisation. These may include interventions on:

- Winter wellness and winter readiness for targeted cohorts.
- Applying a population health approach to waiting list management and/or "prehab" schemes.
- Tailored health inequalities schemes in targeted areas.

[1] Place may mean place-based partnership, neighbourhood/PCN, ICC, sub neighbourhood or even more granular street level.

It is proposed to make resources available to support this work stream at Lancashire and South Cumbria, place-based partnership and neighbourhood level. However, it is anticipated that some of the funding will be distributed into neighbourhoods on the basis of deprivation (as a proxy for the perceived level of health inequalities) in order to provide neighbourhoods facing more significant challenges with the support and resources to make a real, lasting and continued impact on health and social care inequalities.

In addition, this workstream sees an enhancement of capacity to areas with "priority wards". These wards have high levels of deprivation but also have much higher levels of service utilisation than is predicted. Therefore, these wards will have an enhanced level of intervention with a particular focus on avoidable attendances and admissions. It should be noted that this will require local work to better understand the drivers within priority wards, the solutions for which may be through tackling social determinants.

The biggest cause of preventable death in LSC is CVD. Therefore, the initial focus on CVD (including prevention and earlier intervention) is recommended to allow local action to "get going". It is does not infer a disease "silo" approach and, as local capacity and capability for this work develops, so should a more blended approach to comorbidities that has personalised care at its core. In this starting example, CVD should be considered in the broadest sense taking account of, for example;

- Earlier identification and intervention including maximising use of disease registers, health inequalities audits etc.
- "Lifestyle" factors such as smoking, diet etc. and tackling the underpinning enablers for these "choices".
- Broader aspects linked to living and working conditions including work with non-NHS partners including spatial planning etc.
- Maximising understanding and use of social and community networks.
- Maximising treatment.

It is here that the outcomes from the Health Equity Commission will be addressed so it is likely to evolve to include a broader set of priorities, for example action on the first 1000 days etc.

**Investment Overview:**

The investment to support delivery of the interventions for health inequalities is set out below:

| Intervention for Health Inequalities | Funding |
|---|---|
| **1. Neighbourhood/PCN Level** | |
| Health Inequalities Clinical leads in each PCN | £676,992 |
| Neighbourhood Development Support | £512,610 |
| Neighbourhood Clinical Co-ordinators | £1,956,573 |
| 2. **Priority Ward Funding** | |
| Band 6 Priority Ward Role | £922,698 |
| Band 2 Priority Ward Role | £460,422 |
| 3. IT equipment @ £1,500/person | £144,000 |
| **Total** | **£4,673,295** |

Key aspects of the investment are described in more detail below:

5a. Place-based partnership level:

- Funding (via H1 allocations) for continuation (where relevant – local decision) of existing pilot projects (examples may be Morecambe Bay work, accelerator programme in Pennine etc.) currently being undertaken. This will provide a "bridge" between the pilot project and the implementation of this approach at Lancashire and South Cumbria level.
- Local agreement* of how the work will be mobilised. This should include consideration of ensuring the capacity, knowledge and skills for;
    - Programme oversight of population health including at neighbourhood level (cross reference to hex 2 re place-based partnership core population health team)
    - Skills for mobilising across the population health operating model and development programme at place-based partnership and neighbourhood level
    - Sound partnership experience.

*Whilst for local agreement, finances have been based on indicative function to provide more accurate estimates of total budgets required to deliver the required capacity. Local co-ordination function at place-based partnership level will have a level of autonomy to make adjustments to the process to meet local circumstances

5b. Neighbourhood/PCN Level

- Funding for Health Inequalities Leadership capacity in each PCN/neighbourhood in the Lancashire and South Cumbria Health and Care Partnership (anticipating that around a third of PCNs may take advantage of this in Q4 21/22). These are in addition to and compliment the PCN DES. It will be for place-based partnership decision on to ensure a blend in leadership reflecting clinical and non-clinical time.
- Local agreement** of how the work will be co-ordinated at PCN level. This should include consideration of ensuring the capacity, knowledge and skills for;
    - Clinical co-ordination at PCN level.
    - Skills for developing and operationalising a data driven approach to MDTs
    - Skills for undertaking pro-active case finding and case management of the population with clinical multi-morbidity, LTC and risk factors associated with cardio-vascular events, other adverse health outcomes and health inequalities intelligence, using data and intelligence to inform this.
    - Skills for working with identified cohorts to introduce interventions that will protect them improve their overall health and well-being and help them avoid an adverse event. This will include targeted patient facing work with identified cohorts.
    - Ability to take a holistic, person centred approach.
    - Skills in working across organisational boundaries.

**Whilst for local agreement, finances have been based on indicative roles to provide more accurate estimates of total budgets required to deliver the required capacity. It should be noted that for some PCNs this equates to less than a WTE so discussion across PCNs on how this is best deployed is advised. It is anticipated that these types of roles will work "hand in glove" with the Population Health Intelligence Advice function reflected in the Population Health Intelligence strand of the operating model and development programme.

Recruitment to the capacity will be led by each place-based partnership, and the employment arrangement for the function will be a local place-based partnership decision to reflect local context and existing structures.

5c. Priority Wards

Analysis undertaken in conjunction with subject matter experts identified wards with significantly more admissions even than might be expected for their deprivation score. This is symptomatic of ward environments least supportive of prevention and pro-active management of health risks, which then present as crisis and emergency. These areas have been identified as 'Priority' wards for attention of which there are 33 across Lancashire and South Cumbria.

Additional detail on 'priority wards' is set out in appendix 3. In summary each priority ward would receive funding that would enhance capacity for local activity local activity tackling inequalities and would allow for development of multidisciplinary assertive case management and care co-ordination teams targeted to the priority wards. These teams would work to;

- Utilise PHM data driven approaches to identify cohorts at risk of avoidable hospitalisation over the winter period i.e. prediction of conditions and cohorts that are more amenable to prevention in the community, particularly those accounting for most emergency admissions.
- Undertake a rapid appraisal for each priority ward to check what elements of critical structures and processes are or are not in place to support current action. Identified communities may benefit from a more systematic 'place-based' appraisal including assessment of resident access to key facilities self-assessment.
- Utilise the published evidence of which specific conditions are more likely to see impact from integrated community-based interventions.
- Draw on behavioural science of what works in terms of effectively intervening with identified cohorts.
- Upscale application of more personalised approaches (to build resilience and activation) that enable more patient level self-management shown in the evidence as positively impacting on avoidable hospitalisation.
- Link to local discharge processes and teams at place level for rapid discharge and proactive identification of factors that could have prevented hospitalisation, developing local actions to address this including more integrated and co-ordinated care of inpatients (including those with long LoS) as they are discharged to prevent readmission.
- Work with local partners, particularly those outside of the NHS (including the CVFSE) to "case find" those that may be at risk of avoidable hospital attendance or admission and may be living with undiagnosed conditions.
- Apply the "place-based approaches toolkit" to develop a longer-term plan owned by the place-based partnership.

## 6. Hexagon 6 – Research and Return on Investment

**Overview:**

It is clear that an evidence base on the endeavours that we take forward to improve population health is required to prove a return on investment as well as direct the work for our particular needs of Northern and coastal town and rural poverty. Population Health has much less research behind it that other aspects of medicine.

It is therefore really important to us that we develop research and academic partnership on all aspects of what we are doing, which will also help us understand return on investment.

The business case identifies a research and innovation 'hexagon' with funding to facilitate this.

Our four Universities all have research in this area, and we don't have a defined process to rapidly accelerate evidence into practice. SEED has identified health inequalities as its key priority, but it is not clear how they intend

to do this yet. Relationships with Lancaster University are strong through Dr Andy Knox and Talib Yaseen, on behalf of the NHS and Dr Sakthi Karunanithi on behalf of the Directors of Public Health and conversations have also been initiated with UCLAN.

Discussions with the Innovation Agency have initiated on 'pre-markers' to scope if there is any benefit of this innovation on population health.

**Centre for Sustainable Health Collaboration**

As part of the work on this there have been exploratory conversations with 18 Professors from Lancaster University, through the Centre for Health Futures led by Dr Jane O'Brien and Dr Andy Knox.

This is across a number of departments who are excited to work with us, from the schools of medicine, sociology, design, management and health economics. We have initiated work with a core team – Prof Jane O'Brien, Centre for Health Futures, Prof Mike West, Management School, Prof Jo Ryecroft-Malone, Dean of Medicine, Prof Imogen Tyler, Head of Sociology, Prof Bruce Hollingsworth, Health Economics, Prof Leon Cruickshank, Design and Imagination, Prof Jennie Poppay, Medicine and Sociology. They are also acting as a sounding board around the business plan to provide a check and challenge of the intended work.

We have agreed a high level approach in this collaboration:

- Support on the call for evidence for the Health Inequalities Commission
- Embedding evidence into practice through our core team leadership and OD 'hexagon'
- Shape research questions together and work towards a National Institute for Health Research Programme grant

We would like to discuss how the Centre for Sustainable Health Collaboration and the Seed funding can support the work going forward.

**Investment Overview:**

An indicative, recurrent figure of **£1m** has been assumed for research and ROI evaluation.

It is anticipated that existing collaborations will support some of the required work in respect of impact assessment while other aspects may require financial commitment.

Three key strands identified:

**6a. PHM Tool and data**

- Data intelligence enabling segmented targeting alongside assessment of impacts against baseline activity levels.

**6b. Partnership with Lancaster University**

- From design to evaluation including development of short, medium and long term goals.
- Trusted partner in enabling us to learn from mistakes and avoiding unintended consequences
- Engagement of subject matter experts to advise on evidence of impact, working alongside Lancaster Uni. Example may include time from individuals such as Chris Bentley for health inequalities etc.

**6c. Academic resources**

- Funding to support academic research, evaluation, literature review and specialist guidance.

## Appendix 1

Roles to be considered within each place-based partnership as forming one integrated team;

- Care Co-ordinators
- Care Navigators
- Community Champions
- Health Champions
- Health Coaches
- Health and Wellbeing Coaches
- Integrated Care Co-ordinators
- Link Workers
- Social Prescribers
- Trainee Associate Psychological Practitioners
- Wellbeing Coaches

In addition, place-based partnership will need to consider and identify other roles via;

- The Additional Roles Reimbursement Scheme (ARRS)
- Relevant mental health and wellbeing roles
- Local volunteer networks

## Appendix 2

Each place-based partnership to;

**Phase One – estimated as 6mth period**

Each place-based partnership to create a "front door" that allows people to access holistic support to address their social and/or multiple vulnerability without stigma. The design of the "front door" will be informed by population health intelligence of local population need, asset and opportunity as well as by the voice of groups and those with lived experience that the model is focussed around.

