Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee (Formal)

13 January 2022, 1.30 pm – 2.30 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 11 November 2021, matters arising and actions to agree	Chair	Approve	Attached
5.	Key Messages	Andrew Bennett	Discuss	Verbal
Building the system for 2021/22 and beyond				
6.	Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions	Brent Horrell	Approve	Attached
7.	Development of Lancashire and South Cumbria Clinical Commissioning Group Policies - Endoscopic Procedures on the Knee Joint Cavity - Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms in Males - Surgical Intervention for Benign Prostatic Hyperplasia - Male Circumcision	Brent Horrell	Approve	Attached
Managing 2021/22				
8.	CCG Closedown Report	Denis Gizzi	Discuss	Attached
9.	Quality and Performance Report	Kathryn Lord/ Roger Parr	Discuss / Note	Attached
10.	SEND Update	Julie Higgins / Hilary Fordham	Discuss	Attached
Reports from Sub-Committees				
11.	CCG Transition Board	Andrew Bennett	Note	Attached
12.	Quality and Performance Sub-Committee	Kathryn Lord	Note	Attached
Any Other Business				
13.	Any Other Business	Chair	Note	Verbal

Next meeting of the Strategic Commissioning Committee:- Thursday 10 February 2022, 1 pm – 3 pm, MS Teams (Informal meeting) Thursday 10 March 2022, 1pm – 3pm, MS Teams (Formal meeting				

Development of the Integrated Care System
Key terminology visual attached

Lancashire and South Cumbria Integrated Care System (ICS)

NHS ENGLAND

NHS England will set strategic aims and priorities and will continue to commission some services at a regional level, providing support to the NHS bodies working with and through the ICS. NHS England will also agree ICBs' constitutions and hold them to account for delivery.

CARE QUALITY COMMISSION

Independently reviews and rates the ICS.

STATUTORY ICS

LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD (ICB)

The most recent national guidance states that this is the new NHS organisation that will be established on 1 April 2022, subject to the Health and Care Bill (2021) being passed. We expect this is likely to be known publicly as "NHS Lancashire and South Cumbria" and will be accountable for NHS spend and performance and responsible for the day-to-day running of the NHS in Lancashire and South Cumbria.

CROSS-BODY MEMBERSHIP, INFLUENCE AND ALIGNMENT

LANCASHIRE AND SOUTH CUMBRIA HEALTH AND CARE PARTNERSHIP

The broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. The partnership will enable partners to plan for the future and develop strategies using available resources creatively in order to address the longer term challenges which cannot be addressed by a single sector or organisation alone.

INFLUENCE

INFLUENCE

LANCASHIRE AND SOUTH CUMBRIA PARTNERSHIP STRUCTURES

System
Covers a population of 1.8m

Provider collaboratives

Service providers will be collaborating at the various different levels of system, place and neighbourhood according to need. National guidance has been published and a Provider Collaborative Board (PCB) has been established to enable partnership working of the acute, mental health and community providers across Lancashire and South Cumbria.

Place
Covers a population of 114,000 to 566,000

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.
Our five place-based partnerships are Pennine Lancashire, West Lancashire, Fylde Coast, Morecambe Bay, Central Lancashire.

Neighbourhood
Covers a population of 30,000 to 50,000

Primary care networks

Most day-to-day care will be delivered here. Neighbourhoods will develop to bring together partners across health and social care to deliver integrated care and may align with Primary Care Networks.

Some of the information in this summary is subject to the Health and Care Bill (2021) being passed in Parliament.
A detailed glossary for Lancashire and South Cumbria is available on our website: **Lancashire and South Cumbria glossary of language**

Lancashire and South Cumbria
Health and Care Partnership

Item 4

Subject to ratification at the next meeting

Draft Strategic Commissioning Committee

Minutes of Meeting	
Date and time	11 November 2021, 1 pm – 3 pm
Venue	Microsoft Teams
Chair	David Flory

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Roy Fisher	CCG Chair	NHS Blackpool CCG
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
Richard Robinson	CCG Chair	NHS East Lancashire CCG
Adam Janjua	CCG Chair	NHS Fylde and Wyre CCG
Sumantra Mukerji	CCG Chair	NHS Greater Preston CCG
Paul Kingan	Chief Finance Officer (attending for West Lancashire CCG and Fylde Coast CCGs)	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
Julie Higgins	CCG Accountable Officer	NHS East Lancashire and Blackburn with Darwen CCGs
David Blacklock	Healthwatch Representative	Healthwatch Cumbria and Lancashire
Gary Raphael	ICS Executive Director of Finance and Investment	Lancashire and South Cumbria ICS
Sam Proffitt	ICS Director of Provider Sustainability	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 (Audit Chair and Conflicts of Interest Guardian)	Lancashire and South Cumbria ICS
Debbie Corcoran	Lay Member (Patient and Public Involvement)	Lancashire and South Cumbria ICS
Kevin McGee	ICS Provider Collaborative Representative	ICS Provider Collaborative
Clare Thomason	Associate Director – Lancashire and South Cumbria (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	Interim Director of Performance	Lancashire and South Cumbria ICS
Dr Andy Knox	Clinical Lead for Population Health	Lancashire and South Cumbria ICS
Jerry Hawker	Executive Director and SRO – New Hospitals Programme	Lancashire and South Cumbria ICS
Brent Horrell	Head of Medicines Commissioning	NHS Midlands and Lancashire CSU

Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Peter Tinson	Director of Collaborative Commissioning	Lancashire and South Cumbria ICS
Mark Hindle (up to item 7 only)	Managing Director	Lancashire and South Cumbria Pathology Service
Nathan Hearn	Partnership and Integration Manager	North West Ambulance Services
Lorraine Elliott	Designated Lead Nurse for Safeguarding Adults and Mental Capacity Act	NHS Greater Preston, NHS Chorley and South Ribble and NHS West Lancashire CCGs
Lucinda McArthur (from item 9)	Senior Advisor	NHS West Lancashire CCG
Charlotte Redmond	General Management Trainee	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		
6 members of the public were present		

1. Welcome and Introductions

The Chair welcomed committee members, and members of the public observing, to the formal meeting of the Lancashire and South Cumbria (L&SC) Strategic Commissioning Committee (SCC), held virtually via Microsoft Teams.

2. Apologies for absence

Apologies were noted from Andrew Bennett, Sarah Sheppard, Andy Curran, Jane Scattergood, Linda Riley, Peter Gregory and Beth Goodman.

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 9 September 2021

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

RESOLVED: The minutes of the meeting held on 9 September 2021 were approved as a correct record.

Action log – All actions were noted as closed.

5. Key Messages

Peter Tinson presented key messages on behalf of Andrew Bennett, acknowledged the continued pressures faced by health and care colleagues and thanked staff for their care and commitment.

Winter Access Fund - proposals had been submitted to NHS England for the Winter Access Fund to increase resilience across primary care and feedback was awaited. In the meantime, CCGs, Primary Care Networks (PCNs) and practices were implementing priority schemes to ensure pace was not lost around this.

Special Educational Needs and Disability (SEND) - Julie Higgins reminded members that in 2017 a SEND inspection took place in Lancashire, conducted by Ofsted and the CQC, which found serious weaknesses in services. Following an inspection revisit in March 2020, five areas of concern remained: leaders' understanding of data; joint commissioning; diagnostic pathways for ASD; transitions in healthcare; and improving the quality of the local offer. An accelerated progress plan was requested, with oversight by a sub-group including Councillors and Non-Executive Directors. A monitoring meeting took place in September 2021 following which formal confirmation was received that sufficient progress had been made and Lancashire would no longer be part of the formal monitoring regime. This was a result of the commitment and hard work of local authorities, CCGs, families and frontline staff across education, health and social care. A formal report would be brought the next board meeting. The Chair expressed his congratulations to all involved in the improvement work.

Managing 2021/22

6. Pathology Collaboration Update

Mark Hindle (MH) provided an update on the progress made to date in the L&SC Pathology Collaboration and advised of the priority areas of work that were being progressed. The process of due diligence had been completed to identify and assess the risks/issues associated with the formation of the single pathology service. The Committee was assured that no new or unknown issues had surfaced and that there was nothing that would prevent the formation of the single service. The development of the Target Operating Model was now underway.

MH advised that all four acute providers in Lancashire who provide a pathology service to the people of L&SC had collaborated in terms of bringing together the service into one joined up pathology service for L&SC. National policy stipulates that pathology services should be grouped on sensible geographical locations. Work was progressing at pace and the Strategic Outline Business Case had been completed with the aim of acquiring £32m of capital to facilitate and underpin the delivery of a new service model. The model would be 'hub and spoke' with the vast majority of routine work to be undertaken in the hub, a large new laboratory building at Samlesbury, and all hospitals would have essential services provided on site. A TUPE consultation was about to begin to move all staff from their current organisations into one service from the beginning of April 2022. The service would be hosted by Lancashire Teaching Hospitals and the hub was planned to open in late 2023. During 2022/23 there would be a harmonisation of working practices, introduction of new management and clinical structures, development of a new laboratory information system and co-ordinated and centralised automation. This was an opportunity to work together to deliver more resilient, better quality and more efficient services. Formal notification of the allocation for capital was awaited from NHS England/Improvement.

The Chair thanked Mark for his comprehensive presentation and invited comments and questions. A number of comments were made regarding transport, impact on staff, staffing models and the sensitivity of the model to geography and local need. It was noted that whilst the traditional role of pathology service on testing samples would continue, the laboratory system held a vast amount of information which could be utilised to support population health and a more proactive primary prevention approach to health.

Sam Proffitt (SP) highlighted this to be a good example of collaborative work going forward, improving quality and outcomes for people and patients whilst delivering efficiencies and would be working with Mark to get messages like this into the system, as an example to set and pave the way for a Lancashire and South Cumbria approach.

It was confirmed that a further update would be provided to the Committee in due course. The chair asked that the future update include the plans for the intervening years through the transition period up to 2024 and taking up to 2027.

RESOLVED: The ICS Board noted the content of the report which was provided for information.
Mark Hindle left meeting.

7. Quality and Performance

Roger Parr (RP) presented the report which focussed on 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.

The following key issues were highlighted. The urgent care system had been incredibly busy over the last 3 months, due to increasing numbers in the system and more acutely unwell patients. In September 2021 there were 472 validated physical health 12-hour breaches, with a significant increase at Blackpool Teaching Hospitals. Cancer recovery and restoration continued to be the top priority for cancer services. Performance against the diagnostics 6-week target deteriorated in August mainly due to pressures in Blackpool and Lancashire Teaching Hospitals Trusts. GP referrals to secondary care had returned to pre-Covid levels. Elective activity in August 2021 was running at 90% compared to August 2019 levels. Early indications for the September/October position remained challenging. The impact on waiting lists continued to be an upward trend, increasing in the last 5 months. The longest waiting patients were tracked and monitored by providers in the elective recovery group.

Kathryn Lord (KL) provided an overview of nosocomial Covid-19 infections. Positive Covid tests had increased across the patch in every age group, which was starting to impact on system working. Information on the numbers of patients in hospitals and across all sectors were provided in the report.

Covid Vaccination - The Covid vaccination booster programme was being rolled out through various sites including Community Pharmacies, PCNs and hospital hubs and any areas of low uptake were being targeted with community engagement. The school programme was ongoing and would be completed by 17 December 2021, however uptake had been low. It was now nationally mandated that all NHS frontline staff must have received 2 vaccines by 1 April 2022 and a scoping programme to signpost people to support and receive the vaccine was underway. Uptake had increased across the patch with the 'Evergreen' programme, where the general public could attend any site for the first dose of vaccine.

Individual Packages of Care - It was expected that CCGs, apart from Blackpool, would not meet the quality premium target for individual packages of care. Extra funding was available for overdue reviews, and work was being targeted with families to ensure care was received and assessed in a timely fashion.

Safeguarding – the report highlighted items to be escalated to the SCC. It was noted that phase 1 of the national child protection information system was complete in L&SC, in relation to sharing information where children and families were at risk.

Children and Young People – Weekly escalation meetings were in place to review all eating disorder cases, including children and young people in paediatric units or those waiting within a community setting. Work was taking place with specialist commissioning and private providers to ensure pathways were given the greatest option of working. Discussions were being held with families around taking their child out of the area if a bed could be secured more quickly.

Mental health – Nationally, out of area placements remained relatively stable. The significant amount of out of area placements within L&SC were being reviewed and much work was being undertaken regarding inpatient capacity locally.

Cawston Park Reviews – Reviews were on track for completion prior to 31 December 2021. Of those completed, no issues had been escalated to date. A panel would be meeting weekly throughout December to look at key points of learning and key plans for individuals.

Complaints – From 1 April 2022, the ICB would have statutory responsibility in relation to complaints. Work was underway to scope what the service would look like and ensure the right workforce was in place.

Kevin McGee (KM) assured members of the committee that providers were focussed on patient safety and patient flow. Each place had detailed winter escalation plans which were working well with local authority colleagues in terms of social care and discharges. Elective capacity had been ringfenced on certain sites and elective recovery would be focussed on long waits. There was concern regarding an increase in acute and complex cases and critical care beds would also be ringfenced if Covid and respiratory illness rose over the next few months. Capital had been successfully secured to increase critical care capacity, however, staff recruitment was an issue. This risk was being managed hourly, ensuring a balance between elective and emergency capacity remained.

It was requested that future reports consider inclusion of the same data set in each report to support comparability. **ACTION: Kathryn Lord**

Lindsey Dickinson sought assurance about how the elective programme for children and young people was going to be managed through the winter period to ensure ongoing access to surgery in a timely fashion.

Kevin McGee confirmed that capacity for paediatrics was ringfenced within sites across L&SC.

Nicola Adamson added that pressures in paediatric services were reviewed three times a week. The two main tertiary centres for children were Alder Hey and Royal Manchester Children's Hospitals and work was ongoing on a shared transparency and shared waiting list across the two sites. However, some electives were being cancelled in order to manage critical care due to staffing shortages. The North West Network was looking at paediatric surgery transformation programme.

Jerry Hawker highlighted the need to use the information presented in the report to move to an environment of improvement and suggested picking a small number of areas where the system wants to see improvement, develop trajectories and focus on improving those areas to make a difference to our population.

The Chair concluded the discussion and recognised the pressures, demands and challenges faced across the system and emphasised the need to continue to support people to do the best they can. Performance had fallen in a number of areas and there was a need to remain focussed on how to get through and beyond the winter period.

RESOLVED: The Committee noted the contents of the Quality and Performance Report and supported its development.

8. Independent Sector Contracts

Gary Raphael (GR) provided a verbal report on the use of Independent Sector (IS) contracts for treatment of patients. Contracts for £60m per year were held within CCG budgets.

GR advised that as part of the elective recovery programme there was a need for SCC and senior leadership to have oversight of these contracts and three main issues were highlighted. Firstly, that in the first half of this year, IS budgets were underspent by at least £7m and there was a need to get the maximum impact of the contract. The second issue was the operational aspects of the clinical prioritisation process. Patients were prioritised according to need and there were also clear requirements around the need to eradicate long waiters. Improved joint working across both the NHS and IS sectors was required to achieve this. Thirdly, there was a need for a long-term relationship between the NHS and the IS to achieve the capacity required to manage the activity, whilst retaining patient choice. To achieve this, oversight would be developed through the SCC, joined up with the Hospital Cell. Janet Barnsley, Operations Director at Blackpool Teaching Hospitals, and Andrew Harrison, CCG Chief Finance Officer had agreed to undertake work in this area following up on these issues, linking with the elective care recovery group and reporting back to this committee.

The Chair expressed concern regarding the under-utilisation of the contract and requested that a report including a clear analysis of the activity, utilisation across the different parts of the patch, management across the whole of the system and an action plan be prepared for the next meeting.

Action: Executive Team

9. Population Health Operating Model and Development Programme

Julie Higgins introduced the paper which updated the Committee on the population health operating model and development programme which had a £20.87m investment commitment by the L&SC Health and Care Partnership. The paper provided a summary of the proposal including:

- The vision, goals and approach
- Clear context and key challenges
- Overview of the operating model for L&SC through the six strands of enabling capabilities
- High-level overview of impact, interdependencies, funding requirements and next steps.

Also included was a detailed section on the operating model and development programme including each of the six strands of enabling capabilities; detailed design principles; aggregated benefits and key measurements across the operating model; and evidence base underpinning the operating model.

Andy Knox explained that over the last 12 months, the implementation programme had been developed collaboratively with communities, the voluntary and faith sectors and place-based partnerships and expressed his thanks to the team who were working on this. The vision was clear – to improve the health of our population through the tacking of health inequalities. Assurance was provided that key partners including the Kings Fund, Professor Chris Bentley and Sir Michael Marmot had been involved to ensure scrutiny. Discussions had taken place both nationally and regionally and with Directors of Public Health and the programme was embedded across all workstreams.

Andy explained how it was envisaged the model would work. Intelligence and infrastructure would need to be built as this was currently at different levels across place-based partnerships. Data was strong across many parts of the patch and there was an ability to risk stratify, to identify the areas on which to focus and support decision-making. There would be a focus on working with communities to build social movement, community power and a sense of real participation. Leadership and organisational development structures were being built to ensure this could be delivered at place, at system and in neighbourhoods. A population health academy was being developed working with the anchor institutions across the patch and making sure that the teams were able to deliver what was needed on the ground. Once the infrastructure was built the right kind of interventions, based on both clinical and social need, could be enacted to drive behavioural change.

The Chair thanked Julie and Andy for their excellent work on this programme. Members expressed support for the programme and congratulated the team on the progress made. Comments, questions and points of clarification were received and noted or responded to during discussion.

RESOLVED:
The Strategic Commissioning Committee noted and approved:

- **the population health operating model**
- **the financial envelope, accepting that further work was required on budgets,**

The Committee also accepted 'in principle' the next steps in developing the implementation programme, which would report via the Population Health Board to the Senior Leadership Executive, subject to the satisfactory conclusion of the governance processes currently being worked through.

10. Financial Report

Sam Proffitt (SP) provided highlights from the report on the month 6 (H1) financial performance for the CCGs and the position on ICS central functions. The H1 financial target was met and run rates started to reduce. Against the target of £56m savings, £50m had been met. 75% of actions taken to make savings in the first

half of the year were non-recurrent. Longer term plans to improve quality and outcomes for the population, whilst supporting the workforce, needed to be built up.

Plans for H2 were being drafted and showed a lot of pressure in the system. A further £56.6m was to be delivered within the efficiency plan, supplemented by a further £30m of system-wide schemes. Significant activity had taken place during the last couple of weeks to prepare plans to achieve the required level of savings and these had resulted in a number of actions to take forward without compromising ongoing management of winter pressures, urgent care and restoration of services within the financial envelope. This included an event attended by senior system leaders and a system-wide check and challenge session. Alongside, plans were also being developed to reduce duplication and drive out inefficiencies in the system in the longer term.

Gary Raphael confirmed that Aaron Cummins would chair a meeting the following day to consider the position reached within the plans and the group had been given a mandate to make further adjustments on behalf of the system to get to as near to a balanced position as possible.

Paul Kingan advised that there remained an element of risk regarding balancing the CCG plans.

The Chair commented on the need to submit a balanced plan to the regional office.

RESOLVED: The Committee noted the report.

The agenda was taken out of order.

13. Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions

Brent Horrell presented the report and apprised the Committee of work undertaken by the Lancashire and South Cumbria Medicines Management Group (LSCMMG) to develop commissioning recommendations regarding a reversal agent for patients on anticoagulent therapy and confirming the commissioning position on hypersalivation in patients with Parkinson's disease, which was already used, and was not expected to have a significant financial impact.

The paper also described four NICE technology appraisals which were not expected to have a significant cost impact. One may have had a very small cost impact and one had already factored-in the cost in a previous paper that had been approved by the Strategic Commissioning Committee in July 2021.

RESOLVED:
The Committee ratified the collaborative LSCMMG recommendations, as set out in the meeting papers, 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).**

14. Development of Lancashire and South Cumbria Clinical Commissioning Group Policies

Brent Horrell presented the paper relating to the outputs of the Commissioning Policy Development and Implementation Group. Two policies had been reviewed, a pre-existing policy which had been approved previously and a policy on Sensory Integration Therapy. The paper set out the development process and included final recommended policies for consideration. Brent highlighted the public engagement process undertaken which had resulted in a tweaking of the wording in the policy to ensure clarity.

RESOLVED:

The Committee ratified the Lancashire and South Cumbria policies on the following interventions:

- **Sensory Integration Therapy (SIT)**
- **Photorefractive Surgery for the correction of Photorefractive Error.**

The agenda reverted to its original order.

11. Establishing the Integrated Care Board (ICB)

The Chair introduced the item by confirming the appointment of Kevin Lavery to the position of Chief Executive Designate of the NHS Lancashire and South Cumbria Integrated Care Board who would be joining in the next few months.

Jane Cass informed the Committee that the first phase of the consultation on the development of the Board had taken place and valuable feedback had been received. From this a number of changes had been made to the proposed composition, including the proposal for an additional Non-Executive Director to be included, taking the total to four Non-Executive Directors with the potential to supplement further as the Board evolves. This would take the number of Non-Executive Directors to be equal to the number of Executive members on the Board. A further proposed change to partner members was to add a fourth member, the Executive Lead for mental health services, to partner the Executive Lead for the Trust providing acute and community services. Contributions would be drawn from across the patch with confirmation that the voluntary sector and Healthwatch would work in collaboration with the Board as participants.

The next phase would be around other aspects of the constitution, large elements of which were legal or policy requirement and could not be changed and a model constitution template had been issued by NHS England/Improvement. Some content could be localised and there would be a process of engagement with stakeholders encouraging comments on those aspects. It was expected that the engagement process would be completed by mid-November.

RESOLVED: Members noted the update to establishing the ICB.

12. New Hospitals Programme Quarter 2 Board Report

Members noted the update. Questions to be directed to Jerry Hawker outside of the meeting.

RESOLVED: Members noted the update provided within the report.

Reports from Sub-Committees

15. CCG Transition Board

Roy Fisher stressed the importance that colleagues across organisations sign up as quickly as possible to the data sharing agreement, to ensure that the transitional work on the functions can take place as soon as possible.

RESOLVED: Members of the Committee acknowledged the report.

16. Quality and Performance Sub-Committee

RESOLVED: Members of the Committee acknowledged the report.

17. Any Other Business

No other business was raised.

Next formal meeting:
13 January 2022, 1 pm – 3 pm, MS Teams

Strategic Commissioning Committee

Formal Action Log

Updated 6 January 2022

Item Code	Action	Responsible Lead	Status	Due Date	Progress Update
SCC 2021-11-11 Item 8 SCC 2021-12-09 Item 10	**Independent Sector (IS) Contracts** – The Chair requested a written report for the next meeting including an analysis of activity and management of IS contracts across the patch.	Andrew Bennett/ Gary Raphael/ Andrew Harrison	**Propose to close**		Written report prepared and presented at Informal SCC meeting on 9/12/21. At that meeting the Chair requested a group be set up to consider the new ICB's strategic approach to IS contracts and terms of engagement collectively with all IS providers. 06.01.22 – confirmation received that a group of commissioner and provider leads are meeting to take this work forward.
SCC 2021-11-11	**Quality and Performance Report –** Future reports to use the same data set to support comparability (specific reference was made to data on CAMHS and Eating Disorders).	Kathryn Lord	**Propose to close**	09.12.21	03.12.21 - Discussions taken place with the MH and LD/A team about the metrics and using consistent data. Fleur Carney will oversee the report moving forward.

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	13 January 2022
Title of paper	Lancashire and South Cumbria Medicines Management Group (LSCMMG) Commissioning Policy Positions – November-December 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	**6**
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: - *Clonidine 25 mcg Tablets for Vasomotor symptoms associated with menopause* - *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Children and Adults (other than those with Parkinson's Disease).* - *LICENSE REMOVAL - Dapagliflozin for the treatment of patients with T1DM as an adjunct to insulin in patients with BMI ≥ 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy.* - *NICE Technology Appraisals (October-November 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?				

Lancashire and South Cumbria Health and Care Partnership

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

November-December 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:

- *Clonidine 25 mcg Tablets for Vasomotor symptoms associated with menopause*
- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Children and Adults (other than those with Parkinson's Disease).*
- *LICENSE REMOVAL - Dapagliflozin for the treatment of patients with T1DM as an adjunct to insulin in patients with BMI ≥ 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy.*
- *NICE Technology Appraisals (October-November 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:

- *Clonidine 25 mcg Tablets for Vasomotor symptoms associated with menopause*

  Clonidine VMS New Medicine Assessment SCC version.docx

- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Children and Adults (other than those with Parkinson's Disease).*

  Glycopyrronium all indications except PD SCC.docx

- *LICENSE REMOVAL - Dapagliflozin for the treatment of patients with T1DM as an adjunct to insulin in patients with BMI ≥ 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy.*

  https://www.gov.uk/drug-safety-update/dapagliflozin-forxiga-no-longer-authorised-for-treatment-of-type-1-diabetes-mellitus

- *NICE Technology Appraisals (October-November 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

Clonidine 25 mcg Tablets for Vasomotor symptoms associated with menopause

2.1 Clonidine 25 mcg tablets for vasomotor symptoms (VMS) associated with menopause was prioritised for review following a request from East Lancashire CCG.

2.2 LSCMMG members agreed a Green (restricted) RAG rating for clonidine. Clonidine may therefore be initiated and prescribed in both primary and secondary care, however clonidine should be prescribed as a second line treatment option, after consideration of HRT as first line therapy.

2.3 Clonidine is an established treatment for the management of VMS and there are already costs associated with prescribing clonidine. The LSCMMG recommendation is not anticipated to increase the cost burden and may potentially reduce costs if patients use alternative agents as outlined in the new medicine review. For illustrative purposes £100,000 could be saved in Lancashire and South Cumbria if approximately 700-1100 were switched from clonidine to fluoxetine for the management of VMS (depending on dosing).

LICENSE REMOVAL - Dapagliflozin for the treatment of patients with T1DM as an adjunct to insulin in patients with BMI ≥ 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy.

2.4 Dapagliflozin 5 mg is no longer authorised for the treatment of patients with type 1 diabetes mellitus. The removal of the type 1 diabetes indication is not due to any new safety concerns and the other indications of dapagliflozin are unchanged.

2.5 The recommendation for dapagliflozin use in type 1 diabetes has been removed from the LSCMMG website.

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

Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Children and Adults (other than those with Parkinson's Disease).

3.1 Following the review of glycopyrronium bromide in patients with hypersalivation in Parkinson's disease, the LSCMMG requested that glycopyrronium use in other indications be considered.

3.2 LSCMMG members agreed to an Amber 0 RAG rating in all adults with hypersalivation / sialorrhoea. Prescribing of glycopyrronium bromide oral solution may therefore be continued following initiation or recommendation by a specialist. Due to the availability of numerous presentations of oral glycopyrronium, the LSCMMG agreed that the review will be updated to include brand/presentation specific recommendations for oral glycopyrronium

3.3 Prescribing data for the 12 months up to August 2021 identified costs of £460,000 for glycopyrronium bromide prescribing. Although the LSCMMG recommendations will raise awareness of glycopyrronium bromide as a treatment option, the anticipated increase in prescribing is likely to be offset by highlighting the most cost-effective presentations of glycopyrronium bromide to prescribers. No significant cost pressure is therefore anticipated.