- Create a local network of partners, within your place-based partnership structure, to progress and take ownership of this work.
- Identify an Executive level leads (with the right mindset xref to OD and leadership work of place-based partnerships Dev Prog) for this work (minimum of one clinical and one non-clinical).
- Agree best use of initial resource to progress this – there is no guidance on this aside of the resource must be used to progress this first phase of work. If the resource is not required here, areas may factor the equivalent costings into their request to release the second tranche of resource.
- Map the "workforce" to be aligned around the "integrated team".
- Take stock of the training needs of this identified workforce against a Lancashire and South Cumbria Health and Care Partnership provided training needs analysis template.
- Identify and task stock of other related programmes to be considered as part of this work locally to include local Recovery College models, Resilience Networks, Integrated Care Hubs, Care Co-ordination Hubs etc.
- Undertake design work for place based model. Questions to consider may include;
    - Is the "front door" virtual, physical or a combination of both?
    - How does the "front door" relate to other local single points of contact/care co-ordination hubs etc?
    - What is the approach to systematically drawing in population health management data to ensure a data driven model (qualitative and quantitative)?
    - What is local maturity of data sharing across partners, including with district councils?
    - What is the local maturity and relationship with the community, voluntary, faith and social enterprise sector and their role within the model locally?
    - What will the interface be with relevant "clinical" services?
    - What assets are there locally to capitalise on?
    - What will success look like at the individual, street, community, neighbourhood, place-based partnership level?
    - How does this work complement that of your place-based partnership development plan?
- Develop a budget profile for use of the second tranche of resource.

**Phase Two – estimated as 6-18mth period**

- Reconfiguration of "workforce" identified to work as an integrated team including work on agreeing shared values.
- Mobilisation of the model at place level.
- Enabling relevant staff to take up identified training.
- Working closely with place-based partnership OD workstreams to ensure alignment with wider workforce and culture development (see example of the Wigan Deal - https://www.wigan.gov.uk/Council/The-Deal/The-Deal.aspx)

- Collation of impacts using qualitative and quantitative measures including use of stories.

To complement local area mobilisation at the LSC level the following will happen;

- Facilitating closer collaboration around addressing vulnerability alongside mental health.
- Facilitating close collaboration around Local Government public health commissioned services.
- Commissioning of relevant training informed by the training needs assessment undertaken by local areas in the first phase including as a minimum;
    - Making Every Contact Count (MECC)
    - Health coaching (Personalised Care Institute accredited)
    - Care co-ordination
    - Data insight training
    - PAMs training
    - Personalised Care and Support Planning

Appendix 3

**Additional Detail for Priority Wards**


| | |
|---|---|
| **Name of Intervention** | Applying a population health approach to avoidable attendance and hospitalisation by priority wards |
| **Proposal developed by** | Lucinda McArthur (Senior Advisor, NHS West Lancashire CCG) |
| **Drawn from** | *Health Inequalities and COVID-19; focus on communities with greatest socio-economic disadvantage.*<br>Professor Chris Bentley and John Brittain |
| **With engagement from** | Dr Shashi Khandavalli (Clinical Advisor Determinants of Health, Central Lancashire place-based partnership and Clinical Director, Chorley Central PCN)<br>Dr Andy Knox (Clinical Lead Population Health, Lancashire and South Cumbria Health and Care Partnership and Director of Population Health and Engagement, NHS Morecambe Bay CCG)<br>Charlotte McAllister (Head of Urgent Care and Emergency Planning, NHS West Lancashire CCG) |

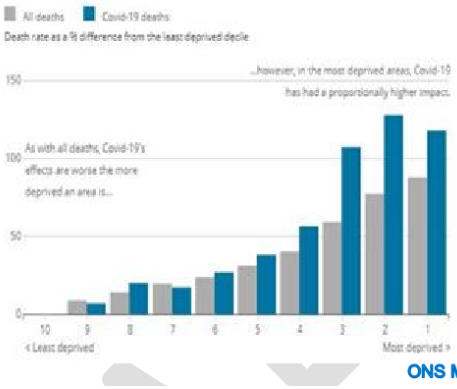
**Brief Description**

Many communities with highest measures of deprivation make relatively much higher use of NHS emergency services and admissions to hospital than those in less deprived areas. Problems often present first to services as crises.

The chart in the benefits section below shows a common example, pre COVID-19, of the differential use of non-elective (emergency) care made by progressive quintiles (20% ranking) of deprivation. It shows that, just for hospital care in normal times, for crisis non-elective care there is a huge disparity in use of emergency services by the most deprived quintiles of population, for whom many problems present first as a crisis.

It was always probable that an emergency such as the COVID-19 epidemic was likely to show a similar pattern. This was clear in the UK when the most-deprived quintile had a mortality rate due to 2009 H1N1 influenza three times higher than the least-deprived quintile. It has now been shown to be the case in 2020, as is clear in the chart below showing the ONS analysis for England. The grey bar shows nearly twice the death rate for all conditions and the blue bars more than twice for COVID-19 – so death rates are exacerbated disproportionality (source: John Brittain and Professor Chris Bentley, *Health Inequalities and COVID-19*).

**Age-standardised mortality rates, all deaths and deaths involving coronavirus (Covid-19)**
**Index of Multiple Deprivation, England. Deaths between 1st March and 17th April 2020**




**ONS May 2020**

NHS England/Improvement's Equity and Health Inequality Team (EHIT) together with RightCare have previously produced a Health Inequalities Pack for each of the CCGs in Lancashire and South Cumbria. One of the outputs in each pack was an analysis of Unplanned Hospitalisations (sensitive to ambulatory or urgent care interventions) per 100,000 population by Local Authority ward (KPI 106a), plotted against a national Index of Multiple Deprivation (IMD) scale. This enabled a calculation of the inequality slope, but also enabled those of the more deprived wards with greater than expected non-elective admissions to be identified.

It was found through this analysis that for many those most deprived wards, the excessive admissions were not restricted just to a few disease areas but were high across a broad range of common conditions. These included, for example, chest pain, heart failure, COPD, cellulitis and asthma. This suggests that:

- It is important that primary care and PCNs make sure there is not unwarranted variation in how particular conditions identified are managed.
- However, just as importantly, the analysis can act as a 'symptom' to identify wards and neighbourhoods where the conditions may be particularly hazardous and unsupportive. Community environment and infrastructures may not be strong or resilient, and there may be barriers and gaps reducing access to and uptake of protective and supportive services.

Further analysis identified ward outliers, wards with significantly more admissions even than might be expected for their deprivation score. This is symptomatic of ward environments least supportive of prevention and pro-active management of health risks, which then present as crisis and emergency. These are the 'Priority' wards for attention upon which this proposal is focussed.

This enhancement of capacity for priority wards would complement local activity tackling inequalities and would allow for development of multidisciplinary assertive case management and care co-ordination teams targeted to the priority wards. These teams would work to;

- Utilise population health management data driven approaches to identify cohorts at risk of avoidable hospitalisation over the winter period .i.e. prediction of conditions and cohorts that are more amenable to prevention in the community, particularly those accounting for most emergency admissions.
- Undertake a rapid appraisal for each priority ward to check what elements of critical structures and processes are or are not in place to support current action. It is likely that many of the identified communities will have been in focus but would benefit from a more systematic 'place-based' appraisal including assessment of resident access to key facilities self-assessment.

- Utilise the published evidence of which specific conditions are more likely to see impact from integrated community-based interventions.
- Draw on behavioural science of what works in terms of effectively intervening with identified cohorts.
- Upscale application of more personalised approaches (to build resilience and activation) that enable more patient level self-management shown in the evidence as positively impacting on avoidable hospitalisation.
- Link to local discharge processes and teams at place level for rapid discharge and proactive identification of factors that could have prevented hospitalisation, developing local actions to address this including more integrated and co-ordinated care of inpatients (including those with long LoS) as they are discharged to prevent readmission. All non-elective admissions should be seen as system failure. These teams would undertake systematic post-discharge reviews, collating themes and trends on why patients were admitted to begin with. This would then inform the QI process.
- Ensure an identified senior mental health practitioner forms part of the team make up.
- Ensure an identified senior social work practitioners forms part of the team make up.
- Exploiting use of technology as part of the local solution for enhanced support to cohorts at risk of avoidable hospitalisation.
- Apply the "place-based approaches toolkit" to develop a longer-term plan owned by the place-based partnership.

Practically funding would be channelled via the place-based partnership to be tailored and contextualised to what fits best around local service provision. Principles by which this funding should be used include;

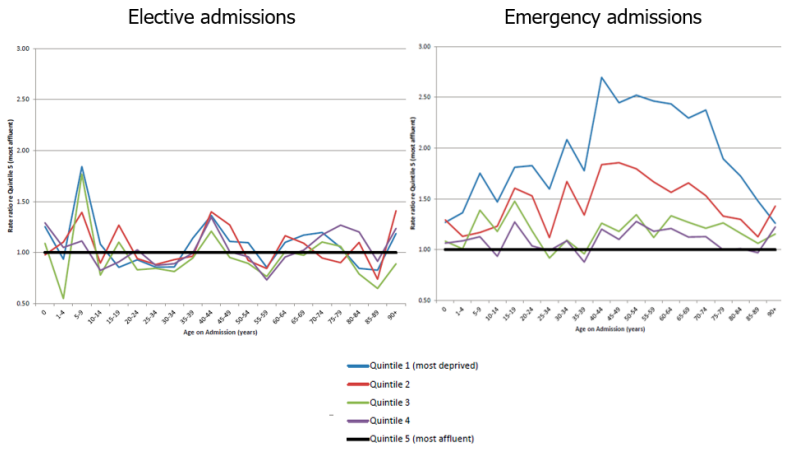
- Ensuring investment into the local CVFSE sector as part of the local approach for rapid appraisal and case finding those who may be living with undiagnosed conditions or whose condition may be poorly controlled as defined by agreed clinical parameters.
- Ensuring local social prescribing provision is part of the local case management care co-ordination approach, including consideration of the need to increase capacity within local social prescribing teams as required.
- Identifying a lead senior clinician and care co-ordinator to provide clinical leadership into the local approach and to undertake clinical reviews as required

Culturally appropriate comms would be required to support this work, funding for which would be drawn from hex 3's participation allocation. This comms would complement general winter messaging but would use population health management intelligence drawn from data and behavioural science to tailor messages for defined cohorts in the priority wards.

**Benefits**

- Prevent avoidable hospital attendances, admissions and readmissions.
- Look to narrow the gap in emergency admission rates between deprivation quartiles, translating into cost saved and outcomes improved.

HOSPITAL ADMISSION RATES
RELATIVE TO 20% MOST AFFLUENT NATIONAL LSOAs




- Deepen understanding at a place level to the underlying problems with care delivery and the barriers to better prevention and pro-active management of health risks in priority wards, which then present as crisis and emergencies.
- Increase levels of patient activation and personalised care.
- Deepen the local (ward level) network for integrated care co-ordination.

Explore public health intelligence and data scientists defining an impact framework. This may include use of;

- Numbers Needed to Treat (NNT)
- Extending NNT to population level by applying Number of Events Prevented in your Population (NEPP)
- Cost of admissions avoided.
- Savings from reaching (for example) the national average for prevalence of relevant conditions/LTC controls/lifestyle interventions
- Cost effectiveness of interventions (QALY where available)

Funding for this type of return-on-investment reporting would be within hex 6's focus on research and return on investment. It could be actuarial in its methodology and could contribute to the case for further investment.

# Lancashire and South Cumbria
# Population Health Operating Model and Development Programme
# Summary Document Annex B

The following annex provides further detail on benefits, measurements and evidence noting that these areas are still under development in parallel with the engagement process on the proposed operating model.