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

NICE Technology Appraisals (October-November 2021).

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

4.2 Two CCG commissioned NICE TAs were identified: **Inclisiran** for treating primary hypercholesterolaemia or mixed dyslipidaemia (TA733); and **Upadacitinib** for treating moderate rheumatoid arthritis (TA744).

4.2..1 NICE do not expect the TA guidance for **Upadacitinib** 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 approximately £9,000 per 100,000 population, based on a population for England of 56.3 million people). This is because the technology is a further treatment option and the overall cost of treatment will be similar.

4.2..2 The NICE TA recommendations for **Inclisiran** are likely to have a significant impact on resources in Lancashire and South Cumbria.

4.2..3 NICE estimates an eligible population of 13,351. If 10% of those currently receiving statins alone switch to inclisiran the year 5 cost impact could be up to £5.34million at the current listed price for **Inclisiran**.

4.2..4 However, inclisiran will be available to the NHS with a significant discount which will offset the estimated cost impact. The length of time that the discount will be in place and the pricing post discount are unknown, it is therefore difficult to gauge the precise cost to the Lancashire and South Cumbria health economy moving forward.

4.2..5 NICE expects Inclisiran will be administered in primary care which may result in an increase in appointments and patient contacts. The Accelerated Access Collaborative, NHS England, and NHS Improvement plan to support the implementation of inclisiran. Details are awaited on possible additional capacity and resources to support delivery of Inclisiran.

5. CONCLUSION

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

- *Clonidine 25 mcg Tablets for Vasomotor symptoms associated with menopause*
- *Glycopyrronium Bromide Oral Solution for Hypersalivation/ Sialorrhoea in Children and Adults (other than those with Parkinson's Disease).*
- *LICENSE REMOVAL - Dapagliflozin for the treatment of patients with T1DM as an adjunct to insulin in patients with BMI ≥ 27 kg/m2, when insulin alone does not provide adequate glycaemic control despite optimal insulin therapy.*
- *NICE Technology Appraisals (October-November 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	13 January 2022
Title of paper	Development of Lancashire & South Cumbria Clinical Commissioning Policies • *Endoscopic Procedures on the Knee Joint Cavity* • *Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms (LUTS) in Males* • *Surgical Intervention for Benign Prostatic Hyperplasia* • *Male Circumcision – re presentation*
Presented by	**Brent Horrell** Chair of Lancashire & South Cumbria Clinical Policy Development and Implementation Group (CPDIG)
Author	**Julie Hotchkiss FFPH** Consultant in Public Health, Midlands & Lancashire Commissioning Support Unit
Agenda item	**7**
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 three intervention specific commissioning policies, and an updated Male Circumcision Policy originally ratified by SCC in September 2021. The 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:

- *Endoscopic Procedures on the Knee Joint Cavity*
- *Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms (LUTS) in Males*
- *Surgical Intervention for Benign Prostatic Hyperplasia*
- *Male Circumcision*

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: 22 December 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:

- *Endoscopic Procedures on the Knee Joint Cavity*
- *Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms (LUTS) in Males*
- *Surgical Intervention for Benign Prostatic Hyperplasia*
- *Male Circumcision – re presentation*

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:
- 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. Endoscopic Procedures on the Knee Joint Cavity Policy

3.1 This is an update to a pre-existing Lancashire & South Cumbria policy that has been in place since November 2017.

3.2 This policy was updated to align local commissioning policy to EBI 1 and 2 guidance and has introduced a criterion based assessment of patient suitability for the procedure. The revised policy incorporates the Evidence-Based Interventions policy 2E Arthroscopic Surgery for Meniscal Tears into the existing L&SC Policy for Elective Endoscopic Procedures on the Knee Joint Cavity. However, the proposed changes are relatively minor. The three additions being:

> "*8.1.1 Where the patient has had an acute injury and an MRI scan reveals a potentially repairable meniscal tear ~~has shown~~*
> ***OR***
> *8.1.2 There is evidence of mechanical damage to the ligaments which need repair ~~and/or cartilage~~.*
> ***OR***
> *8.1.3 Where the patient has a locked knee (mechanical block to extension) if a bucket handle tear of the meniscus is present*"

3.3 A final version of the policy was presented to CPDIG on 19 August 2021 following clinical consultation. The clinicians consulted were broadly in agreement with the recommendations,

with minor amendments to some wording and with the removal of one of the recommended commissioning areas.

3.4 The Policy was approved by CPDIG and passed to public engagement where there were no recommended amendments or comments received.

4.0. Urology Policies x 2
Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms (LUTS) in Males Policy & Surgery for Benign Prostatic Hyperplasia

4.1 Two new Lancashire & South Cumbria policies have been developed.

4.2 They are based on the Evidence-Based Interventions policies 2H Cystoscopy for men with uncomplicated lower urinary tract symptoms and 2I Surgical intervention for benign prostatic hyperplasia (BPH). The content was shaped into clear criteria with the Lancashire and South Cumbria (L&SC) principles for decision making being applied.

4.3 These areas were prioritised for policy development as benchmarking data would suggest that activity levels in some providers in Lancashire & South Cumbria are high compared to other providers and waiting times for urology surgery were long.

4.4 The policies were approved at the April 2021 CPDIG meeting prior to going out for clinical and public engagement.

4.5 Clinical engagement produced feedback that was largely consistent with the policy as recommended, with only a slight change to the grammar required.

4.6 The Policies were approved by CPDIG and passed to public engagement where there were no recommended amendments or comments received.

5.0. Male Circumcision Policy

5.1 A Lancashire & South Cumbria policy has been in place since November 2017.

5.2 This policy was updated and ratified through Strategic Commissioning Committee in September 2021.

5.3 Since ratification, a query relating to the normal development of retractability of the foreskin with maturation has been considered and it was noted that retractility increases with maturity. Following this consideration, the policy has been amended to “not routinely commission” circumcision in the case of physiological phimosis in children and up to 18 years.

CPDIG agreed to add criterion 8.3:

> The CCG will not routinely commission circumcision for non-retraction of the foreskin (physiological phimosis) in children up to 18 years of age, as retractility increases with maturity.

6.0 Conclusion

The SCC are asked to ratify the following collaborative commissioning policies:

Endoscopic Procedures on the Knee Joint Cavity
Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms (LUTS) in Males
Surgical Intervention for Benign Prostatic Hyperplasia
Male Circumcision

Brent Horrell, Chair of the CPDIG
04.01.22

Lancashire and South Cumbria
Health and Care Partnership

Appendix i- Policies for approval

Lancashire and South Cumbria Clinical Commissioning Groups (CCGS)

Policies for the Commissioning of Healthcare

Policy for Elective Endoscopic Procedures on the Knee Joint Cavity

	Version Number:	Changes Made:
Version of: 19 August 2021	**1.4**	**Based on clinical engagement feedback: Removed:** Endoscopic procedures for the management of patellofemoral pain syndrome where there is lateral facet overload, when an x-ray/MRI is carried out prior to consideration of arthroscopy.
Version of: 21 April 2021	**1.3**	**Added "**there is evidence of" before haemarthrosis in 8.1.5
Version of: April 2021	**1.2**	**Brought into line with national Evidence-Based Intervention policy "**Arthroscopic surgery for meniscal tears". 3 criteria amended in Section 8, one reference updated and one replaced. Codes will be checked once amendments agreed.
Version of: December 2017	**1.1**	**OPCS and ICD codes added to appendices**
Version of: November 2017	**1**	**Pan-Lancashire and South Cumbria ratified policy**

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other polices in that suite.
1.2	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Scope and definitions**
2.1	Knee Arthroscopy is a surgical technique whereby a small telescope is inserted into a joint to inspect, diagnose and treat intra-articular problems. Knee irrigation or washout involves flushing the joint with fluid, which is introduced through small incisions in the knee.
2.2	The scope of this policy includes requests for an endoscopic procedure on the knee joint cavity for patients 16 and over. Procedures include: • Removal/repair of torn meniscus • Lateral release • Arthroscopic washout • Diagnostic arthroscopy • Plica reconstruction • Autologous chondrocyte implantation

	• Micro fracture
2.3	Endoscopic procedures on the knee joint cavity have the intended outcome of diagnosing or treating conditions affecting the knee joint. These conditions include: • Damaged ligaments or cartilage • Loose bodies within the knee joint • Patellofemoral syndrome • Plica syndrome
2.4	The CCG recognises that a patient may: • Suffer from one of the conditions listed in 2.3 • Wish to have a service provided for their condition • Be advised that they are clinically suitable for an endoscopic procedure on the knee joint cavity, and • Be distressed by their condition and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
3	**Appropriate Healthcare**
3.1	The Commissioning Organisation considers that the purpose of these procedures is to improve the health of patients by reducing pain, discomfort and disability and, therefore, accords with the Principle of Appropriateness in the *Statement of Principles.*
4	**Effective Healthcare**
4.1	The Commissioning Organisation recognises that endoscopic procedures on the knee joint cavity are effective in the following circumstances: • Arthroscopic repair of mechanical damage to the cartilage and ligaments of the knee joint cavity for patients who have MRI confirmation of injury and where the specialist opinion that the benefits of the procedure outweigh the risk of harm.
4.2	The Commissioning Organisation considers that endoscopic procedures on the knee joint cavity are not effective in the following circumstances: • Arthroscopic washout or debridement of an osteoarthritic knee in the absence of mechanical locking • To determine the diagnosis of knee symptoms in the absence of a prior MRI scan, except where an MRI scan is contraindicated. • Endoscopic plica resection for the second line treatment of patients with plica syndrome in whom conservative management has failed. • Autologous chondrocyte implantation for the treatment of knee problems caused by damaged articular cartilage except in the context of ongoing or new clinical studies that are designed to generate robust and relevant outcome data, including the measurement of health related quality of life and long-term follow-up (Ref 3). • Micro fracture for the management of articular cartilage lesions.
5	**Cost Effectiveness**

5.1	The Commissioning Organisation considers that endoscopic procedures on the knee joint cavity are cost effective in 4.1 above.
5.2	The commissioning organisation considers that endoscopic procedures on the knee joint cavity are not cost effective in 4.2 above 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 Commissioning Organisation recognises that endoscopic procedures on the knee joint cavity satisfy the criteria within the 'Ethical' component of the *Statement of Principles.*
7	**Affordability**
7.1	The Commissioning Organisation recognises that this policy satisfies the criteria within the 'Affordability' component of the *Statement of Principles*.
8	**Policy**
8.1	The commissioning organisation commissions endoscopic procedures on the knee joint cavity in the following circumstances:
8.1.1	Where the patient has had an acute injury and an MRI scan reveals a potentially repairable meniscal tear
	OR
8.1.2	There is evidence of mechanical damage to the ligaments which need repair/reconstruction.
	OR
8.1.3	Where the patient has a locked knee (mechanical block to extension) if a bucket handle tear of the meniscus is present
	OR
8.1.4	There is a palpable loose body or a loose body seen on x-ray which is considered to be causing symptoms of pain and disability.
	OR
8.1.5	There is evidence of haemarthrosis or osteochondral injury on x-ray.
	OR
8.1.6	Where the MRI scan is inconclusive or contraindicated, it will be for the specialist to make a clinical judgement on whether an arthroscopy is required, based on the patients' history and findings.
	AND
8.1.7	The documented specialist clinical opinion is that the benefit of the procedure outweighs the risk of harm. This includes those patients for whom an MRI scan is contraindicated
8.2	The commissioning organisation does **not** commission endoscopic procedures on the knee joint cavity in the following circumstances:
8.2.1	Where the procedure is to undertake a washout or debridement of an osteoarthritic knee in the absence of mechanical locking
8.2.2	Where the procedure is undertaken to treat chondral defects by re-establishing the articular surface of the knee joint e.g. autologous cartilage implantation, marrow stimulation techniques including abrasion arthroplasty, drilling and micro fracture and mosaicplasty/osteochondral transplantation
8.2.3	Endoscopic plica resection for the second line treatment of patients with plica syndrome in whom conservative management has failed.

8.2.4	To determine the diagnosis of knee symptoms in the absence of a prior MRI scan, except where an MRI scan is contraindicated.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
10	**Force**
10.1	This policy remains in force for a period of three years from the date of its adoption, or until it is superseded by a revised policy, whichever is sooner.
10.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
11	**References**
	1. NICE CG177 Osteoarthritis: care and management (2014). Last updated 11 December 2020, section 1.4.10 2. NICE IPG 230 Arthroscopic knee washout, with or without debridement (2007) 3. Evidence-Based Interventions. List 2 Guidance. Academy of Royal Colleges. November 2020. 4. Commissioning Guide: Painful osteoarthritis of the Knee. British Association of Knee Surgery (BASK) and British Orthopaedic Association (BOA). (2013)

Date of adoption:
Date for review:

	Appendix 1
1.1	**Codes** The codes applicable to this policy are:

OPCS codes	ICD codes
W821, W822, W823, W828, W829, W831, W848, W851, W858, W859, W861, W868, W869, W843, W852, W853, W879	M222, M234, M236, M239, M250, M939 M2351, M2352-M2354, M2357, M2359-M2364, M2367, M2369, M2381-M2384, M2387, M2389, M2391-M2394, M2397, M2399, S834, Q778-779, Q788-789,

Lancashire and South Cumbria Health and Care Partnership

Lancashire and South Cumbria Clinical Commissioning Groups (CCGS)

Policies for the Commissioning of Healthcare

Policy for Cystoscopy for Lower Urinary Tract Symptoms (LUTS) in Males Policy

Version Number:	Changes Made:
V0.1	Original (from Evidence Based Interventions)
V0.2	"Men" changed to males. OPCS Codes added.
V0.3	2.3c amended – the words "investigation of" were inserted before "lower urinary tract symptoms"

	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 commission cystoscopy in adult males when a thorough history and examination, complemented by assessments and contextual information such as smoking and occupational history, as detailed in Section 2.4, is undertaken and one or more of the following features are present:
	• Recurrent infection
	• Sterile pyuria
	• Haematuria
	• Profound symptoms
	• Pain
1.2	In addition, it may be reasonable to undertake flexible cystoscopy before undertaking some urological surgical interventions.
	OR
	Exceptionality has been demonstrated in accordance with Section 8 below.
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	Cystoscopy is a diagnostic procedure used to examine the lining of the bladder and urethra. Either a rigid or flexible endoscope may be used, under general or local anaesthesia, respectively. Rigid cystoscopy is undertaken when flexible cystoscopy offers insufficiently clear views, or when biopsy is indicated. Cystoscopy can cause temporary discomfort, occasionally pain and haematuria (blood in the urine) and is associated with a small risk of infection. In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example).
2.3	The CCG recognises that a patient may have certain features, such as

	a) having lower urinary tract symptoms; b) wishing to have a service provided for lower urinary tract symptoms; c) being advised that they are clinically suitable for investigation of lower urinary tract symptoms, and d) being distressed by lower urinary tract symptoms, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.4	Assessment of men with LUTS should focus initially on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and International Prostate Symptom Score where appropriate. This assessment may be initiated in primary care settings. Specialist assessment should also incorporate a measurement of flow rate and post void residual volume. Additional contextual information may also inform clinical decision-making around the use of cystoscopy in men with LUTS. Such factors might include, but not be limited to: — Smoking history — Travel or occupational history suggesting a high risk of malignancy — Previous surgery. Other adjunct investigations may become necessary in specific circumstances and are dealt with in NICE guideline CG97.
2.5	In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example). However, no evidence was discovered in preparing NICE guideline CG97 to suggest any benefit, in terms of outcome, related to performing cystoscopy in men with uncomplicated LUTS (i.e. LUTS with no clinical evidence of underlying bladder pathology). The consensus opinion of the NICE guideline development group therefore aligned with the position that unless likely to uncover other pathology, cystoscopy should not be performed in men presenting with LUTS. The European Association of Urology guideline on the management of nonneurogenic male LUTS summarises evidence demonstrating a lack of clear correlation between findings on cystoscopy and findings on investigations into bladder function (urodynamic assessment).
3	**Appropriate Healthcare**
3.1	The purpose of cystoscopy for lower urinary tract symptoms is normally to investigate those symptoms.
3.2	The CCG regards the achievement of this purpose as according with the Principle of Appropriateness. This policy does not rely on the principle of appropriateness. If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question when considering an application to provide funding.
4	**Effective Healthcare**
4.1	The policy criteria are based on the Principle of Effectiveness as outlined in the national Evidence-Based Interventions List 2 Guidance[1], NICE guidance CG 97[2] and the various studies as listed in the Section 10 (References).
5	**Cost Effectiveness**

5.1	The CCG considers that an intervention cannot be cost-effective if it not effective, and therefore this policy is also based on the Principle of Cost Effectiveness.
6	**Ethics**
6.1	The CCG does not call into question the ethics of cystoscopy for lower urinary tract symptoms and therefore this policy does not rely on the Principle of Ethics. 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 cystoscopy for lower urinary tract symptoms and therefore this policy does not rely on the Principle of Affordability. 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.
9	**Force**
9.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
9.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
10	**References**
	1.Evidence-Based Interventions List 2 Guidance. Academy of Medical Royal Colleges, published November 2020. https://www.aomrc.org.uk/wp-content/uploads/2020/12/EBI_list2_guidance_150321.pdf. 2.NICE clinical guideline 97. Lower urinary tract symptoms in men: Management. Last updated June 2015 https://www.nice.org.uk/guidance/cg97. 3. European Association of Urology guideline on the management of non-neurogenic male LUTS: https://uroweb.org/guideline/treatment-of-non-neurogenic-male-luts/. 4. Shoukry, I., et al. Role of uroflowmetry in the assessment of lower urinary tract obstruction in adult males. Br J Urol, 1975. 47: 559: https://pubmed.ncbi.nlm.nih.gov/1191927/ 5. Anikwe, R.M. Correlations between clinical findings and urinary flow rate in benign prostatic hypertrophy. Int Surg, 1976. 61: 39: https://pubmed.ncbi.nlm.nih.gov/61184/. 6. el Din, K.E., et al. The correlation between bladder outlet obstruction and lower urinary tract symptoms as measured by the international prostate symptom score. J Urol, 1996. 156: 1020: https://pubmed.ncbi.nlm.nih.gov/8583551/.

OPCS codes
M45.5, M45.8, M45.9 and not M45.1, M45.2, M45.3, M45.4 (biopsies or rigid cystoscope)

Date of adoption
Date for review

Lancashire and South Cumbria Clinical Commissioning Groups (CCGS)

Policies for the Commissioning of Healthcare

Policy for Surgical Intervention for Benign Prostatic Hyperplasia (BPH)

Document control: Surgical Intervention for Benign Prostatic Hyperplasia (BPH) **Policy**		
	Version Number:	**Changes Made:**
Version of: 08/04/2021	V0.1	

	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 commission surgical intervention for benign prostatic hyperplasia when the following conditions are met:
	• The man has been counselled thoroughly regarding alternatives to and outcomes from surgery with regard to physical, emotional, psychological and sexual health. If appropriate, carers should be involved,
	AND
	• Due consideration to the surgical modality to be used has been undertaken (see Section 2.2)
	AND
	• The man experiences severe voiding symptoms
	AND
	• Conservative management options and drug treatments have been unsuccessful
	OR (instead of c and d)
	• The man has complicated BPH with chronic urinary retention with renal impairment as evidenced by hydronephrosis and impaired Glomerular Filtration Rate (GFR)
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	The commonest and longest-standing surgical intervention for BPH is Transurethral resection of prostate (TURP). This involves removing some tissue from the prostate using cystoscopy. TURP is undertaken on an in-patient basis, with a catheter left in place for 24-48 hours post-op. It may be done under either general or spinal anaesthetic. TURP causes temporary discomfort, occasionally pain, haematuria and is associated with small risks of infection and acute urinary retention after removal of the catheter. There is also a risk of sexual dysfunction following TURP. There are small but significant risks of significant harm, including severe fluid and electrolyte imbalances associated with absorption of large volumes of irrigating fluid (TUR syndrome). Other surgical modalities include, among others: — Transurethral incision of the prostate (TUIP) or Bladder Neck Incision (BNI) — Holmium LASER enucleation of the prostate

	— 532 nm ('Greenlight') laser vaporisation of the prostate — UroLift — Transurethral needle ablation of the prostate (TUNA) — Transurethral vaporisation of the prostate (TUVP) — Transurethral water vapour therapy (Rezum). Open simple/benign prostatectomy is uncommonly undertaken in men with very large prostates and problematic symptoms. Newer ablative therapies are currently under evaluation and non-surgical procedures such as prostatic artery embolisation (PAE).
2.3	The CCG recognises that a patient may have certain features, such as e) having benign prostatic hyperplasia; f) wishing to have a service provided for benign prostatic hyperplasia. g) being advised that they are clinically suitable for surgical intervention for benign prostatic hyperplasia, and h) being distressed by having benign prostatic hyperplasia, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.4	NICE guidance CG97[1] provides clear evidence, in clinical and cost-effectiveness terms, that patients with urinary voiding symptoms presumed secondary to BPH, should be offered surgical intervention only when those symptoms are severe, or when conservative management options have been unsuccessful. TURP has long been the mainstay of surgical treatment for voiding LUTS presumed secondary to BPH. The newer surgical modalities outlined above in Section 2.2 have therefore been evaluated in comparison with TURP, as well as conservative management. NICE CG97 accordingly incorporated a comprehensive matrix of comparative studies between treatment modalities within its evidence review. This reflects increasing complexity in decision-making around surgical intervention, increasingly involving 'which', as well as 'when' or 'whether' surgery should be offered. This policy, which is in accord with the national Evidence-Based Interventions List 2 Guidance[2] reflects the full breadth of comparative studies between surgical intervention and conservative management, as well as between different modalities of surgical intervention forming the basis of NICE CG97.
3	**Appropriate Healthcare**
3.1	The purpose of surgical intervention for benign prostatic hyperplasia is normally to treat symptoms of "prostatism", principally difficulty voiding urine.
3.2	The CCG regards the achievement of this purpose as according with the Principle of Appropriateness. This policy does not rely on the principle of appropriateness. If a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question when considering an application to provide funding.
4	**Effective Healthcare**
4.1	The policy criteria are based on the Principle of Effectiveness as outlined in the national Evidence-Based Interventions List 2 Guidance[2], NICE guidance CG 97[1] and the various studies as listed in the Section 10 (References).
5	**Cost Effectiveness**
5.1	The CCG considers that an intervention cannot be cost-effective if it not effective, and therefore this policy is also based on the Principle of Cost Effectiveness.

6	**Ethics**
6.1	The CCG does not call into question the ethics of cystoscopy for lower urinary tract symptoms and therefore this policy does not rely on the Principle of Ethics. 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 cystoscopy for lower urinary tract symptoms and therefore this policy does not rely on the Principle of Affordability. 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.
9	**Force**
9.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
9.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
10	**References**
	1.NICE clinical guideline CG97. Lower urinary tract symptoms in men: Management. Last updated June 2015 https://www.nice.org.uk/guidance/cg97. 2.Evidence-Based Interventions List 2 Guidance. Academy of Medical Royal Colleges, published November 2020. https://www.aomrc.org.uk/wp-content/uploads/2020/12/EBI_list2_guidance_150321.pdf 3. NICE guidance UroLift for treating lower urinary tract symptoms of benign prostatic hyperplasia (Medical technologies guidance MTG 26): https://www.nice.org.uk/guidance/mtg26/ 4. European Association of Urology guideline on the management of non-neurogenic male LUTS: https://uroweb.org/guideline/treatment-of-non-neurogenic-male-luts/. 5. GIRFT Urology Report: https://www.gettingitrightfirsttime.co.uk/surgical-specialty/urology-surgery/

OPCS codes
M61.1, M61.2, M61.3, M61.4, M61.8, M61.9, M64.1, M65.2, M65.3, M65.4, M65.5, M65.8, M65.9, M66.1, M66.2, M68.1, M68.3 Diagnosis code: N40 Hyperplasia of prostate

Date of adoption:

Lancashire and South Cumbria Clinical Commissioning Groups (CCGS)

Policies for the Commissioning of Healthcare

Policy for Male Circumcision

Male Circumcision Policy		
Date:	**Version Number:**	**Changes Made:**
Proposed August 2021	1.3	JH proposal to add not routinely commission circumcision for physiological phimosis. Clarified that it was all age.
Reviewed July 2021	1.2	Changed word order of title. No change to content required.
Version of: December 2017	1.1	OPCS and ICD codes added to appendices
Version of: November 2017	1	Pan-Lancashire and South Cumbria ratified policy

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other polices in that suite.
1.2	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Scope and definitions**
2.1	Circumcision is a surgical procedure with a range of medical indications.
2.2	The scope of this policy relates to requests for Male Circumcision at all ages.