## 1. Benefits

The process to develop an initial outline of benefits associated with delivery of the population health operating model and development programme has been through a review of anticipated benefits associated with each of the six key strands of enabling capabilities (hexagons) and then aggregated into the following summary. It sets out short, medium and long terms benefits.

**Short term (0-6mths);**

- Greater understanding of each place-based partnership and where there are gaps in delivery or opportunities to scale up approaches that are already working.
- Greater understanding of the need for tailored support to level up localities.
- Co-produced design of the model to be embedded contributing to the place-based partnership development programme maturity matrix.
- Bringing an asset focus to work within neighbourhoods, harnessing the benefit and added value of local knowledge and work together in a multi-disciplinary way to address areas of challenge constructively and holistically.
- Continuing to build out the data hub/data orchestration ecosystem with all partner organisations, enabling the use of data system-wide to target resource effectively and to avoid duplication of effort.
- Enabling the system to be pro-active and ready, including for future pressures and a hard winter through agreeing a common set of reporting matrices to inform a single approach to reporting dashboards.
- Commencing with the establishment of new Health Inequalities Clinical Leads in each of the Lancashire and South Cumbria Primary Care Networks (PCNs) with dedicated time to undertake population health-related activities.
- Establishment of Health Inequalities Senior Leads in place-based partnerships from all other key partners (e.g. local authorities).
- Co-production of local plans which fully engages with the health inequalities agenda (taking account of CORE20+5 and the learning from the Health Equity Commission) together with the needs, assets and opportunities within neighbourhoods and an understanding of what matters most to local people.
- Place-based partnership workforce training offers around personalised care, health coaching and Making Every Contact Count as per the national personalised care programme. This offer is targeted at the entire health and care workforce within each place-based partnership and will be mobilised through each place-based partnership.

**Medium term (6-18mths);**

- Reduced pressure in GP settings.
- Reduction in avoidable hospital attendances and admissions.

- Reduction in length of stay.
- Development of expertise in population health management, stakeholder and asset mapping, engagement and co-production within neighbourhoods (including with PCNs) and at place, to drive a systematic approach to use of data for improving outcomes and tackling inequalities.
- Development of a deeper understanding of health inequalities (including quantitative data and qualitative insight) within neighbourhoods by relevant partners in that neighbourhood, including PCNs.
- Identification of key stakeholders and assets within the local community and the development of partnership working with these organisations by PCNs.
- A clearer understanding of the issues affecting the health and wellbeing of the initial target population by PCNs.
- A more systematic approach to identifying and supporting those with social and/or multiple vulnerability using data to assist with the identification and assessment of individuals and/or cohorts of the population who may benefit from intervention (case finding).
- Additional evidence towards a number of place-based partnership development domains, including domain 4 (delivering integrated services).
- More efficient use of the workforce working collectively to empower people and build on their strengths, with greater openness to expanding MDTs to allow 'top of license' working.
- More robust local provision to continue to support those experiencing economic hardship as a result of the COVID-19 pandemic.
- More culturally tailored provision for health inclusion groups and broadened opportunity to engage with local cultural and religious groups as appropriate.
- Demonstrable impact for those supported including through use of Patient Activation Measures (PAMs) and the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) as essential as well as other evidence-based measures offered through the NHSE Framework Agreement.

**Longer term (19mths**+);

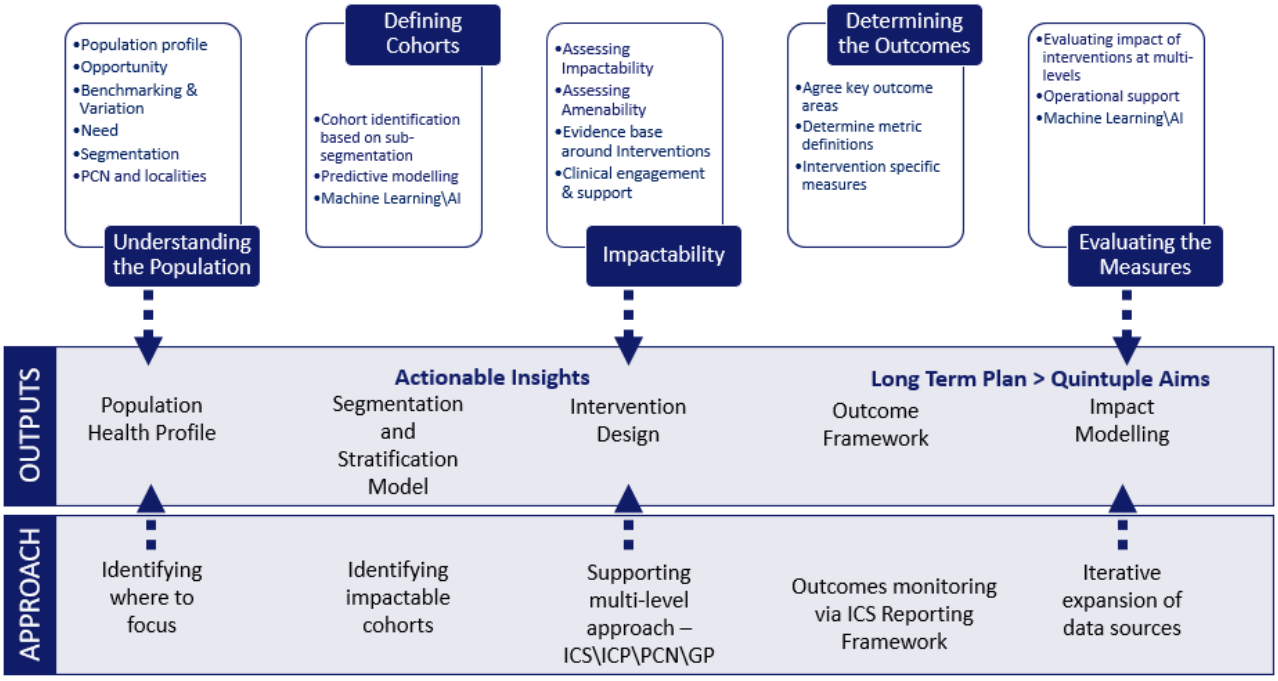
- Measurable improvements[1] in health inequalities, health and wellbeing, experience, quality and access to services within the locality.
- Key outcomes should be defined by the place-based partnership in line with their place-based approach to performance. This should include an understanding that disaggregates to the 20% most deprived and again to priority wards. This should also be enhanced by evidence of what matters most to people within local communities.
- Earlier identification and diagnosis of undiagnosed conditions and better management of long term conditions achieved through wider work, including with non NHS partners, addressing the core determinants of health in each place-based partnership.
- Demonstrable impact on related outcomes including some that will be:
    - Disease specific (respiratory, diabetes and hypertension as examples),
    - Behaviour specific (smoking and alcohol and examples)
    - Reflect system utilisation (avoidable interactions with health and care, decreased readmissions).
- Demonstrable impact on identification of undiagnosed conditions (including via sweating the asset of practice registers).

[1] Improvements should be observable in medium term using logic modelling to identify interim outputs and also quickly achievable targets e.g. improved uptake of cervical screening in target community, increased registration of migrant workers.

- Narrower gap between expected and actual prevalence on practice-based disease registers, finding those living with undiagnosed conditions.
- Demonstrable impact on related outcomes reflective of the core determinants of health which may include employment, housing etc.
- Demonstrable impact on patient reported outcomes measures based on clearer understanding of patient/citizen self-reported goals and building that insight into collaborative care planning with that individual.
- Reduction in the prevalence of all age and premature mortality associated with cardio-vascular events and other long-term conditions identified across the respective hexagon workstreams.
- Mobilised staff across every place-based partnership empowered and applauded for taking more holistic, person-centred approaches.
- Cost benefit savings and efficiencies in the system based on impact modelling including economic modelling linking to return on investment.
- Overall increased health and well-being of the population due to addressing core determinants.
- Reduction in other health related adverse outcomes.

## 2. Measurement

In terms of a data-based infrastructure to enable tracking and measurement, the diagram below outlines the flow of using the data available in providing analysis and interpretation, supporting data driven decision making and evaluation.




Each place-based partnership will, as part of their own local design, agree success measures relevant to their own place and their own place-based partnership's approach to performance (which in turn will link to the place-based partnership development programme).

For consistency across the Lancashire and South Cumbria Health and Care Partnership, each place-based partnership will embed PAMs and an appropriate validated wellbeing measure that will be confirmed once the national NHSEI Outcomes Measure Framework Agreement is published. In addition, place-based partnerships will want to use measures that are relevant to their local place and that dovetail with the local place-based partnership outcomes framework.

Using systems that overlay health inequalities, social multi-morbidity alongside clinical multi-morbidity will give a more accurate health inequalities picture.

For place-based interventions on health inequalities, each neighbourhood will be responsible for selecting a target population which may be subject to health inequalities-based deprivation, protected characteristics and membership of vulnerable groups. This selection will be made using local "soft" intelligence and a population health management approach supported by input from Business Intelligence (BI) specialists.

Following further participation work, the PCN for that neighbourhood will be responsible for completing the thematic analysis and co-producing solutions and outcomes with their local community or selected group. It should be noted that the responses received could be wide ranging, may not focus on the anticipated area of healthcare and might reflect the impact of core determinants of health (e.g. poverty,) and may require input from other partners (e.g. local authorities, CVFSE etc.).

It will be important to baseline relevant data to allow measurement of improvements in health outcomes and access to services by groups experiencing health inequalities. However, the measurement of actual improvements in health and wellbeing may not be realistic for several months or years. It is, therefore, proposed that logic models will be developed for each cycle of engagement which will allow the identification of realistic timeframes and metrics to enable assessment of impact of the designed interventions over the long term, and allow the measurement of intermediate steps to be undertaken to demonstrate the impact in the short and medium term.

In terms of an initial baseline that can be used across place-based partnership teams, however, our recommendation would be that teams leverage the place-based partnership maturity matrix (appendix 1) to evaluate current state as they embark on population health work, and again at agreed points in the implementation of population health projects to assess potential impact of the work on embedding place-based partnerships and population health and population health management driven approaches as "business as usual".

Qualitative data and case studies about the impact on the selected population are vital and can be used to produce powerful narratives which can demonstrate impact on the health and wellbeing of both individuals, groups, and communities and enable sharing of best practice approaches that have driven improved health and well-being outcomes.

## 3. Evidence

The following sections provide summary evidence examples of areas delivered by the population health operating model. This work will be developed further, as part of "hex 6", research and return on investment, to underpin the population health operating model.

**Behavioural Science:**

Applying a population health approach and systematically using data and behavioural science to identify areas of risk and apply actionable interventions will mitigate harm in both the short, medium and long term and ensure the positive outcomes for our patients / citizens and our teams.

Latest data[2] indicates that people most able to self-manage use:

- 38% fewer emergency admissions
- 32% fewer A&E attendances
- 19% fewer outpatient appointments
- 18% fewer GP appointments

**Social Vulnerability and Health Inequalities:**

The Center for Disease Control and Prevention defines social vulnerability as "the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss".