2.3	The scope of this policy does not include Female circumcision which has no medical indication and is prohibited in law by the Female Genital Mutilation Act 2003 (Ref 1) and is the subject of multi-agency guidelines from the Department of Health (Ref 2).
2.4	The CCG recognises that a patient may: • suffer from a condition for which male circumcision has been offered. • wish to have a service provided for their condition, • be advised that they are clinically suitable for the treatment, and • be distressed by their condition, and by the fact that that this service is not normally commissioned by this Commissioning Organisation. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.5	For the purpose of this policy the CCG defines male circumcision as the surgical procedure to remove of all or part of the foreskin of the penis.
3	**Appropriate Healthcare**
3.1	The CCG considers that the purpose of circumcision is to prevent, diagnose and treat a medical condition and therefore, accords with the Principle of Appropriateness.
4	**Effective Healthcare**

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

7.1	The CCG recognises that this service satisfies the criteria within the 'Affordability' component of the Principles for Commissioning Health and Health Care document.
8	**Policy**
8.1	The CCG will commission male circumcision when one or more of the following criteria are satisfied (Ref 4):
8.1.1	Congenital abnormalities with functional impairment
8.1.2	Distal scarring of the preputial orifice
8.1.3	Painful erections secondary to a tight foreskin
8.1.4	Recurrent bouts of infection (Balanitis / Balanoposthitis)
8.1.5	Redundant prepuce, pathological phimosis, and paraphimosis (inability to pull forward a retracted foreskin).
8.1.6	Lichen sclerosus (balanitis xerotica obliterans) -chronic inflammation leading to a rigid fibrous foreskin.
8.1.7	Pain on intercourse secondary to a tight foreskin (Phimosis)
8.1.8	Traumatic injury
8.1.9	Potentially malignant lesions of the prepuce, or those causing diagnostic uncertainty.
8.1.10	Exceptionality has been demonstrated in accordance with section 9 below.
8.2	The CCG will not commission male circumcision for non-therapeutic purposes such as cultural, religious or cosmetic reasons (Ref 5)
8.3	The CCG will not routinely commission circumcision for non-retraction of the foreskin (physiological phimosis) in children and up to 18 years of age, as retractility increases with maturity.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
10	**Force**
10.1	This policy remains in force until it is superseded by a revised policy.
11	**References**

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

Date of adoption:
Date for review:

OPCS Codes	N303 Circumcision Z412 Routine and ritual circumcision
ICD 10 Codes	Exclusions - if they have any of these in any position they are out of scope N47X Redundant prepuce, phimosis and paraphimosis, N480 Leukplakia of penis N481 Balanoposthitis L900 Lichen sclerosus, C600 Malignant neoplasm of the prepuce, L905 Scar conditions and fibrosis of skin, L910 Hypertrophic scar

Strategic Commissioning Committee

Date of meeting	**13 January 2022**
Title of paper	**CCG Closedown**
Presented by	**Denis Gizzi**
Author	**Helen Curtis/Stephanie Betts**
Agenda item	**8**
Confidential	**no**

Purpose of the paper
Reports on progress of CCG closedown against the programme plan is provided as a standing agenda item to the Transition Board. This paper gives the Strategic Commissioning Board oversight of the update to be presented to the Transition Board on 11 January 2022
Executive summary
Progress made in November and December 2021 is highlighted in the following areas: • Programme Plan - The Governance Leads Meeting continues to provide oversight of progress against the programme plan. In December, a detailed mapping exercise took place across the LSC CCGs in collaboration with subject matter experts to determine the steps that need to be taken to complete each milestone, along with indicative timescales for completion. This is in the process of being agreed via the LSC closedown executive leads for each sub section of the due diligence checklist. In the meantime, the CCGs are working collectively on milestones where it makes sense to do things once and are taking early action where possible. The reporting timetable for Q4 will be clarified in January following a review of timescales and reporting cycle once there is further clarification of what the delay means and any national recommendations as to how it is to be handled. The IT/IG subgroup have retained the group as one following previous discussions to split IT and IG into separate groups, as it was felt that there were benefits to being part of conversations on progress against programme plan actions that impacted IT and IG jointly. • MIAA Closedown Audit - Terms of Reference (TOR) have now been agreed and the audit criteria will take place during quarter three and through the transition via assurance spot checks against priority areas within the CCG/ICB Transition Programme Plan. • MIAA Audit Committee Event – An event will be held in conjunction with MIAA towards the end of January 2022. The focus will be on both the establishment of the ICB and the closedown of the CCGs. The event is aimed at the audit committee chairs and members who play a key role in their statutory body to ensure requirements are delivered appropriately. Key

attendees will be the 8 CCG Audit Committee Chairs and members, but will also include Chief Finance Officers, Governance Leads, representatives from External and Internal Audit and NHSEI. The content of the sessions will reflect latest guidance, updates and issues.

- Critical Path - The Critical path is attached for information at appendix 1

- Risk Register - The staffing capacity risk (R0055) has been reviewed across the LSC footprint with enhanced mitigations put in place. Due to the national level 4 position and Booster Vaccination Programme, it was agreed that the score be maintained at 16, with ongoing review and oversight. Attached at appendix 2

- Scenario Planning Exercise - Discussions took place in December regarding undertaking a scenario planning exercise to highlight risks and actions should there be a delay to the transfer date. The 2022 / 2023 NHS Planning Guidance published on 24 December 2021 outlined a change to the implementation date from 1 April 2022 to 1 July 2022. Further discussions need to take place at LSC level to determine next steps with this exercise.

- NHS Organisation Data Services Reconfiguration Toolkit - NHS Organisation Data Services (ODS) has released a reconfiguration toolkit, which details the changes and what CCGs and existing ICSs need to do to prepare for them to take effect. Additionally, the toolkit is for the purpose of reconfiguration of ODS codes, and any ODS associated activity required for the ICB transition Year 2022/23. It also provides information on ODS timescales. The IG/IT working subgroup are managing progress of the CCGs against the requirements of the reconfiguration toolkit

Recommendations

The Strategic Commissioning Committee is asked to note the content of this paper.

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			x	
Equality impact assessment completed			x	
Privacy impact assessment completed			x	
Financial impact assessment completed			x	

Associated risks			y	
Are associated risks detailed on the ICS Risk Register?			y	

Report authorised by:	Denis Gizzi

Lancashire and South Cumbria
Health and Care Partnership

CCG CLOSEDOWN UPDATE

1. Programme Plan

1.1 The Governance Leads Meeting continues to provide oversight of progress against the programme plan. In December, specialty leads acted as 'Subject Matter Experts' reviewing the overall programme plan detail in terms of what has been submitted, when it is due and by whom, and were asked to approve this detail in terms of appropriateness and consistency across Lancashire & South Cumbria CCGs.

1.2 The IG/IT subgroup have retained the group as one following previous discussions to split IT and IG into separate groups, as it was felt that there were benefits to being part of conversations on progress against programme plan actions that impacted IT and IG jointly. The group has representation across all 8 CCGs and MLCSU specialists. It is the specialist sub-groups that drive the granular detail of the plans.

1.3 The reporting timetable for Q4 will be clarified in January.

1.4 The Programme Plan has now also been updated to include any aspects of the Readiness to Operate timeline that are specifically referenced in the due diligence guidance.

1.5 In accordance with the reporting timeline, the latest version of the programme plan and subsequent exception report will be presented to the Transition Board for comment on 11 January 2022

2. MIAA CCG Closedown Audit

2.1 MIAA have been asked to support the Lancashire & South Cumbria system as part of the CCG closedown process, by providing further support through the undertaking of 'assurance spot checks' against priority areas within the CCG/ICB Transition Programme Plan. MIAA will provide assurance on the reported progress against specific actions in the CCG/ICB Transition Plan

2.2 The terms of reference for this review have been agreed and the audit will take place over Qtr 4 and through the transition. The 'assurance spot checks' will be across the eight CCGs in Lancashire and it will complement the work MIAA is conducting at the CCGs re: local transition arrangements/governance In particular MIAA will review the processes upon which the CCGs rely on for preparing and assessing the completeness of actions in the Transition Programme Plan and that they are appropriately designed and consistently applied to deliver the action objective.

2.3 We are working with MIAA to hold an event towards the end of January that will focus on the transition and closedown of the CCGs, with an importance put on ensuring that everyone is fully briefed and sighted on the expectations, not least the audit committee chairs and members who play a key role in their statutory body to ensure requirements are delivered appropriately. The proposal is to facilitate an engagement event, providing updates, share challenges and solutions. Key attendees will be the 8 CCG Audit Committee Chairs and members, but will also include Chief Finance

Officers, Governance Leads, representatives from External and Internal Audit and NHSEI. The content of the sessions will reflect latest guidance, updates and issues. It is envisaged that this would include transition and ICB and Place development, with a specific focus on CCG closedown, final accounts, financial framework, contracts, governance and decision making.

3. Critical Path and ICB timeline

3.1 The latest version of the Critical Path is attached at Appendix 1– no amends since the last Transition Board.

4. Risk Register

4.1 All 6 risks on the closedown risk register have been reviewed since the Transition Board last met and the updates were presented to the executive's group. This risk register is attached at appendix 2

4.2 The staffing capacity risk (R0055) has been reviewed during the month of December, with comments taken from across LSC CCGs to enhance mitigations in line with our local risk on capacity. Despite the enhanced mitigations, it was agreed at the Governance Leads Meeting in December that the risk score of 16 would be maintained due to level 4 national position and the Vaccination Booster Programme.

4.3 There have been no other changes in content or score to the other risks on the risk register to escalate to the Transition Board.

5. Scenario Planning Exercise

5.1 Ahead of the publication of the 2022/23 planning guidance, a letter to NHS leaders from NHS England and NHS Improvement received 29th December 2021 has set out that there will be a delay in the establishment of Integrated Care Boards (ICBs).

5.2 To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established, which replaces the previously stated target date of 1 April 2022. The establishment of ICBs, and timing for the process remains subject to the passage of the Health and Care Bill through Parliament

5.3 In order to prepare for any potential risks associated with a delay in the establishment of the ICBs, a scenario planning exercise is being considered to work through potential risks and mitigations. Further discussions need to take place at LSC level to determine next steps with this exercise.

6. Organisation Data Services (ODS) Reconfiguration Toolkit

6.1 Following the announcement of the forthcoming Integrated Care Systems (ICS), the Organisation Data Services (ODS) has been working with NHSE/I on the approach for reflecting ICS organisations within the ODS data.

From April 2022 the codes to identify STPs will be retained and the name changed to reflect their new status. It's expected that all CCG's will be statutorily abolished on the 1st April 2022 (now potentially July 2022), and from this point all statutory obligations will be managed by the ICB entities.

6.2 NHS Organisation Data Services (ODS) has released a reconfiguration toolkit, which details the changes and what CCGs and existing ICSs need to do to prepare for them to take effect. Additionally, the toolkit is for the purpose of reconfiguration of ODS codes, and any ODS associated activity required for the ICB transition Year 2022/23. It also provides information on ODS timescales. The IG/IT working subgroup are managing progress of the CCGs against the requirements of the reconfiguration toolkit.

6.1 The Strategic Commissioning Committee are asked to note the update outlined in this paper and appended documents.

Helen Curtis/Stephanie Betts
4 January 2022

Risk No	Risk or I	Category of Risk/Issue	Risk / Issue Description	Raised by	Date Adde	Risk Owner	Updates from	Impact: 1	Probabili	Risk Score	Mitigating actions	Residual	Residual F	Residual	Risk Open or	Date Updated
R0020	Risk	Commissioning Reform	Reluctance / difficulty in shifting to new ways of working RISKS duplication of effort, with activities being done multiple times (i.e. in each CCG) when could be done once	Vicki Ellarby	11/05/21	Andrew Bennett	Helen Curtis	3	3	9	Establishment of SCC and its sub committees has enabled a greater focus on work being undertaken across the 8 CCGs collectively rather than separately within each CCG The functions workstream will provide some mitigation as this is looking at all CCG functions and assessing what needs to be done prior to transfer to ensure when transition completes that the functions are up and running For the accelerator functions discussions are already taking place regarding what products can be delivered once across the system. Establishment of the executives group, governance leads group, and finance group for closedown provides some mitigating control. With regards to functions separate groups will not be established to manage these functions to closedown, instead closedown has been added as an additional remit to the existing functions group to prevent duplication of work and meetings. Programme plan for closedown in process of being finalised which will ensure consistency of completion of milestones and prevent duplication.	3	1	3	Open	09/09/21
R0021	Risk	Commissioning Reform	Future leadership structures from April 2022 onwards are uncertain, particularly for CCG Leaders below Board level which RISKS a reduction in their level of commitment to designing future ways of working associated with system development	Vicki Ellarby	11/05/21	Andrew Bennett	Helen Curtis	3	2	6	LSC currently working to a distributed leadership model which includes large number of CCG colleagues leading and/or participating in system level ways of working Establishment of the executives group, governance leads group, and finance group for closedown provides some mitigating control. HR framework was released last month which now provides better structure for staff planning. Lancashire and South Cumbria colleague briefing to take place this month further to the guidance being published. HRRG are working through all staff groups to identify actions needed.	3	1	3	Open	09/09/21
R0054	Risk	Commissioning Reform	There is a RISK that whilst the CCGs within NHS LSC focus on transition during 2021/22, that the quality and safety of services reduces due to the new structure not yet being fully established and the current structure beginning to disband.	Helen Curtis	23/08/21	Andrew Bennett	Helen Curtis	5	2	10	Chief Officer and Deputy Chief Officer NHS Chorley and South Ribble and NHS Greater Preston CCGs have been appointed to the roles of executive sponsor and executive programme director for closedown. □ All CCGs within NHS LSC have agreed to continue to run Quality and Safety Sub Committees until the new structure is fully established to ensure no reduction in reporting or oversight□ A Quality and Safety Committee for NHS LSC has been established, with terms of reference agreed, and membership from the Chairs of all respective CCG Quality and Safety Committees to provide a consistent link between system level development and CCG transition.□ Maintenance of Serious Incident Group in which all serious incidents are reviewed□ Access to NPSA portal where incidents are reported and serious incidents flagged to the CCGs□ Engagement meetings with the acute trusts and community providers to identify any improvements required□ Attendance at Lancashire Safeguarding Board and CSAP which identifies any themes and trends in relation to safeguarding incidents providing a source of intelligence around quality□ CQC are maintaining inspections and will provide feedback from their findings□ CCG incident command structures in place in which areas of pressure are discussed and actions agreed Organisational memory template is in place. As part of the due diligence process in relation to quality governance this will now be disseminated to all CCGs for completion and ongoing capture of legacy and live issues. Two nurses away days have taken place which have been exploring quality during transition. Director of Nursing and Quality is in place with objectives established for transition. Members report continues to be submitted to the Quality Surveillance groups.	5	1	5	Open & New	09/09/21
R0055	Risk	Commissioning Reform	There is a risk that due to the uncertainty of the staffing structure and working arrangements in the new NHS LSC system, that current CCG staff leave to secure alternative employment, leaving insufficient staff to manage CCG closedown and transition, and to undertake the new responsibilities of the new system, and resulting in a loss of system knowledge and expertise. This risk is also impacted by the demands on CCG staff increasing as the workforce is required to deliver against business as usual, strategy and planning, and closedown and transition (inclusive of place based modelling) during this transition phase. This may result in the ability to deliver against all of these CCG responsibilities and may also result in reduced resilience and wellbeing for CCG staff.	Helen Curtis	23/08/21	Andrew Bennett	Helen Curtis	4	4	16	Chief Officer and Deputy Chief Officer NHS Chorley and South Ribble and NHS Greater Preston CCGs have been appointed to the roles of executive sponsor and executive programme director for closedown. All CCGs have identified a closedown executive, and senior management leads/programme management lead who meet in working groups to share closedown workload and good practice to make the most effective use of capacity across LSC. □ All CCGs within LSC providing staff with regular communications on system development, and LSC-wide communications have been established to provide staff briefings across the system. Regular communications provided to staff via CCG and system newsletters and regular presentations by each executive team.□ LSC-wide Human Resources Reference Group established to manage the HR requirements of transition.□LSC-wide recruitment protocol in place to ensure consistent approach across the system to recruitment throughout transition. This protocol has been reviewed and changed to ensure that it continues to be fit for purpose in the developing context, and to support the need for appropriate levels of capacity and capability to be maintained in all functions. Secondment policy in place for all CCGs to ensure risk assessment and approval of line manager process before staff are seconded out of the CCG.□ LSC-wide Health and Wellbeing Group established to oversee staff well-being programmes and ensure that HWB resources are available to all staff, including national, system, and CCG well-being tools, networks and support, and a regular HWB survey to act as 'temperature check'. National OD support offered to those posts identified as not covered by the Employment Commitment.□ LSC-wide executives closedown group will monitor any issues with regards to sufficient workforce and reporting of staff leavers via ESR. Staffing capacity issues will be monitored via this risk which the executives group will receive at each meeting and report back to the Transition Board. Work regarding the consolidation of staffing capacity across LSC continuing as part of the transition to the new structure. Accelerator functions have been identified and are working LSC-wide. Other	4	4	16	Open & New	21/11/21
R0056	Risk	Commissioning Reform	There is a RISK that in the closedown of CCGs and the transition to the new NHS statutory integrated care body, some CCG functions may be incorrectly closed down or transferred resulting in a loss of functional expertise,	Helen Curtis	23/08/21	Andrew Bennett	Helen Curtis	4	2	8		4	1	4	Open & New	09/09/21
R0057	Risk	Commissioning Reform	There is a RISK that the closedown of CCGs and the transition to the new NHS body is not managed in line with national guidance resulting in an unsuccessful closedown, transfer and establishment process.	Helen Curtis	23/08/21	Andrew Bennett	Helen Curtis	4	2	8	The governance leads are utilising the future NHS collaboration platform so we have first sight of any guidance and tools as they are published. □ MIAA supporting the programme and linked in with developments in guidance nationally Governance structure in place for closedown to monitor delivery of the programme plan National guidance released August 2021 MIAA are working closely with Programme Director to finalise the programme pan in line with the milestones of the national guidance via populating the due diligence checklist. This is being done in conjunction with the ICB receiver lead in order that this avoids either duplication or gaps. MIAA have a weekly meeting in place with Programme Director to ensure all milestones remain on track. MIAA link for closedown to provide assurance that the implementation of the plan is being delivered in line with the national guidance	4	1	4	Open & New	09/09/21