Its accompanying Social Vulnerability Index identifies 4 themes which give insight into the types of contributors to an individual experiencing social vulnerability;

- Socioeconomic Status,
- Household Composition,
- Minority Status and Language,
- Housing/Transportation

Residents of underserved/deprived neighbourhoods or communities are at increased risk of mental illness, chronic disease, higher mortality, and lower life expectancy. It is well documented that language and lack of understanding of cultural norms in culturally diverse communities is often a barrier to accessing healthcare. There is a direct association between crowded housing and adverse health outcomes, such as infectious disease (as with the COVID-19 pandemic) and mental health problems. Critically, many of these factors are interdependent thus increasing and adding to the complexity of an individual's vulnerability.

The NUKA system in Alaska[3] demonstrated the impact of a 'single front door' both on citizen/patient experience and system resourcing/costs in a community with cultural diversity and related inequality of access. Results included:

- 36% reduction in hospital admissions and ED visits
- 28% reduction in GP visits
- 95-96% patient and staff satisfaction
- Please see case study below for further detail

**Advisory Board Case Study:**

Case Study.pdf

All of the hexagon workstreams will make a significant contribution **to embedding behaviour change science into primary care and place-based partnerships** to help individuals reach their goals of which there are tools available to aid demonstrating impact.

[2] https://www.health.org.uk/sites/default/files/Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf
[3] https://pubmed.ncbi.nlm.nih.gov/23984269/

**Useful reading:**

- Cottam Report (2020)[4]
- Build Back Fairer: The COVID-19 Marmot Review (2020)[5]
- Advisory Board Webinar Lancashire and South Cumbria Health and Care Partnership January 2021

HighRiskActivationEquation_12.1.2020.pd

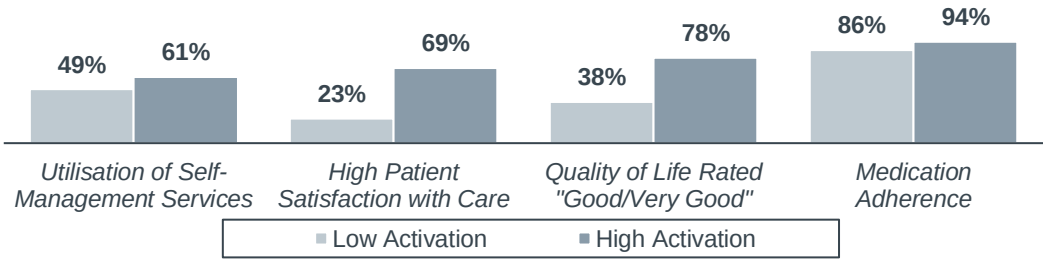
**Patient Activation Measures:**

A number of the hexagon workstreams outline use of the PAM tool as essential to the delivery and assessment of impact and improved outcomes for patients and citizens related to behavioural change and co-ownership of care pathway design. National evidence[6] suggests that patients improving their PAM scores by at least one level will reduce their system usage by 29%.

There are also a number of national and international best practice case studies[7] from which we can learn re long-term implementation and ROI of a PAM-based approach. Mosen et al[8] (2007) demonstrated positive impact on measures for those with higher level of activation, which is a key aim of the population health operating model.

**Association of Patient-Activation with Outcome Measures**

n=4,108; p<0.0001




Pre COVID-19, Knapp and McDaid[9] (2011) presented a strong economic case for mental health promotion and prevention, suggesting that costs of mental health problems would become unaffordable by 2026 if treatment and support arrangements and employment patterns (for example) remain unchanged. The authors used economic modelling to demonstrate the significant 'value for money' provided by prevention interventions such as proposed in this workstream.

There are examples of where the principles of this approach are being embedded locally, with Blackpool's work on PAMs as part of the vanguard being one.

Nationally and internationally, there are good examples of the impact this approach has had, which includes;

[4] https://www.ucl.ac.uk/bartlett/public-purpose/sites/public-purpose/files/iipp_welfare-state-5.0-report_hilary-cottam_wp-2020-10_2020-09-15_final_web.pdf
[5] https://www.health.org.uk/publications/build-back-fairer-the-covid-19-marmot-review
[6] https://www.health.org.uk/sites/default/files/Reducing-Emergency-Admissions-long-term-conditions-briefing.pdf
[7] Patient Activation Measure: An emerging tool for patient self-management (advisory.com)
[8] Mosen DM, et al., Journal of Ambulatory Care Management, 2007, 30: 21-29; Hibbard JH, et al., Health Affairs, 2013, 32: 216-222
[9] https://www.pssru.ac.uk/pub/Knapp_et_al_2011_MHPMHP-Economic-Case.pdf

- A US-based early implementer of PAM with heart failure patients (VA San Diego) used PAM to create tailored pathways to influence patient activation and behavior/choices over time. This work on behavioural change saw the average PAM score improve. A single point increase in PAM score has been shown to correlate to a 2% decrease in hospitalisation and 2% increase in medication adherence.
- Voluntary Action Rotherham saw a 13 – 17% reduction in A&E attendances for service users.


VAR.pptx

- Lehigh Valley Health Network (USA) asked patients or 'key learners' with readmission-sensitive conditions to teach-back answers to four condition-specific questions per day over three days. From an Acute perspective alone (but with significant cost implications for the system) the initiative reduced readmissions by 25% and decreased average length-of-stay by 26%.

Adopting this approach to population health will make a significant contribution **to embedding behaviour change science into primary care and place-based partnerships** to help individuals reach their goals of which there are tools available to aid demonstrating impact.

**Evidence of good practice across LSC related to all of the Hexagon areas of focus:**

There are several examples of engagement, involvement and coproduction, at community level, in partnership with communities, and the CVFSE, examples of these include:

- **Healthy Fleetwood**: https://www.healthierfleetwood.co.uk/
- **Social Prescribing in Pennine Lancashire**: https://eastlancsccg.nhs.uk/get-involved/patient-public-involvement/social-prescribing, , https://www.bprcvs.co.uk/index.php/services/social-prescribing-team

A powerful approach to community engagement has previously been used by Co:Create in Leicester, Leicestershire and Rutland and most recently in Morecambe Bay. The report for Leicester, Leicestershire and Rutland is attached below.


Co-production approaches in prima

There is also learning from a health behaviour coaching case study in Morecambe Bay.


Active Lives Community Classes

Outcomes and evidence for health behaviour coaching: Health coaching | Health Education England (hee.nhs.uk). Additional evidence supplied under hexagon 2.

Examples of existing good practice across LSC include:

- **The approach to community engagement and co-production that has been developed and fostered by Integrated Care Communities (ICCs) in Morecambe Bay**. This work took learning from Art of Hosting/Art of

Connecting Communities approaches (reflected within the social movement strand of the population health operating model and development programme).

- **NHS England (NHSE) funded pilot project specifically related to addressing health inequalities undertaken with eight Primary Care Networks (PCNs) in Morecambe Bay**. The methodology built upon 'traditional' approaches to population health management, allowing PCNs to gain a new, broader perspective on health/social care inequalities and a new understanding of the lives and health and social care needs of the target population via direct engagement.
- **The PCN Accelerator programme in Pennine Lancashire**, with work in Hyndburn Central PCN focusing on children and families, a new approach to joint working providing opportunity to work with partners outside of the NHS and health e.g. councils and employment support agencies to overcome barriers and to support make positive changes in their lives to achieve the best possible health and wellbeing.
- **Development of 4x4 vulnerability matrices in West Lancashire**, drawing on data reflective of social vulnerability alongside that for clinical vulnerability and multi-agency winter ready schemes.
- **Neighbourhood care teams on the Fylde Coast** are a legacy of the NHS New Models of Care Vanguard, which risk-stratified and segmented the local population in order develop specific interventions for specific population segments. The neighbourhood care teams are multi-disciplinary teams, based in the community, built around health and wellbeing workers. The health and wellbeing workers use a behaviour change and personalised care approach to support people to take control of their own personalised health and wellbeing plan, drawing in support from other members of the team (e.g. nursing, physiotherapy, occupational therapy) as required by the needs and goals of the individual.
- The PCN population health management scheme launched in **Central Lancashire** is an **place-based partnership -wide introduction to embedding the population health management methodology into everyday practice**. All PCNs have embraced the ethos, focussing on areas such as frailty, obesity, respiratory and mental health, building upon relationships with non-NHS partners to understand the wider determinants of health and support our most vulnerable people.

**The Wigan Deal – Strong local leadership/impact:**

Widespread cultural changes are needed in public services to realise the full potential of this kind of approach, and this involves challenging engrained ways of working. In Wigan this has been achieved through bold leadership and a long-term strategic commitment to working differently with local people and communities.

Further information on the work in Wigan is available through the following links:

- https://www.wigan.gov.uk/Council/The-Deal/index.aspx
- https://www.kingsfund.org.uk/publications/wigan-deal

## Appendix 1

The place-based partnership Maturity Matrix was developed within Lancashire and South Cumbria by the place-based partnerships, led by the place-based partnership Directors and endorsed by the ICP Development Advisory Group; however, it has been externally assessed by AQuA, who have validated its use as a framework based on their vast experience in this area.

The following criteria are drawn from the common place-based partnership Narrative and were used to support each place-based partnership in assessing its maturity against the roles and functions outlined within the narrative:

- Place-based leadership and collaboration
- Listening to the voice of our communities
- Planning integrated services
- Delivering integrated services
- Population health management
- Improving quality of services
- Maximising the use of resources
- Valuing and developing the workforce

The document below includes the benchmark/status for each place-based partnership. More detailed place-based partnership level presentations are available to help inform areas for improvement. To avoid duplication local Leaders of these population health initiatives will work with the place-based partnership development programme to use the place-based partnership maturity matrix process to help measure progress of any approaches at place-based partnership level and overall, at Lancashire and South Cumbria Health and Care Partnership.

Maturity Matrix summary of all ICPs

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | 11th November 2021 |
| **Title of paper** | Financial Report |
| **Presented by** | Gary Raphael, ICS Executive Director of Finance and Investment |
| **Author** | Elaine Collier, ICS Head of Finance |
| **Agenda item** | **10** |
| **Confidential** | No |

| **Purpose of the paper** |
|---|
| For noting. |
| **Executive summary** |
| This paper reports on the month 6 (H1) financial performance for the CCGs and the position on ICS central functions. It also starts to consider the H2 planning process and H2 financial envelope information. |
| **Recommendations** |
| The Board is asked to **note** the report. |
| **Governance and reporting** (list other forums that have discussed this paper) |

| **Meeting** | **Date** | **Outcomes** |
|---|---|---|
| None | | |

| **Conflicts of interest identified** |
|---|
| Not applicable |

| **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 | | | |
| Are associated risks detailed on the ICS Risk Register? | | X | | |
| Report authorised by: | Gary Raphael, ICS Executive Director of Finance and Investment | | | |

Lancashire and South Cumbria Health and Care Partnership

**Strategic Commissioning Committee Financial Report**

## 1. Introduction

1.1 This paper reports on the month 6 financial performance for CCGs and ICS central functions. It also looks forward to the H2 financial planning process.

## 2. Financial Performance

2.1 At month 6, we are pleased to report that we have delivered the H1 plan, ending the first half of the year with a small surplus. This is a considerable achievement for the L&SC system and has been a real challenge to deliver. It has only been made possible by deploying a range of non-recurrent measures (underspends on certain budgets) to cover shortfalls on areas such as: a £5.9m shortfall on our H1 efficiency plan and a £10m gap on our elective recovery plan.

2.2 Table 1 below shows a summary of the month 6 position by sector. The year-to-date and H1 outturn show achievement of a small surplus of £0.4m which is £2.4m better than our plan, due to the resolution of £2m of NWAS 111First funding which was outstanding during planning.

Table 1 – L&SC summary financial position as at the end of month 6, September 2021:

| Financial Position Overview - M06 | | | | | | |
|---|---|---|---|---|---|---|
| Surplus / (Deficit) | Year-to-date | | | Forecast Outturn | | |
| | Plan £m | Actual £m | Variance to Plan £m | Plan £m | FOT £m | Variance to Plan £m |
| CCGs | 0.0 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 |
| NHS Providers | (2.0) | 0.3 | 2.3 | (2.0) | 0.3 | 2.3 |
| **System Financial Performance** | **(2.0)** | **0.4** | **2.4** | **(2.0)** | **0.4** | **2.4** |

2.3 Appendix 1 shows a more detailed overview of the financial performance by CCG and providers, showing income and expenditure by sector.

2.4 Table 2 below reports on the ICP performance against the plan.

Table 2 – L&SC ICP summary financial position at the end of month 6, September 2021:

| System performance Surplus / (Deficit) - M06 | | | | | | |
|---|---|---|---|---|---|---|
| By ICP | Year to Date | | | Forecast Outturn | | |
| | Plan £m | Actual £m | Variance to Plan £m | Plan £m | Forecast £m | Variance to Plan £m |
| Central Lancashire ICP | (0.0) | 0.0 | 0.0 | (0.0) | 0.0 | 0.0 |
| Fylde Coast ICP | (0.0) | 0.0 | 0.0 | (0.0) | 0.0 | 0.0 |
| Pennine Lancashire ICP | 0.0 | (0.0) | (0.0) | 0.0 | (0.0) | (0.0) |
| Morecambe Bay ICP | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| West Lancashire MCP | (0.0) | 0.1 | 0.1 | (0.0) | 0.1 | 0.1 |
| North West Ambulance Service NHS Trust | (2.0) | 0.3 | 2.3 | (2.0) | 0.3 | 2.3 |
| Lancashire and South Cumbria NHS FT | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **ICP Financial Performance** | **(2.0)** | **0.4** | **2.4** | **(2.0)** | **0.4** | **2.4** |

## 3. Efficiencies

3.1 L&SC set an ambitious £56.6m target for efficiencies in H1. This comprised 3% for all trusts and 3% of influenceable spend for CCGs.

3.2 At month 6, we can report that we delivered £50.7m efficiencies, which is £5.9m short of our plan. The shortfalls occurred within the Central Lancashire and Morecambe Bay CCGs, while providers and other CCGs have been able to deliver their original plans and/or achieved a level of mitigation to cover any shortfalls.

3.3 The actuals also show that 75% of this achievement was non-recurrent in nature. Whilst this H1 shortfall has been offset through other non-recurrent means, the gap and non-recurrent nature of schemes will have a real impact on future delivery.

3.4 The efficiency plan for H2 is even more ambitious than H1. The plan is for organisations to deliver a further £56.6m, supplemented by £30m of system-wide schemes. The efficiency programme is reported below by ICP:

Table 3 – L&SC ICP efficiency delivery as at the end of month 6, September 2021:

| Efficiencies : CIPS / QIPPS - M06 | | | | | | |
|---|---|---|---|---|---|---|
| ICP | YTD | Forecast Outturn | | | | |
| | Actual £m | Forecast Recurrent £m | Forecast Non-Rec £m | TOTAL Forecast £m | Plan £m | Variance to Plan £m |
| Central Lancashire ICP | 9.3 | *1.5* | *7.8* | 9.3 | 13.0 | (3.7) |
| Fylde Coast ICP | 12.6 | *0.9* | *11.7* | 12.6 | 12.6 | 0.0 |
| Pennine Lancashire ICP | 13.1 | *2.4* | *10.7* | 13.1 | 13.1 | 0.0 |
| Morecambe Bay ICP | 8.1 | *4.9* | *3.2* | 8.1 | 10.2 | (2.1) |
| West Lancashire MCP | 1.9 | *0.7* | *1.3* | 1.9 | 2.1 | (0.1) |
| North West Ambulance Service NHS Trust | 3.6 | *1.2* | *2.4* | 3.6 | 3.6 | 0.0 |
| Lancashire and South Cumbria NHS FT | 2.1 | *1.0* | *1.2* | 2.1 | 2.1 | 0.1 |
| **ICP Performance** | **50.7** | ***12.5*** | ***38.2*** | **50.7** | **56.5** | **(5.9)** |
| | | *25%* | *75%* | | | |

## 4. Run-Rate Monitoring

4.1 The ICS has recently introduced a monthly collection of run-rate data to help understand the monthly financial performance of each of our organisations and to enable us to demonstrate the impact of the efficiency programme or other actions taken. For CCGs run rates overall have held level at the £272m per month mark for H1, which is not surprising given that the amounts paid to NHS providers have been determined nationally on a block contract basis.

## 5. H2 Planning

5.1 At the time of writing this report, we are working through the H2 planning process. We have now received the financial envelope for H2 and the planning guidance, with the final system submission being due on 16 November 2021. The financial envelope for H2 is shown in table 4 below.

Table 4 – H2 financial envelope compared to H1:

| L&SC - Financial envelope | H1 | H2 |
|---|---|---|
| | £m | £m |
| CCG allocations | 1,510.2 | 1,546.5 |
| Top up funding | 117.7 | 99.3 |
| Covid funding | 94.4 | 90.6 |
| Growth funding | 68.1 | 80.5 |
| **FINANCIAL ENVELOPE** | **1,790.4** | **1,816.9** |

5.2 At first glance, the H2 envelope funding looks favourable when compared to H1. However, the H2 envelope includes £24.6m of funding to cover H1 backpay for the recent NHS pay award. The envelope also needs to fund the inflationary and pay award pressures for H2.

5.3 The system top-up funding has been reduced significantly in H2. This is mainly due to an additional targeted efficiency. The maximum targeted efficiency applied nationally is 1.50%, which relates to the scale of excess resource that systems are consuming relative to their adjusted FIT position (Financial Improvement Trajectory). For L&SC, this equates to 1.49% (a £24.8m reduction), the highest in the North West (the adjusted FITs are made up of CCG published allocations and other previously notified funding like FRF, MRET). In addition to this amount is a 0.82% efficiency deduction made to inflation funding = £13.6m, making a total efficiency requirement in H2 above H1 levels of £38.4m. As mentioned above, as a system we were already planning for a £30m efficiency increase in H2, meaning that the national requirements represent an £8.4m increase on our existing plans.

5.4 Covid funding has also been reduced for all systems (£6m for L&SC) to reflect the change in IPC guidelines.

5.5 Growth funding includes £10.3m new and additional capacity funding to reflect increased levels of non-elective activity. It could be argued that the system is already incurring additional spend in this area, so to spend this new money will only increase the level of efficiencies that we must deliver.

## 6. ICS Central Functions

6.1 Table 5 below provides an update on the financial position for ICS central functions. Nationally funded budgets are currently showing a significant year-to-date underspend, but we anticipate that these funds will be spent as they relate to key deliverables set by regional and national teams. There are several purchase orders working through the system for these funds and we are also working to identify if there is likely to be any slippage on these areas.

6.2 In addition to these budgets is around another £80m in CCGs for SDF for which there is currently not a combined and collective view of commitments and deliverables. ICS finance is working with CCGs to obtain this overview and will hopefully be able to report on this aspect of our budgets later in H2.

Table 5 – ICS central functions summary financial position at month 6, September 2021:

| ICS Central Functions - M06 | | | | | | | |
|---|---|---|---|---|---|---|---|
| ICS Central Functions | | Year-to-date | | | Full Year Forecast | | |
| | | Budget | Actual | Under/(over) spend | Annual Budget | Forecast Outturn | Under/(over) spend |
| | | £000 | £000 | £000 | £000 | £000 | £000 |
| ICS Core Budgets | | | | | | | |
| | Clinical Portfolios | 157 | 125 | 32 | 313 | 313 | 0 |
| | Enabling Functions | 907 | 839 | 68 | 6,440 | 6,440 | 0 |
| | Executive Functions | 1,261 | 1,095 | 166 | 2,459 | 2,459 | 0 |
| | Other Support Functions | 185 | 224 | (40) | 369 | 369 | 0 |
| | | 2,509 | 2,283 | 226 | 9,581 | 9,581 | 0 |
| | | | | | | | |
| Nationally Funded Budgets | | 5,463 | 1,946 | 3,517 | 10,890 | 10,890 | 0 |
| | | | | | | | |
| System Funded Budgets | | 412 | 154 | 258 | 823 | 823 | 0 |
| | | | | | | | |
| **TOTAL** | | **8,383** | **4,383** | **4,000** | **21,294** | **21,294** | **0** |

## 7. Recommendation

8.1 The SCC is requested to **note** the contents of the report.

**Gary Raphael**
**ICS Executive Director of Finance and Investment**
**3rd November 2021**

Lancashire and South Cumbria
Health and Care Partnership

**Appendix 1**

Detailed overview of financial performance by CCG and provider sector.

| Financial Position Overview - M06 | | | | | | |
|---|---|---|---|---|---|---|
| Surplus / (Deficit) | Year-to-date | | | Forecast Outturn | | |
| | Plan £m | Actual £m | Variance to Plan £m | Plan £m | FOT £m | Variance to Plan £m |
| Acute Services | (1,043.1) | (1,041.8) | 1.3 | (1,043.1) | (1,041.8) | 1.3 |
| Mental Health Services | (198.7) | (198.5) | 0.2 | (198.7) | (198.5) | 0.2 |
| Community Health Services | (151.0) | (152.0) | (1.0) | (151.0) | (152.0) | (1.0) |
| Continuing Care Services | (89.1) | (99.7) | (10.6) | (89.1) | (99.7) | (10.6) |
| Primary Care Services | (199.2) | (198.7) | 0.5 | (199.2) | (198.7) | 0.5 |
| Primary Care Co-Commissioning | (136.9) | (135.9) | 1.0 | (136.9) | (135.9) | 1.0 |
| Other Programme Services | (56.8) | (56.3) | 0.5 | (56.8) | (56.3) | 0.5 |
| Running Costs | (16.0) | (15.7) | 0.3 | (16.0) | (15.7) | 0.3 |
| Hosted Services | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| COVID Outside Env & ERF Unvalidated | (8.0) | 0.0 | 8.0 | (8.0) | 0.0 | 8.0 |
| Total CCG Net Expenditure | (1,898.9) | (1,898.8) | 0.1 | (1,898.9) | (1,898.8) | 0.1 |
| In-Year Allocation | 1,898.9 | 1,898.9 | 0.0 | 1,898.9 | 1,898.9 | 0.0 |
| **CCG Total** | **0.0** | **0.1** | **0.1** | **0.0** | **0.1** | **0.1** |
| Income Excl Reimbursements | 1,634.1 | 1,645.3 | 11.2 | 1,634.1 | 1,645.3 | 11.2 |
| COVID-19 Reimbursements | 5.1 | 22.0 | 16.9 | 5.1 | 22.0 | 16.9 |
| Total Income | 1,639.2 | 1,667.3 | 28.1 | 1,639.2 | 1,667.3 | 28.1 |
| Pay | (1,091.2) | (1,116.4) | (25.2) | (1,091.2) | (1,116.4) | (25.2) |
| Non Pay | (529.1) | (529.8) | (0.8) | (529.1) | (529.9) | (0.8) |
| Non Operating Items (exc gains on disposal) | (21.0) | (20.8) | 0.2 | (21.0) | (20.8) | 0.2 |
| Total Expenditure | (1,641.2) | (1,667.0) | (25.8) | (1,641.2) | (1,667.0) | (25.9) |
| **NHS Provider Total** | **(2.0)** | **0.3** | **2.3** | **(2.0)** | **0.3** | **2.3** |
| **System Financial Performance** | **(2.0)** | **0.4** | **2.4** | **(2.0)** | **0.4** | **2.4** |