Critical Path for CCG Closedown and ICB Establishment 2021/22

Key:

Blue border = CCG Closedown

Purple border = ICB Establishment

Green fill = Complete

Amber fill = Not yet complete

Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22
Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar

Monitoring of programme plan

Engagement within CCGs, between CCGs, between CCGs and Receiver

Develop the outline structure and close down plan, including a critical path showing key stage requirements, tasks and risks. Existing, well-grounded close down models will be employed in order for the programme to commence a due diligence process

All core functions expected to transfer from CCGs to NHS LSC will be categorised and risk assessed

Evidence collated & reported to Transition Board

Leadership of programe

Governance structure

Consider external assurance contracts required for notice e.g. internal audit, external audit and counter fraud

Draft a plan for how the Information Governance arrangements can be 'sent' to NHS LSC

Consider any legacy arrangements, e.g. claims which are not closed at the time of transition or lodged after transition

Develop a risk register for closedown

Secure external support (from MIAA) and establish formal groups to action the programme scope

The group will oversee that all key functions will comply with closedown assurance requirements and ensure they are compatible with the requirements of NHS LSC and the regulator.

Confirm that a high level due diligence plan in place (process, sign off, etc confirmed)

Complete and submit pre-delegation assessment framework assessments re how ICBs will receive delegated responsibilities for Dental (Primary, Secondary and Community), General Ophthalmic Services and Pharmaceutical Services to national team

Evidence collated & reported to Transition Board

Guidance released - map all products against this

Programme plan monitoring and exception reporting begins

Following appointment and discussion with the designate ICB Chair, CCG(s) to start to consult (i.e. engage) with 'appropriate' stakeholders to develop a draft constitution for the new ICB in line with the model ICB constitution (including standing orders).

Refresh SDP at Q2 2021/22, including clear implementation plans, and share with NHSEI

Assess progress against the Readiness to Operate Statement at Q2 2021/22 and share with NHSEI regional team

Due diligence processes started (if not before) - ie process and programme prepared

Commence ODS Reconfiguration Toolkit activities - ie take action in accordance with instructions from NHS Digital once new ODS codes and ODS Reconfiguration Toolkit received (precise timing dependent on NHS Digital work programme but the date is due to be confirmed by 31.10.21 and an indicative release date is mid-November for the ODS Reconfiguration

First stage of ICB constitution consultation (engagement) exercise in relation to size and composition of ICB Board closed

Second stage of ICB constitution consultation (engagement) exercise closes

CCG(s) to submit the revised constitution to their regional team for review, having completed their consultation (appropriate stakeholder engagement) process and having considered the feedback from this

Refresh SDP at Q3 2021/22 and share with NHSEI regional team

Assess progress against the Readiness to Operate Statement at Q3 2021/22 and share with NHSEI regional team (reviewed and moderated where necessary and submitted by regional teams to national team a week later)

Evidence collated by each CCG and stored in evidence files

Routine programme plan monitoring and exception reporting in place

Audit against evidence files

Confirm list of GP practices for each new ICB (check against list of practices held by NHSD)

Confirm LSOAs and ICB boundaries and ensure that reporting systems are ready to be updated from 1 April

Confirm ODS Reconfiguration toolkit activities on target

Confirm information governance preparations made / planned for the new ICB (eg Caldicott Guardian) and the information governance / Data Security and Protection Toolkit (DSPT) arrangements, notably records retention - as per DSPT checklist

Assess progress against the Readiness to Operate Statement and share with NHSEI regional team

Final sign-off of the list of GP practices and the list of sites (offices)

Written assurance from CCG AOs to ICB designate CEs that due diligence processes have been completed

Consider feedback from regional team and submit final draft ICB constitution (including standing orders) for final review by the regional team

System development plan (SDP) is in place indicating how the ICB will work with its partners in the ICP from April 2022 to meet the needs of the population, with a focus on reducing health inequalities

Ensure that the ICB Scheme of Reservation and Delegation (SoRD) is prepared

Ensure that ICB Standing Financial Instructions (SFIs) is prepared

Ensure that the ICB Governance Handbook (setting out the governance arrangements) is prepared

Ensure that ICB functions and decision map is prepared - including (where applicable) place boundaries, place-based leadership, and place-based governance arrangements (e.g. with Health and Wellbeing Boards); delegations (where appropriate); and any supra-ICB governance arrangements

Ensure that the standards of business conduct policy is prepared

Ensure that the conflicts of interest policy is prepared

Ensure that essential policies identified through risk assessment (eg commissioning [eg IVF commissioning], safeguarding, HR) and prepared

Document joint commissioning arrangements for 2022/23 (including joint committees with local authorities, trusts / foundation trusts, other ICBs

Ensure that provider partnership arrangements which will apply from 1 April 2022 are agreed in line with relevant guidance. These include provider collaboratives, primary care networks and other collaborative arrangements

Evidence collated by each CCG and stored in evidence files

All transition actions to be completed

Shadow forms begin

Ensure that governance and delivery arrangements for the people function are agreed and ready for operation as set out in line with relevant guidance, and workforce and organisational development priorities identified in the system development plan

Ensure that quality and safety systems and functions are ready to take effect from 1 April 2022, including implementation of System Quality Groups in line with the National Quality Board's guidance

Ensure that EPRR responsibilities are clear and systems and function ready to operate from 1 April 2022 in line with relevant guidance

Ensure that ICB public involvement and engagement strategy / policy is prepared in line with relevant guidance

Ensure that arrangements for system oversight in 2022/23 between the NHS England and NHS Improvement regional team and the ICB are prepared

Ensure that planning for 2022/23 has been carried out in line with relevant guidance

Ensure that there is evidence of compliance with the Public Sector Equalities Duty, and wider equalities duties, in the transfer and establishment process

Ensure that appropriate arrangements are made in relation to NHS Resolution schemes (Clinical Negligence Scheme for Trusts, Liabilities to Third Parties Scheme and the Property Expenses Scheme) to provide indemnity in line with NHS Resolution guidance (when available)

ICB's CE designate and NHSEI's RD approve the final Statement of Readiness for the ICB to confirm readiness to proceed and submit to the regional / national team

First ICB Board meeting diaried to able to note / approve (as appropriate): Constitution, governance handbook, appointments, key strategies, policies and delegation arrangements (covering both joint commissioning and formal delegations)

New ICB website and 'first day' arrangements and communications in place

Direct Commissioning Agreements for the new ICB signed by the CE of the ICB and returned to the co-commissioning team

Final constitution (including standing orders) and including any delegation agreements published

Final governance documents published

Confirm that all actions as required by the ODS Reconfiguration Toolkit have been delivered in full or are on target

Confirm that ready for operational closure of legacy CCG ODS codes – Exact due date to be confirmed

Strategic Commissioning Committee

Date of meeting	**13 January 2022**
Title of paper	**ICS Quality and Performance Report**
Presented by	**Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs** **Kathryn Lord, Director of Quality and Chief Nurse from Pennine Lancashire CCGs**
Author	**Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs** **Kathryn Lord, Director of Quality and Chief Nurse from Pennine Lancashire CCGs**
Agenda item	**9**
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. 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:	Kathryn Lord

ICS Quality and Performance Report

January 2022

1. Introduction

1.1. 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.

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

1.3. The Q&P sub committee 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

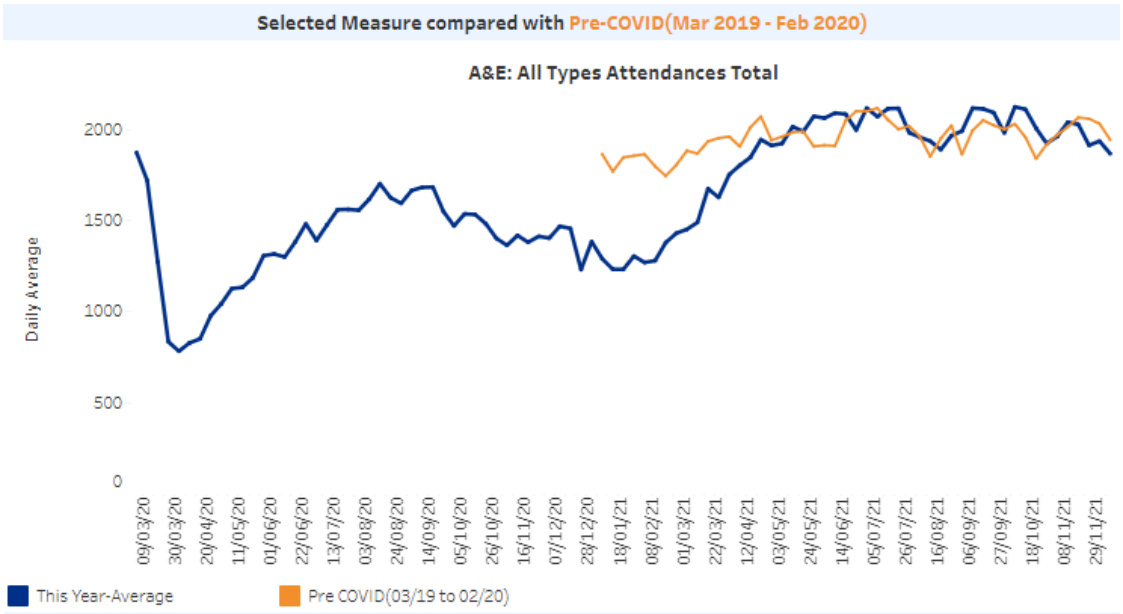
This month the report focuses on the following elements of Quality and Performance:

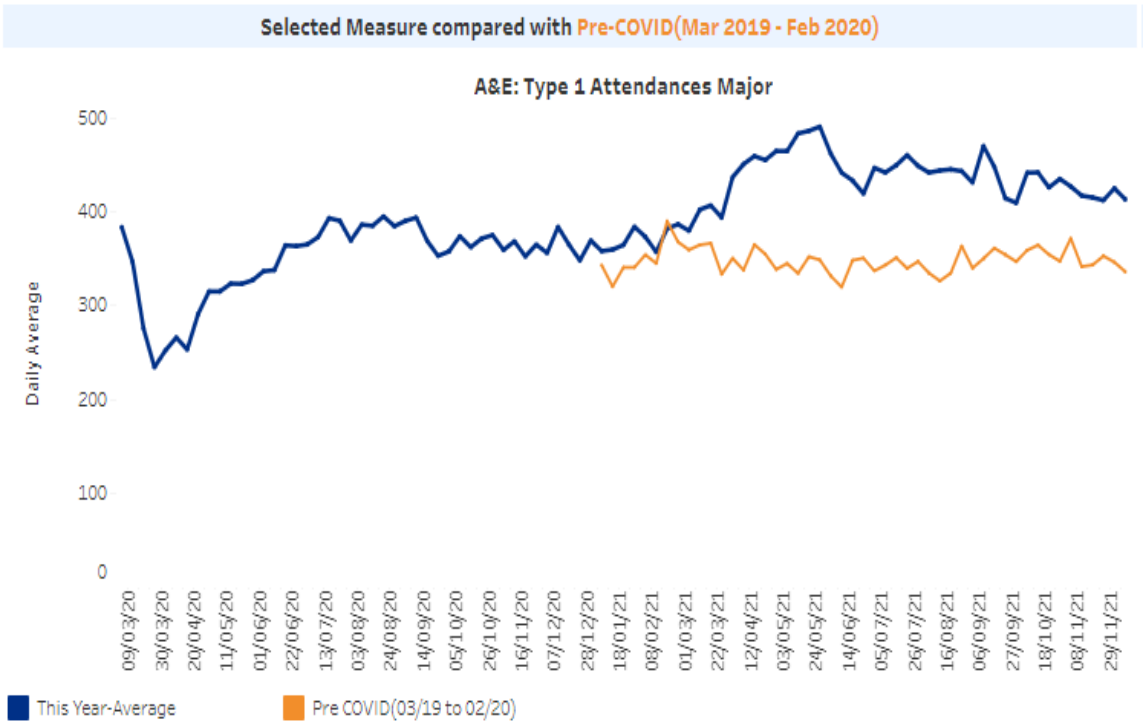
- Urgent Care
- Cancer Services
- Diagnostics
- Elective Care
- Nosocomial Infections
- Individual Patient Activity and Continuing Healthcare
- Safeguarding
- Mental Health
- Learning Disabilities and Autism
- Glossary
- Appendices
    - Appendix 1: Over 52 week waiters for L&SC CCGs split by Specialty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

3. Urgent Care

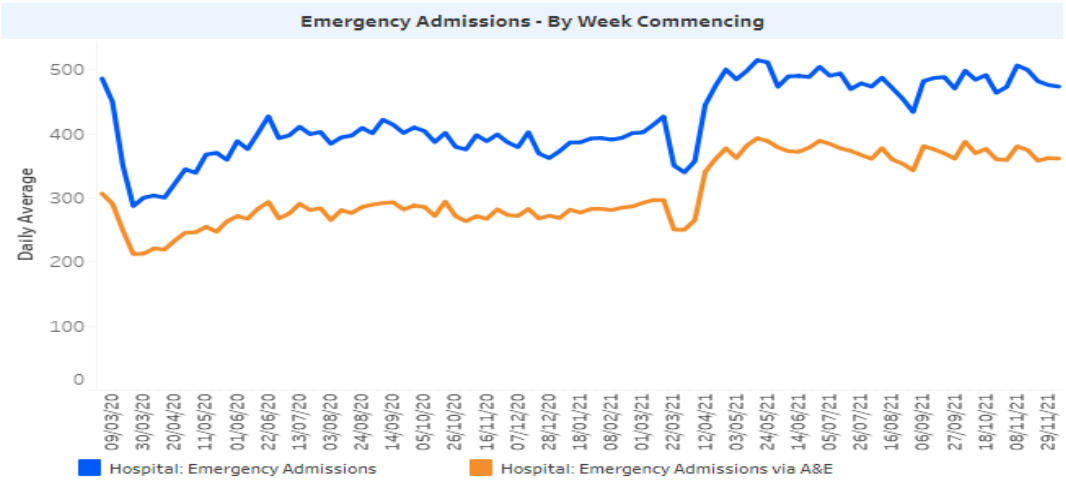
3.1. In November 2021 L&SC all type A&E performance was 74.7% compared to 71.7% in CM and 65.3% in GM against the national 95% standard. Cumulatively April to November 2021, L&SC performance is 78.7% compared to 75.2% for CM and 70.1% in GM. This is a further reduction in performance compared to the previous month.

3.2. As reported previously the 'all type' activity continues to be similar to pre-COVID levels. Type 1 activity remains slightly above pre-COVID levels however more patients are classified as requiring higher acuity care.



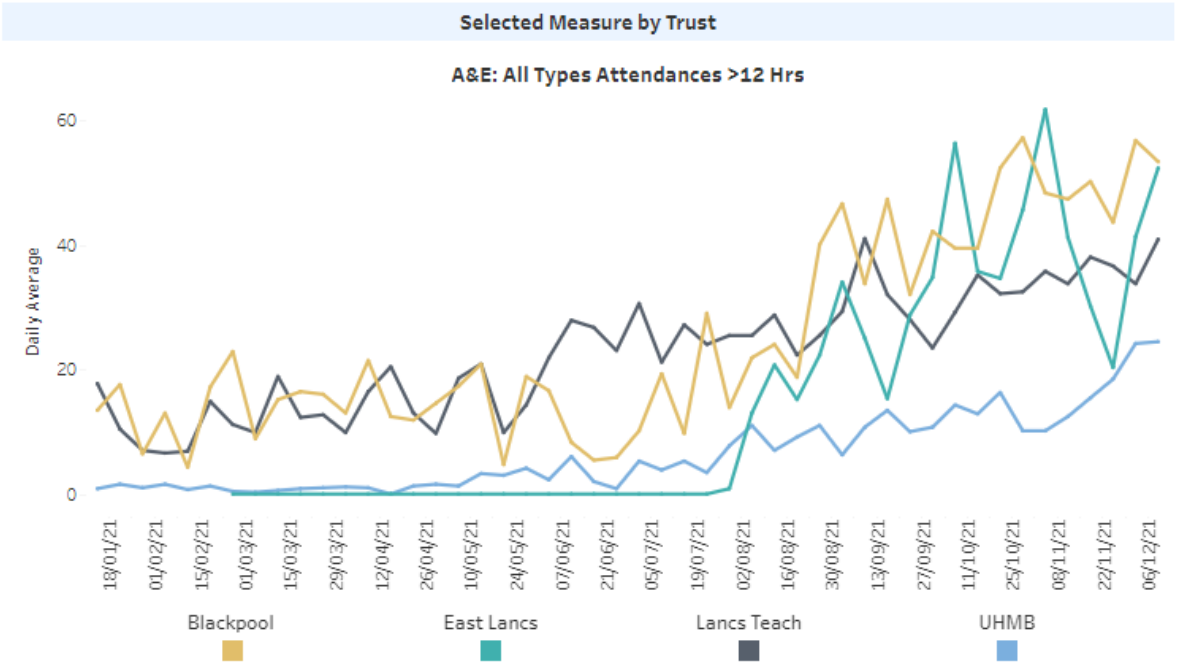


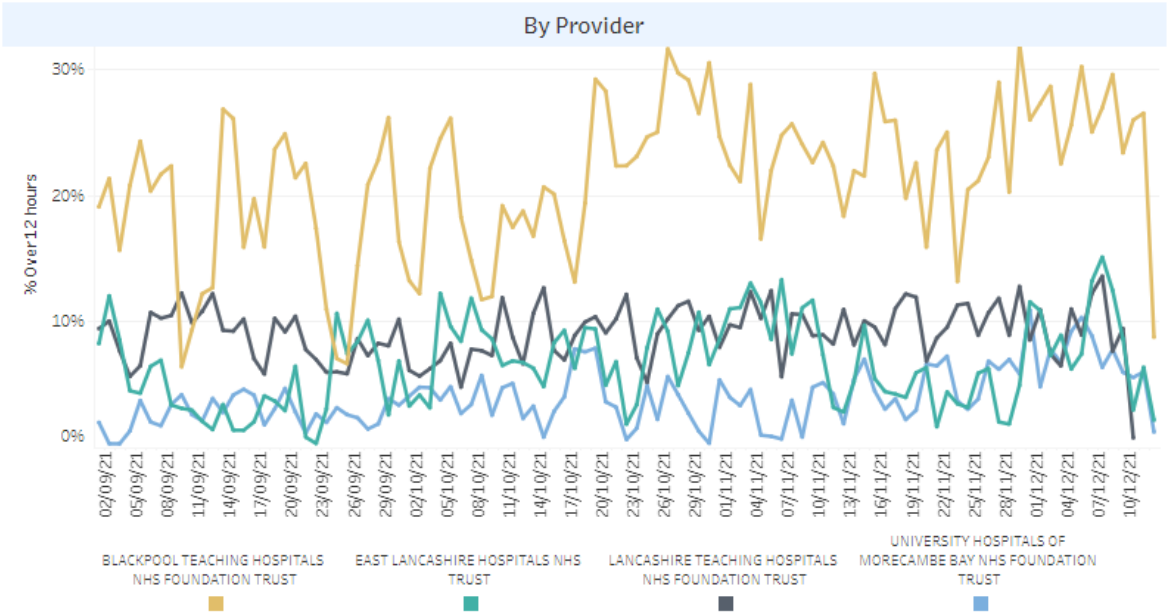
3.3. The most significant change in activity is that more people are now being admitted via ED into the hospital rather than through direct admission pathways such as GPs referring direct into a medical assessment unit.



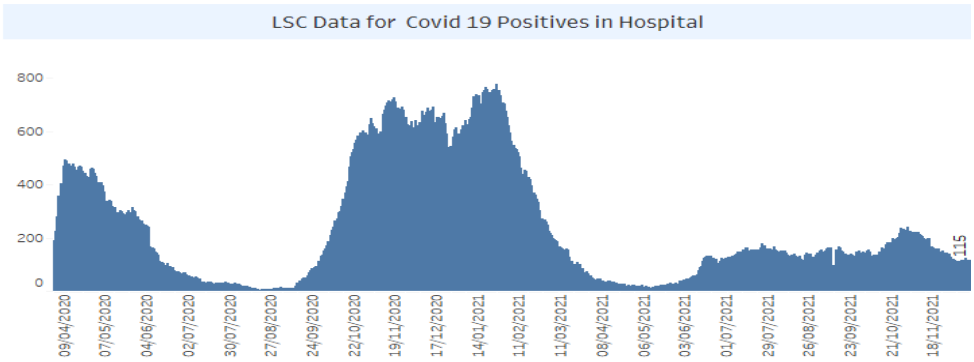
3.4. <u>12 hour waits</u>

3.4.1. The number pf patients waiting over 12 hours from attendance to ED for admission has continued to be high throughout November across the system with the highest number of waiters at the BVH and RBH sites. As a percentage of total activity BTH is an outlier in terms of the number of patients waiting over 12 hours in ED.





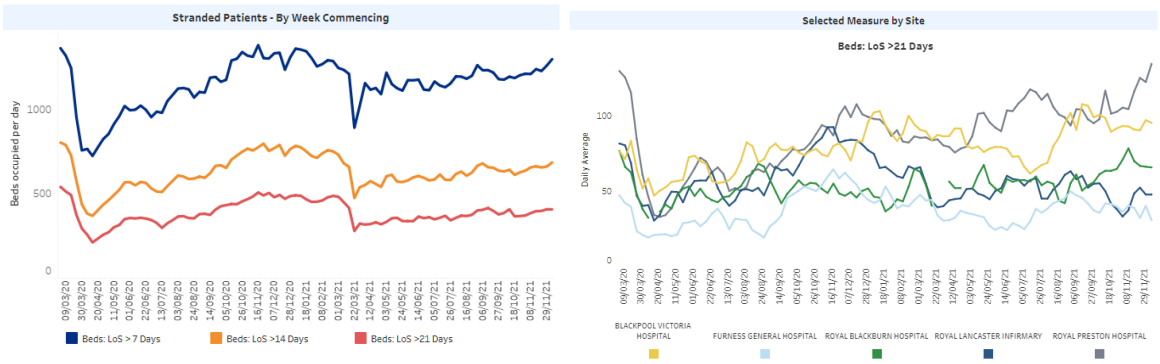
3.4.2. The main reason for long waits is availability of acute medical beds in hospitals. The timeliness of bed allocation is impacted on the staffing available to operate these beds safely and the need to cohort patients in COVID and non-COVID beds. A high number of patients are also in hospital beds that are medically fit for discharge but required further care support.



3.4.3. 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. There is a process in place where CCGs receive the details of long waits as they occur and seek assurance of care delivery, escalation processes and collaborative working between providers.

3.5. <u>Length of Stay</u>

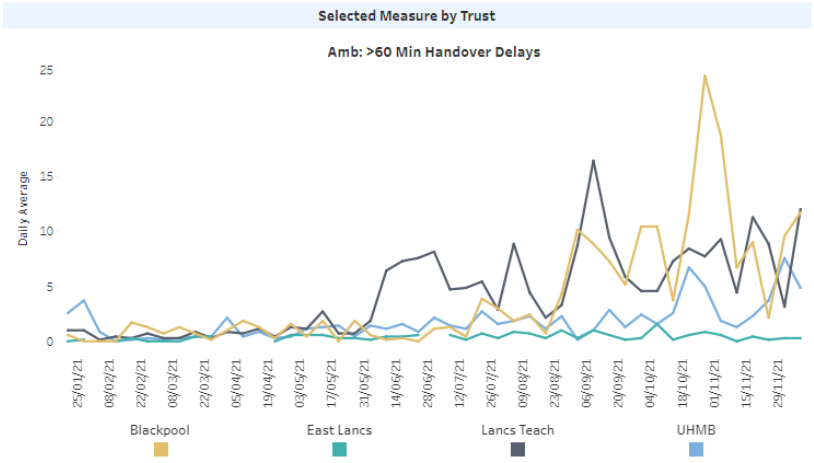
3.5.1. The below chart shows the number of patients within the 4 L&SC acute trusts with a length of stay greater than 7 days broken further into subsets of over 14, and 21 days LOS. These numbers include both those that medically need to be in our hospital beds and those who do not. There has been in increase in these metrics throughout November notably on the over 21 days metric on the BTHT and RPH sites.