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **11 November 2021** |
| **Title of paper** | **New Hospitals Programme Quarter 2 Board Report** |
| **Presented by** | **Jerry Hawker, Programme SRO** |
| **Author** | **Rebecca Malin, Programme Director**<br>**Matthew Burrow, Project Manager** |
| **Agenda item** | **12** |
| **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 2 period; July – September 2021.<br><br>The report includes the evolution of the programme scope, progress on the key products that have been developed to support business case development along with the public, patient and workforce communications and engagement activities underway.<br><br>This quarterly report is presented to the following Boards;<br>• University Hospitals of Morecambe Bay FT<br>• Lancashire Teaching Hospitals FT<br>• East Lancashire Hospitals Trust<br>• Blackpool Teaching Hospitals FT<br>• Lancashire & South Cumbria FT<br>• Integrated Care System (ICS)<br>• Provider Collaborative<br>And the Strategic Commissioning Committee. |
| **Recommendations** |
| **I**t is recommended the Board;<br>• Note the progress undertaken in Q2.<br>• Note the progress in developing key products to support business case (section 4). |

| **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 Q2 BOARD REPORT

## 1. Introduction

1.1 This report is the 2021/22 Quarter 2 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 Q2, MIAA (Mersey Internal Audit Agency) have begun working with the programme 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 business case processes. The report is due to conclude in November 2021.

3.2 The programme has continued to embed the governance arrangements approved by the Strategic Oversight Group (SOG) in August 2021. The Governance Advisory Group has provided valuable guidance to the programme through the input from the Trust Executive and Non-Executive Directors and members of the Strategic Commissioning Committee. In addition, the monthly Trust Engagement Meeting has supported the communication of progress and key messages with the Trusts management teams.

3.3 The Oversight Groups have met and delivered assurance to the Programme Management Group throughout Q2 on key products.

3.4 The programme undertook a review of key and strategic risks in Q2 to strengthen the risk register with stakeholders, which has further embedded those risks within the programme. In August, the risk management strategy, policy and risk appetite statement were approved. 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 Progress against plan (for the period July – September 2021)

### 4.1 Programme scope

Members will recall that in Q1, system partners were integral to refining the scope of the programme to focusing on hospital facilities/sites, with the integrated care system's clinical strategy determining the clinical model, including configuration of services.
A number of interconnected initiatives have brought further intelligence and thinking to the scope of the programme. Firstly, discussions between the ICS and NHSEI regarding wider system delivery focusing on achievement of sustained operational, quality and financial improvement have enabled the programme to be firmly placed in the scope of longer term system improvement. Secondly, further evidence published in the system diagnostic on the ICS financial position has provided clarity on productivity and efficiency opportunities. Finally, alongside the review of a hospitals clinical strategy, the programme has supported the progression of a primary and community care programme and the development of a draft infrastructure plan. These present an opportunity to further align the scope of the programme with these linked, emerging

strategies. In response to this, the programme is rapidly developing how these work in tandem with the programme and inform the next steps.

4.2 **Key products to support business case development –** During Q2, a number of key products were developed and reviewed by the SOG. These products represent key building blocks in the development of the business cases, including the process and methodology that supports progressing from a long list of proposals to the final short list of options. 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 programme working and oversight groups and was presented to SOG with their support. The products are:

4.3 **Framework model of care** – clinical leads have worked 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 was approved by the Clinical Oversight Group (COG) and SOG in August 2021. The framework has been shared with the ICS Provider Collaborative Board (PCB) to ensure alignment, and reviewed by the North West Clinical Senate in the role of critical friend to help support the programme to further develop the document.

4.4 **Publication and formal approval of the longlist –** the programme held a Longlist and Critical Success Factors (CSFs) Workshop on the 4 October 2021, in which the stakeholders (clinical and non-clinical staff, Healthwatch and patient representatives) approved the longlist and CSFs providing constructive feedback to strengthen the CSFs. An online survey about the longlist was launched to capture feedback from members of the public, which received more than 100 responses in the first 24 hours.

4.5 **Estates prioritisation exercise –** the programme has held several joint workshops with finance, clinical and estates colleagues across the system to prioritise areas for investment. This is in support of any proposals for new infrastructure on existing sites.

## 5 Programme timeline

5.1 The programme remains on track to start building in 2025, with new hospital facilities opening by 2030.

5.2 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 required public consultation.

## 6 Public, patient and workforce communications and engagement

6.1 A number of key communications, involvement and engagement activities have taken place during this period namely:

6.2 Our Case for Change went live on the New Hospitals Programme website– https://newhospitals.info/CaseForChange. A proactive communications campaign followed to create awareness of the existence of the Case for Change and to highlight key themes, this included media releases; the launch of a new Case for Change conversation on the Big Chat and internal communications updates across the local NHS. In addition, a summary version of the Case for Change and draft Easy Read has been published online on the New Hospitals Programme Case for Change hub.

6.3 The longlist was published and an online survey created to capture feedback from members of the public, which obtained more than 100 responses in the first 24 hours. As of 19 October, more than 2,000 responses have been received.

6.4 Several key reports have been produced throughout the quarter sharing insights on views and aspirations for the New Hospitals Programme: A report on the 'Big chat' conversation highlighting strong support for a solution that embraced holistic care and tackled health inequality, but travel and location were the most discussed issues. A benchmarking insight report was received and polling indicates that people North and South of the region do not wish to travel in either direction for anything but the most complex treatments and for no more than an hour. The report demonstrated a very high public awareness of the programme (30%) and over half of the people who are aware of the programme think it is about building a brand-new hospital somewhere.

## 7 Stakeholder management

7.1 The Board will recognise there will be a breadth of stakeholders in such a programme. During Q2, there has been a continuation of internal and external communications including stakeholder updates with MPs and local authorities. Engagement has continued with MPs across the region with a focus on the process the NHP is following and the longlist of proposals. Finally, work on the socio-economic benefits of new hospital facilities continues working closely with with the Lancashire Local Enterprise Partnership (LEP).

## 8 Next period – Q3 2021/22

8.1 The next quarter will require critical actions to be undertaken by the programme. These include further developing potential estates solutions, clinical strategy, social value and articulating and quantifying the benefits new hospital facilities bring to the region.

## 9 Conclusion

9.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 2 2021/22.

## 10 Recommendations

10.1 The Board is requested to:

- Note the progress undertaken in Q2.
- Note the progress in developing key products to support business case (section 4).

**Rebecca Malin**
**Programme Director**
**October 2021**

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

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | 11th November 2021 |
| **Title of paper** | Lancashire and South Cumbria Medicines Management Group (LSCMMG) Commissioning Policy Positions – September-October 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** | **13** |
| **Confidential** | No |

| **Purpose of the paper** |
|---|
| To present the policies developed by the LSCMMG and to assure the SCC of the process taken. |
| **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>- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Adults with Parkinson's Disease*<br>- *Idarucizumab (Praxbind®) for adult patients treated with Pradaxa (dabigatran etexilate) when rapid reversal of its anticoagulant effects is required for emergency surgery/urgent procedures or in life-threatening or uncontrolled bleeding.*<br>- *NICE Technology Appraisals (July-September 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: | Brent Horrell |

Lancashire and South Cumbria Health and Care Partnership

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

**September-October 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:

- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Adults with Parkinson's Disease*
- *Idarucizumab (Praxbind®) for adult patients treated with Pradaxa (dabigatran etexilate) when rapid reversal of its anticoagulant effects is required for emergency surgery/urgent procedures or in life-threatening or uncontrolled bleeding.*
- *NICE Technology Appraisals (July-September 2021).*

1.2 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.

1.3 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).

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

- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Adults with Parkinson's Disease*

  Glycopyrronium New Medicine Assessment SCC.docx

- *Idarucizumab (Praxbind®) for adult patients treated with Pradaxa (dabigatran etexilate) when rapid reversal of its anticoagulant effects is required for emergency surgery/urgent procedures or in life-threatening or uncontrolled bleeding.*

  Idarucizumab New Medicine Assessment SCC.docx
- *NICE Technology Appraisals (July-September 2021).*
  Available at https://www.nice.org.uk/guidance/published?type=ta

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

N/A

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

***Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Adults with Parkinson's Disease***

*3.1* Glycopyrronium for treatment of Hypersalivation in patients with Parkinson's disease was prioritised for review following a request by a Parkinson's disease specialist clinician at Blackpool Teaching Hospitals.

3.2 LSCMMG members agreed to an Amber 0 RAG rating for Parkinson's disease and also agreed to look at widening the scope for other conditions at a future meeting. Prescribing of glycopyrronium bromide oral solution may therefore be continued following initiation or recommendation by a specialist.

*3.3* The potential annual cost burden if 5% of the total eligible patient population with symptoms of excessive drooling of saliva were initiated on to glycopyrronium bromide oral solution (112 patients across Lancashire and South Cumbria) is estimated to be £366,464.

***Idarucizumab (Praxbind®) for adult patients treated with Pradaxa (dabigatran etexilate) when rapid reversal of its anticoagulant effects is required for emergency surgery/urgent procedures or in life-threatening or uncontrolled bleeding.***

3.4 Idarucizumab (Praxbind®) is licensed for adult patients treated with Pradaxa (dabigatran etexilate) when rapid reversal of its anticoagulant effects is required for emergency surgery/urgent procedures or in life-threatening or uncontrolled bleeding. Idarucizumab was prioritised for review following reports of its use in local trusts.

3.5 LSCMMG agreed to a Red RAG rating (only initiated and prescribed in hospitals by specialists).

3.6 It is estimated that 18 patients may require idarucizumab annually in Lancashire and South Cumbria. Assuming each patient required a single treatment (£2,400) the total spend in Lancashire and South Cumbria would be approximately £43,000.

***NICE Technology Appraisals (July-September 2021).***

3.7 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.

3.8 Four CCG commissioned NICE TAs were identified: **Adalimumab, etanercept, infliximab and abatacept** for treating moderate rheumatoid arthritis after conventional DMARDs have failed (TA715); **Ixekizumab** for treating axial spondyloarthritis (TA718); **Secukinumab** for treating non-radiographic axial spondyloarthritis (TA719); and **Bimekizumab** (TA723) for treating moderate to severe plaque psoriasis.

3.9 NICE TA guidance recommendations for **secukinumab, ixekizumab** and **bimekizumab** are not expected to create significant costs or capacity issues in the Lancashire and South Cumbria health economy.

3.9..1 NICE do not expect this TA guidance for **bimekizumab** 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.

3.9..2 NICE do not expect this TA guidance for **secukinumab and ixekizumab** to have a significant impact on resources. Both treatments are expected to be cost neural

3.10 NICE TA guidance for **Adalimumab, etanercept, infliximab and abatacept** are not likely to have a significant impact on resources in Lancashire and South Cumbria. The increased cost relates to widening availability of the agents to patients with moderate severity rheumatoid arthritis (RA).

3.11 However, with cost effective treatment choices, the associated cost pressure associated with these agents will not be additional to the cost pressure identified for filgotinib (an agent which has been approved by NICE for the same indication and ratified by the SCC in July 2021). The costs of using these agents are expected to replace the costs of using filgotinib.

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

N/A

## 5. CONCLUSION

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

- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Adults with Parkinson's Disease*
- *Idarucizumab (Praxbind®) for adult patients treated with Pradaxa (dabigatran etexilate) when rapid reversal of its anticoagulant effects is required for*

*emergency surgery/urgent procedures or in life-threatening or uncontrolled bleeding.*

- *NICE Technology Appraisals (July-September 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** | 11 November 2021 |
| **Title of paper** | Development of Lancashire & South Cumbria Clinical Commissioning Policies<br>- *Sensory Integration Therapy (SIT)*<br>- *Photorefractive Surgery for the correction of Photorefractive Error* |
| **Presented by** | **Brent Horrell**<br>Chair of Lancashire & South Cumbria Clinical Policy Development and Implementation Group (CPDIG) |
| **Author** | **Julie Hotchkiss FFPH**<br>Consultant in Public Health, Midlands & Lancashire Commissioning Support Unit |
| **Agenda item** | **14** |
| **Confidential** | No |

| **Purpose of the paper** |
|---|
| To present the policies developed by the L&SC CPDIG and to assure the SCC of the process taken. |
| **Executive summary** |
| The Commissioning Policy Development and Implementation Working Group (CPDIG) has completed a review of two intervention specific commissioning policies. Revised and updated policies have been prepared for adoption across Lancashire and South Cumbria. This paper sets out the development process and includes the final recommended policies for consideration. |
| **Recommendations** |
| That the SCC ratify Lancashire and South Cumbria policies on the following interventions:<br>- *Sensory Integration Therapy (SIT)*<br>- *Photorefractive Surgery for the correction of Photorefractive Error* |

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

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

**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: | Brent Horrell |

Name of Author: Yvonne Bentley- Birch
Date Produced: 1 November 2021

**Lancashire & South Cumbria Clinical Policy Development and Implementation Group**

**Policies for the Commissioning of Healthcare**

## 1. Introduction

1.1 The purpose of this paper is to apprise the SCC of the work undertaken by the Lancashire & South Cumbria Clinical Policy Development and Implementation Group (CPDIG) to develop commissioning recommendations on the following:

- *Sensory Integration Therapy Policy*
- *Photorefractive Surgery for the correction of Photorefractive Error*

## 2. Development Process

2.1 Policy development has been completed in accordance with the process approved by the CPDIG, which has been shared with the SCC previously.

2.2 The review process included the following key steps:
- an evidence review by an allocated policy lead;
- clinical stakeholder engagement;
- public and patient engagement;
- notification of local Health, Overview and Scrutiny Committees;
- consideration of any financial implications
- an Equality Impact Risk (EIRA) Assessment;

## 3. Sensory Integration Therapy (SIT) Policy

3.1 This policy was developed at the request of the Lancashire and South Cumbria Children's Network. This was partly prompted by requests to include sessions of private sensory integration therapy in the package for children in receipt of an Education, Health and Care Plan.

3.2 In July 2019 an evidence review of sensory diets/sensory integration therapy was undertaken.

3.3 Following discussions, CPDIG and the Lancashire and South Cumbria Children's Network acknowledged the findings of the evidence review that there was a lack of evidence of effectiveness for clinic-based sensory integration therapy. However, they agreed assessment of sensory needs be incorporated into existing assessment pathways for children with ASD/ neurodevelopmental issues. Advice and guidance to parents and teachers on management of the child should include consideration of sensory needs and how they may be addressed in daily life.

3.4 It was agreed that a policy be developed for the use of stand-alone, one-to-one clinic-based therapy, confirming that due to the absence of evidence of effectiveness it would not be routinely commissioned.

3.5 Following the pause in policy development due to Covid, a draft Sensory Integration Therapy policy was presented to the March 2021 CPDIG meeting, where it was agreed to proceed to clinical engagement.

3.6 A final version of the policy was presented to CPDIG on 20 May 2021 following clinical consultation.

- The clinicians consulted were broadly in agreement with the recommendation that stand-alone, one-to-one clinic-based therapy would not be routinely commissioned.
- This was also supported by a recent publication, referenced by one of the respondents, on the informed view of Sensory Integration along with an evidence spotlight from the Royal College of Occupational Therapists (RCOT) which was published after the evidence summary was completed.

3.7 The Policy was approved by CPDIG on 20 May with the recommendation that it is passed to public engagement.

**Outcomes of public engagement**

3.8 The CPDIG were presented with the outcome of the public engagement on 16.09.21, with a report being considered at the 21.10.21 meeting.

- Most of the respondents did not support the policy as written, however, there appeared to be misunderstanding amongst some respondents that the policy only applied to not routinely commissioning stand-alone, one-to-one clinic-based therapy, rather than taking an active decision not to invest in autism services.
- There was a great deal of support, clinical and public, for greater use of sensory assessments as part of the overall package of assessment of needs and use of the findings in planning with the parents and carers how to shape the environment to help development and achievement of personal goals.
- There was demand for stand-alone, one-to-one clinic-based therapy integration therapy from a cohort of people who have experience of the service and some support from some healthcare professionals, however a number of professionals and some of the public supported the “not routinely commissioned” policy.

**Consideration of engagement responses**

- CPDIG considered the results of the public engagement, the clinician responses, the evidence spotlight from the Royal College of Occupational Therapists and the paucity of published evidence.

- CPDIG agreed to amend the policy wording to make it clearer that the policy relates only to stand-alone, one-to-one clinic-based therapy, in section 1.1. The rest of the policy remained unchanged.

**4. Photorefractive Surgery for the correction of Photorefractive Error**

The Policy for commissioning of Photorefractive Surgery for Correction of Refractive Error was adopted on 5 September 2018.

The Policy was approved by the Lancashire and South Cumbria Commissioning Policy Development and Implementation Group (CPDIG) on 19 August 2021.

This policy is based on the principle of appropriateness, and there has been no change in circumstances which would now make this surgery an appropriate use of NHS resources.

To comply with the agreed policy naming convention the Policy has been re-named to become Photorefractive Error- Surgical correction Policy.

As no change to the clinical content of the policy has been made, no clinical or public engagement has been undertaken.

**Conclusion**

**5.** The SCC are asked to ratify the following collaborative commissioning policies:

- *Sensory Integration Therapy Policy.*
- *Photorefractive Surgery for the correction of Photorefractive Error Policy*

Brent Horrell, Chair of the CPDIG
01.11.21

Lancashire and South Cumbria Health and Care Partnership

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

**Policies for the Commissioning of Healthcare**

**Sensory Integration Therapy Policy**

| **Document control: Sensory Integration Therapy Policy** | | |
|---|---|---|
| | **Version Number:** | **Changes Made:** |
| Version of 21.10.2021 | V0.3 | "(stand-alone, one-to-one clinic-based therapy)" added to 1.1 to make what is not being commissioned clearer |
| Version of 24.02.2021 | V0.2 | Changes following CPDIG 18.02.21 to clarify what the procedure/service is |
| Version of: 19.02.2020 | V0.1 | Policy drafted by Julie Hotchkiss |

| | |
|---|---|
| | **Introduction** |
| | |
| | This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right, but will be applied with reference to other policies in that suite. |
| | |
| **1** | **Policy** |
| | |
| **1.1** | The CCG will not routinely commission sensory integration therapy (stand-alone, one-to-one clinic-based therapy), as it considers that the intervention does not accord with the Principles of Effectiveness and Cost-Effectiveness[1]. |
| | |
| **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** | In current practice there is no single agreed definition of what constitutes Sensory Integration Therapy. The various schools use different theories and approaches and involve markedly different procedures. The Ayres Sensory Integration® is an attempt at standardisation, but even within that school there is no single specific intervention described. For the purpose of this policy the CCG defines sensory integration therapy as stand-alone, one-to-one clinic-based therapy for children or adults who have been assessed to have a degree of sensory dysfunction. |
| | |
| **2.3** | The scope of this policy includes requests for stand-alone, one-to-one clinic-based therapy and the provision of associated recommended equipment, such as weighted blankets, for sensory disorder/dysfunction. |
| | |
| **2.4** | The scope of this policy does not include: |

| | |
|---|---|
| | • the incorporation of consideration of a patient's sensory needs during the multidisciplinary assessment and diagnosis process.<br>• the provision of advice and support for parents, teachers and carers on the management of sensory dysfunction, including how to structure daily activities and adapt environments, etc dependent on symptom severity, age and individual circumstances as part of a multidisciplinary commissioned service provided by local NHS provider |
| | |
| **2.5** | The CCG recognises that a patient may have certain features, such as<br>• having sensory disorder/dysfunction,<br>• wishing to have a service provided for their sensory disorder/dysfunction,<br>• being advised that they are clinically suitable for sensory integration therapy, and<br>• be distressed by their sensory disorder/dysfunction, and by the fact that 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 purpose of sensory integration therapy is normally to support or improve a patient's adaptive responses to sensory experiences. |
| | |
| **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** |
| | |
| **4.2** | This policy relies on the Principle of Effectiveness as the CCG considers there is insufficient evidence to demonstrate sensory integration therapy is effective in supporting or improving a patient's adaptive responses to sensory experiences. |
| | |
| **5** | **Cost Effectiveness** |
| | |
| **5.1** | This policy relies on the criterion of Cost-Effectiveness in that the CCG considers that it is not possible for a procedure to be Cost-Effective if it is not Effective. |
| | |
| **6** | **Ethics** |
| | |
| **6.1** | The CCG does not call into question the ethics of sensory integration therapy 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 when considering an application to provide funding. |
| | |
| **7** | **Affordability** |
| | |
| **7.1** | The CCG does not call into question the affordability of sensory integration therapy and therefore this policy does not rely on the Principle of Affordability.<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 be affordable in this patient when considering an application to provide funding. |
| | |
| **8** | **Exceptions** |
| | |
| **8.1** | The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies. |
| | |
| **8.2** | In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality. The current NICE guidance for Autism Spectrum Disorders does not make any mention of sensory integration therapy[2]. |
| | |
| **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. SIGN 145 Assessment, diagnosis and interventions for autism spectrum disorders. A national clinical guideline. Healthcare Improvement Scotland. June 2016 https://www.sign.ac.uk/assets/sign145.pdf<br>2. Autism spectrum disorder in under 19s: support and management. CG170, Published August 2013. https://www.nice.org.uk/guidance/cg170 |

*Date of adoption of v1.1* *November 2021*
*Date for review* *November 2024*

Lancashire and South Cumbria
Health and Care Partnership

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

**Policies for the Commissioning of Healthcare**

# Photorefractive Surgery for the correction of Refractive Error Policy

| | Version Number: | Changes Made: |
|---|---|---|
| Version of 12.08.2021 | V1.1 | Brought version control table to the front page.<br>Changed word order of title.<br>Content reviewed. No further amendments required. |
| Version of 05.10.2018 | V1 | Policy ratified by Healthier Lancashire and South Cumbria's Joint Committee of Clinical Commissioning Groups |

| | |
|---|---|
| | This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite. |
| | |
| **1** | **Policy Criteria** |
| | |
| **1.1** | The CCG considers that surgery for the correction of refractive error does not accord with the Principle of Appropriateness, therefore the CCG will not routinely commission this intervention. |
| | |
| **2** | **Scope and definitions** |
| | |
| **2.1** | 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). |
| | |
| **2.2** | Photorefractive surgery is a procedure to correct visual refractive error. |
| | |
| **2.3** | The scope of this policy includes but is not limited to requests for surgery to correct myopia, hyperopia, astigmatism and presbyopia including:<br>• Photorefractive keratectomy (PRK)<br>• Laser in-situ keratomileusis (LASIK)<br>• Laser assisted subepithelial keratomileusis (LASEK)<br>• Laser assisted subepithelial keratomileusis with corneal collagen cross linking (LASEK-CXL)<br>• Small incision lenticule extraction (SMILE) |
| | |
| **2.4** | The CCG recognises that a patient may have certain features, such as;<br>• Having a refractive error due to myopia, hyperopia, astigmatism or presbyopia. |

| | |
|---|---|
| | • Wishing to have a service provided for their refractive error<br>• Being advised that they are clinically suitable photorefractive surgery and<br>• Be distressed by their refractive error 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. |
| | |
| **3** | **Appropriate Healthcare** |
| | |
| **3.1** | The purpose of photorefractive surgery is normally to correct a patient's refractive error, removing or reducing the requirement for glasses or contact lenses. However corrective surgery is considered a cosmetic treatment and compared to the use of spectacles or contact lenses, not an efficient use of NHS resources. |
| | |
| **3.2** | This policy relies on the criterion of appropriateness in that the CCG considers that other services competing for the same CCG resource more clearly have a purpose of preserving life or of preventing grave health consequences. |
| | |
| **4** | **Effective Healthcare** |
| | |
| **4.1** | The CCG does not call into question the effectiveness of photorefractive surgery and therefore this policy does not rely on the Principle of Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the purpose of the treatment is likely to be achieved in this patient without undue adverse effects before confirming a decision to provide funding. |
| | |
| **5** | **Cost Effectiveness** |
| | |
| **5.1** | The CCG does not call into question the cost-effectiveness of photorefractive surgery and therefore this policy does not rely on the Principle of Cost-Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be Cost Effective in this patient before confirming a decision to provide funding. |
| | |
| **6** | **Ethics** |
| | |
| **6.1** | The CCG does not call into question the ethics of photorefractive surgery and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding. |
| | |
| **7** | **Affordability** |
| | |
| **7.1** | The CCG does not call into question the affordability of photorefractive surgery 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. |

## Appendix 1: Associated OPCS/ICD codes

The codes applicable to this policy are:

| OPCS codes | ICD codes |
|---|---|
| C442, C444, C445 | H442, H521, H522, H524 |

*Date of adoption* *05.10.2018*
*Date for review* *05.10.2021*

*Date of adoption of v1.1* *November 2021*
*Date for review* *November 2024*

# Strategic Commissioning Committee

| | |
|---|---|
| **Date of meeting** | **11th November 2021** |
| **Title of paper** | **CCG Transition Board Update Report** |
| **Presented by** | **Andrew Bennett, Executive Director of Commissioning, LSC ICS** |
| **Author** | **Dawn Haworth, Senior Programme Manager** |
| **Agenda item** | **15** |
| **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 October meeting of the CCG Transition Board the agenda focussed on the following areas:<br>1. CCG Close down process<br>2. HR and OD Workstream Update<br>3. Communications & Engagement Update<br>4. Direct Commissioning Update<br><br>The attached highlight report summarises the progress against items 1-3, as reported at the Transition Board. In relation to item 4, a paper was presented setting out the draft high level action plan for the delegation of NHSE&I direct commissioning functions for Pharmaceutical Services and General Medical Services from 1 April 2022.<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** |
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|---|---|---|---|---|
| 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 | YES | | | |
| 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 Minor Delays |
| 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 | | 30/06/21 | Complete |
| **C02** | **Develop and agree transitional functional allocation of resources** | Andrew Bennett | Whilst any proposed significant changes will need to wait until after the establishment of the new ICB, in line with national HR guidance regarding management of change, work to develop new operating models and resourcing proposals to inform transitional arrangements for 2021/22 was due to be presented for consideration at the CCG TB and then ICS OG for agreement during October. Unfortunately it has not been possible to progress this work as planned. The work has been paused pending completion and sign-off of a Data Sharing Agreement between NHS system partners. A revised timeline for this work will be confirmed once the DSA has been agreed by all partners. | 31/12/21 | In progress but with significant issues |
| **C03** | **Agree plan for transactional close-down of CCGs in line with due diligence, checklist and guidance** | Denis Gizzi<br>Helen Curtis | MIAA have provided a briefing note regarding the developments in the guidance to date, the additional guidance was published on 19 August 2021. We are now liaising with MIAA to match the guidance to the outline programme plan in order to finalise<br>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 to base the programme plan.<br>External support secured (from MIAA) who will provide programme management support. Representatives from MIAA attend the executives and governance groups. Programme plan is in the process of being populated and will be submitted to the Transition Board October 2021. | 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. Place Based Partnerships common narrative updated and shared. Introductory Provider Collaborative statement agreed for internal briefings. Communications and engagement review panel being established to quality check and challenge communications and engagement approaches and materials relating to the system developments commencing in September. Developed glossary and visual of the system for leaders to address consistency of language. | 31/03/22 | In Progress but with minor issues/delays |

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| **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 Place Based Partnerships engagement leads and Place Based Partnerships programme directors. Outputs of the session include an approach to align Place Based Partnerships engagement plans with consistent timing, approach communications objectives and evaluation methods. Regular meetings between Place Based Partnerships Communications and Engagement leads have been established. Place Based Partnershipss have identified 2x case studies per Place Based Partnerships which are being developed along with system case studies.<br>A survey has been developed and launched collectively which is being shared with staff across place-based partnership organisations as a tracking study of involvement and understanding of vision and purpose of the partnerships linked to the maturity matrix work.<br>Website information developed and Place-based partnerships have asked to be embedded on their websites.<br>Social media schedule of sharing case studies commencing this week to highlight good practice examples and impact of new ways of working. | 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). The ICS website has been updated with latest materials and documents.<br><br>Delivered first Colleague briefing sessions in July and shared video of the sessions plus responses to staff questions raised.<br><br>Delivered second set of Colleague briefing sessions in September and shared video of the sessions. Working with HR on responses to staff questions raised. Dates planned in November for next Colleague Briefings.<br><br>Updates to the website including documents, materials, glossary, videos with leaders and case studies (Sept 2021). | 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. This is expected to also advise on Board level posts.<br><br>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 which reports into the CCG TB.<br><br>22/9 - HR Framework received and key HR issues being reviewed with recommendations put forward via HRRG and for approval at CCG Transition Board. This includes FTC, Secondments and Board Level posts.<br><br>Workforce Due Diligence templates now available and have been included in overarching People Service Project Plan to manage workforce closedown and transition activity. | 31/03/22 | In Progress no issues/delays |

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| | | | Chair confirmed and authorised by NHSEI subject to legislation being approved by parliament.<br>CEO appointment likely to take place during September. Expected that national process will be issued for local implementation.<br><br>22/9<br>Chair appointed confirmed<br>Chief Officer national advert published with selection process to take place in October. Preferred candidate will require national approval via established authorisation process.<br>Further senior leadership posts and board posts will follow the Chief Officer appointment being confirmed.<br>National position given on remuneration levels for senior posts. | | |
| **E04** | **Recruitment into NHS LSC senior leadership team and associated governance arrangements** | Cath Owen | | 31/03/22 | In Progress no issues/delays |
| **E05** | **Organisational development** | Cath Owen | OD support programme offer made available by NHSEI for AOs and Senior Directors within CCG. OD support programme for all staff to be developed and made available by end of Q3 subject to HR technical guidance.<br>22/9<br>OD Programme for senior leadership developed nationally and regionally and continue to be expanded.<br>Support for all other staff will be focused on Health and Wellbeing via action plan developed following regular survey across LSC and establishment of HWB Sub Group (reporting to HRRG). | 31/03/22 | In Progress but with minor issues/delays |
| **E06** | **Staff engagement and consultation** | Cath Owen | Several communications now issued. 2 x all-staff brieifng sessions taken place with 2 further briefings planned in September. Monthly staff bulletin in place with regular provision of FAQs.<br>Staff Side engaged and being regularly updated via establshed formal mechanisms. NW Social Partnership Forum updated on progress.<br>22/9<br>Further staff briefings have taken place with updated FAQs to be issued and regular system wide staff communication bulletin now agreed.<br>CCG Staff Partnership Forum provided with regular monthly update and attendance at LSC and North West Social Partnership Forums have taken place to also provide update. | 31/03/22 | In Progress no issues/delays |

Lancashire and South Cumbria
Health and Care Partnership

# Strategic Commissioning Committee

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| **Date of meeting** | **11 November 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** | **16** |
| **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 4 November 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:

- Communications and Engagement – GP Services
- Monitoring of Regulated Care Services
- Workforce and Capacity – Significant Risk

**Recommendations**

The SCC is asked to:

- Note the contents of the report
- 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 | | | | |

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|---|---|---|---|---|
| Are associated risks detailed on the ICS Risk Register? | | | | |

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

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

## 1. Communications and Engagement – GP Services

1.1 It was agreed that public communication and engagement need to be enhanced so that the public is well informed of access to available GP services as well as providing some insight into the current pressures on GP practices.

## 2. Monitoring of Regulated Care Services

2.1 Concern was raised regarding the lack of dedicated resource for the return to regular monitoring of regulated care services by face to face visits to care homes. This was highlighted as a key risk to patient safety and business critical for system flow and discharge.

## 3. Workforce

3.1 It was highlighted that pressures on workforce capacity across the system poses a significant risk to service provision and patient safety as well as impacting on system flow. This risk is common to all areas of Lancashire and South Cumbria ICS.

## 4. Conclusion

4.1 Members of the Quality and Performance Sub-Committee agreed that items 1 – 3 above should be brought to the attention of the SCC for acknowledgment and further discussion.

## 5. Recommendations

5.1 The SCC is requested to:

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

Una Atton
04.11.21