3.5.2. Many of the patients in acute hospital bed that are medically fit are waiting to return home with formal support (pathway 1) or waiting for discharge to assess bed in a 24hr designated setting environment (pathway 2). On the 6th December 2021, 335 patients were in L&SC acute beds waiting a discharge pathway.

3.6. <u>Ambulance Delays</u>

3.6.1. During November 2021 60+ minute ambulance delays have continued with most delays at the BTHT and RPH sites.



3.6.2. The below 6-point plan has been developed by NWAS and Commissioners and agreed with NHSE/I to reduce ambulance handover delays and improve ambulance response performance.

Summary of the 6 Point Plan

System Actions

1. **Improvement in hospital handover** – to achieve and sustain target 30-minute turnaround time and eliminate extreme delays. Executive Lead – Lesley Neary, Chief Operating Officer, Southport & Ormskirk Hospitals
2. **Mental health** – ensure NWAS (111 & 999) timely access into mental health crisis services where an ambulance response and or conveyance is not needed as there is not an immediate physical threat to life. Executive Lead – Clare Duggan, North West Regional Director of Strategy and Transformation, NHS England/ Improvement
3. **Access into key pathways** – 111 & 999 clinicians' direct access into key pathways including SDEC, 2-hour community response services and Clinical Assessment Service. Executive Lead – Yvonne Rispin, North West Director of Ambulance Commissioning, Blackpool CCG

NWAS Actions

4. **Increase double crewed ambulance capacity** – introduction of 'blue light' trained drivers and additional clinicians. Executive Lead – Ged Blezard, Director of Operations, NWAS
5. **Increase non-conveyance** – maximum utilisation of hear & treat and see & treat. Executive Lead – Chris Grant, Executive Medical Director, NWAS
6. **Reduce 'lost' ambulance hours** – improve resource availability and utilisation. Executive Lead – Steve Hynes, Deputy Director of Operations, NWAS

3

3.7. Friends and Family Test (FFT)

For the month of October 2021, 78% of survey respondents reported a positive experience of using L&SC Type 1 and 3 UEC departments (England average of 75%), with 14% reporting a negative experience (England average 17%). RPH is an outlier with 59% reporting a positive experience and 32% a negative experience.

3.8. Level 4 National Incident

On the 13th December 2021 NHSE/I declared a Level 4 National Incident, in recognition of the impact on the NHS of both supporting the vital increase in the vaccination programme and preparing for a potentially significant increase in COVID-19 cases. The below actions directly relate to urgent care:

1. **Maximise capacity across acute and community settings, enabling the maximum number of people to be discharged safely and quickly and supporting people in their own homes.**
   The operational imperative is to create the maximum possible capacity within acute care settings to support patient safety in the urgent care pathway, which is currently under significant pressure as the data on ambulance response times and 12 hour waits in A&E shows.

2. **Support patient safety in urgent care pathways across all services and manage elective care.**
   In particular eliminating handover delays, prioritising 999 and 111 call handling capacity, provision of two-hour crisis response services.

3. **Support staff and maximise their availability.**
   The experience of the pandemic has shown, once more, that the NHS is nothing without its exceptional staff. NHS staff have been severely tested by the challenges of dealing with the pandemic and its of vital importance that we collectively support them over the months ahead.

4. **Ensure surge plans and processes are ready to be implemented if needed.**
   In light of the move to a Level 4 national incident a command-and-control structure has been stood up with the L&SC Hub supporting the daily system coordination. All systems and NHS organisations are reviewing and testing their incident management and surge plans to assess their number of beds (G&A, community and critical care), supplies and staffing, learning the lessons from previous waves of COVID-19, and making preparations to have the capacity in place to meet a potentially similar challenge this winter.

4. Cancer

4.1. Headlines

- L&SC remains the most restored system for referrals seen at 125% compared to England at 113%referrals seen
- Significant volume of referrals in breast, colorectal, head and neck and gynaecology – placing pressure on trusts
- Lung referrals have increased but are the least restored pathway
- Urology, primarily prostate, referrals have increased and have been in line with 2019 baseline most weeks
- Backlog of patients waiting over 62-days continues to reduce
- Progress continues to be made to stop the clocks of those patients diagnosed as non-cancer
- Significant staffing pressures because of winter pressures and COVID

- Reduction in cancellations at LTHT
- Diagnostic capacity is a major issue, particularly for Endoscopy, CT, and MRI
- Cancer screening programmes are not fully recovered, with issues within Bowel Screening

4.2. Constitutional Wait Times

- Constitutional wait times standards have not been consistently met across L&SC since 2018
- Current (October 2021) ranking against other Alliances

Standard	Cancer Alliance Ranking
2WW	10/21
Breast Symptomatic	16/21
FDS	16/21
1st Treatment	14/21
62 Day referral to treatment	15/21

- 14 Day performance has deteriorated recently due to pressures in breast and skin
- Lower GI, Gynaecology and skin are the main drivers for our 31-day first treatment performance with a mixture of volume and theatre constraints driving longer waits for treatments - pressure is within surgery not chemo- or radiotherapy
- Pressures within Gynaecology, head and neck, lower and upper GI and urology contributing to our 62-day performance. The improvement in our national rank is because of performance in other areas deteriorating over the last few reporting periods. Our performance has remained consistent

4.3. Performance October 2021

4.3.1. The table below compares L&SC's performance against North West Alliances and the England for October 2021. This includes monitoring against the faster diagnosis standard.

	Urgent suspected cancer	Breast symptomatic	Faster Diagnosis Standard	1s treatment	Subsequent surgery	Subsequent drugs	Subsequent radiotherapy	Urgent GP suspected cancer	Urgent Screening	Consultant upgrade
BTH	88.2%	90.2%	66.9%	98.2%	96.7%	100.0%		70.9%	9.1%	71.4%
ELHT	83.4%	67.5%	71.5%	93.2%	86.8%	100.0%	100.0%	72.2%	83.9%	89.5%
LTH	79.4%	21.3%	77.0%	91.4%	86.4%	100.0%	93.5%	66.6%	50.0%	81.9%
UHMB	82.0%	55.0%	76.3%	93.0%	81.1%	100.0%		51.6%	50.0%	83.0%
LSC	82.6%	60.7%	73.0%	93.4%	86.3%	97.7%	98.0%	65.6%	62.7%	81.8%
NW	82.8%	58.8%	71.1%	94.7%	91.2%	99.2%	99.4%	68.3%	70.5%	77.0%
England	81.3%	67.6%	73.5%	93.5%	85.7%	99.1%	95.5%	67.8%	73.2%	76.2%
Standard	**93.0%**	**93.0%**	**75.0%**	**96.0%**	**94.0%**	**98.0%**	**94.0%**	**85.0%**	**90.0%**	**n/a**

4.3.2. The table above shows that in October 2021 L&SC ICS performance against the cancer waiting times targets has been challenging. Although the Cancer waiting times standards remain NHS constitutional targets, and will continue to be monitored monthly, our focus is on reducing the backlog of patients which will have an adverse impact on performance.

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

CCG	2 weeks 93% standard	2 week breast 93% standard	31 day 96% standard	62 day 85% standard
BwD	82.39%	67.39%	91.94%	73.73%
Blackpool	87.73%	90.79%	96.74%	57.69%
CSR	78.49%	14.81%	93.81%	79.31%
EL	83.45%	66.17%	94.59%	69.23%
FW	87.04%	79.63%	94.23%	75.44%
GP	81.26%	26.56%	95.79%	68.66%
MB	81.78%	58.44%	89.47%	50.00%
WL	77.36%	75.00%	91.30%	53.66%
CA CCGs	82.62%	60.74%	93.38%	65.59%

4.3.4. October 2021 is the first reporting period of the Faster Diagnosis Standard which is now a constitutional target and the only one to form part of the 2021-22 plan. The Trusts and Alliance have established a FDS group to manage performance improvement. Performance is challenging in Gynae, Lung, Lower and Upper GI, Prostate, and Head and Neck

4.3.5. There are several challenges that are impacting upon performance across all trusts. The volume of referrals for key specialties in having a negative impact on ability to see patients in a timely fashion, as evidenced in the deteriorating 14-day position related to two main specialties, lower GI, and Breast. Evidence demonstrates that delays at the beginning of the pathway increase a patient's likelihood of breaching 62-days.

4.3.6. Endoscopy capacity and the high demand in the lower GI pathway contribute to a larger proportion of all breaches of the 62-day standard. Referrals for lower GI have been double those seen in 2019. Surgical pressures at LTHT, our largest surgical provider, and Oncology workforce pressures are extending pathway length for patients. Non-elective demand across the whole region is also impacting trusts' ability to undertake elective activity. Whilst all trusts have ring-fenced cancer treatment, the alliance continue to monitor the situation via weekly escalation meetings. Mutual aid across the region is significantly challenging as all systems are under pressure.

4.3.7. L&SC Cancer Alliance are ranked 1st out of the 21 Cancer Alliances in England in terms of restoration of urgent cancer referral numbers seeing an additional 944 referrals in October 2021 vs October 2019. 441 of those additional referrals seen are in suspected Lower GI alone.

4.3.8. Restoration of treatments is 92%. The "gap" in treatments vs October 2019 is from screening (81%) and other sources (82%). Treatments against urgent suspected cancer referrals are 102%.

4.3.9. Restoration of first treatments by modality for October 2021 vs October 2019 are Chemotherapy (87%), Radiotherapy (86%) and surgery (83%). To note, this is overall treatments not just those from 2WW referrals.

4.3.10. 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	112%	100%
ELHT	115%	91%
LTH	101%	87%
UHMB	132%	67%
CA	125%	92%

4.4. Cancer Wait Time Improvement Plan

- Pathway improvement work within most challenged pathways building in RDC principles in gynaecology, prostate, upper and lower GI, sarcoma, non-specific symptoms, lung, and breast. These will continue into 2022-23 year
- Focussed work on non-cancer patients remain
- Demand and capacity training delivered by IST
- Pathway analyser tool training delivered, and a programme of pathway analysis will commence in January 2022
- Investment in additional trackers and navigators across all trusts
- Investment in new workforce models for pathway reviews in prostate, GIs NSS
- Implementing a new breast pain pathway across the system including additional roles to support front-end capacity in suspected breast cancer services
- External review of endoscopy booking and listing processes
- Successful regional bid for hub and spoke endoscopy academy status, £700k to deliver training and development in collaboration with GM and C&M systems
- 60 individual projects underway within cancer services
- FIT project underway to look at GP uptake of FIT for all lower GI referrals and developing processes and procedures for utilising FIT results to design alternative pathways for cohorts of patients
- Significant endoscopy transformation programme
- Shortlisted for SBRI innovation funding for Cytosponge primary care bid, would support reduced pressure on endoscopy services
- CCE Training bid as part of the CDC year 2 plans – to allow CCE to be rolled out in readiness for next year's programme
- Pinpoint – L&SC to participate in pinpoint trial from January onwards as part of SBRI innovation funding

4.5. Key Risks and Issues

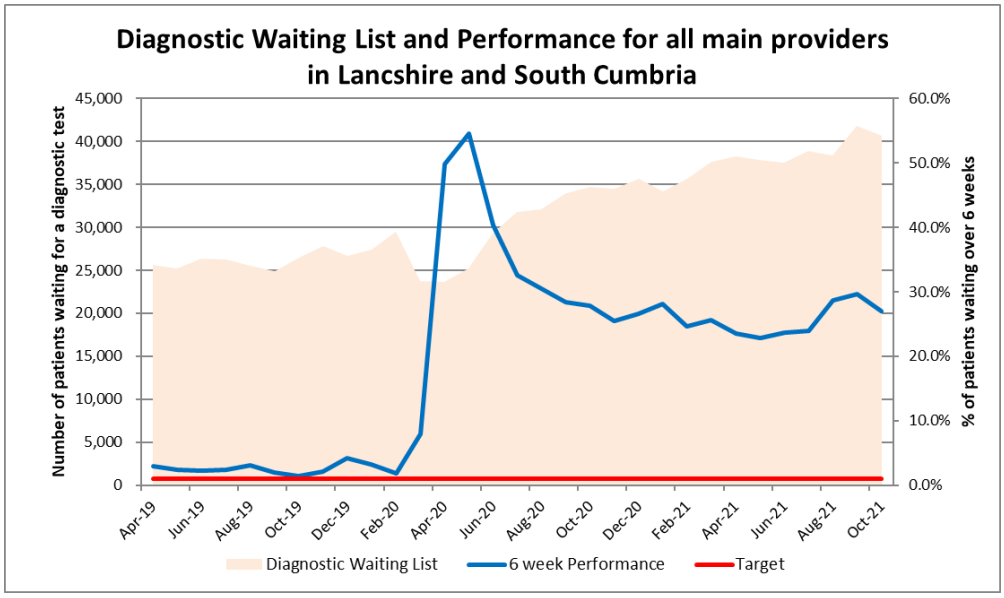
Issue	Description	Mitigation
Ongoing COVID related pressures leading to reduced capacity to deliver fully restored services	Current bed occupation and COVID cases in hospital impacting on elective programme with some isolated cases of cancer surgery being cancelled	Weekly oversight of Cancer Surgery 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 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

Issue	Description	Mitigation
Lack of diagnostic capacity	LSC has lower ratio of diagnostic capacity compared to other NW regions for key imaging and endoscopy modalities	Working with Diagnostics programme re: roll out of CDHs, and large investment in endoscopy workforce schemes. Capital bid successful for endoscopy during 2020- £6.9m
EUS provision	Insufficient capacity for EUS across the system	Short- and medium-term plan in place with provider Mutual aid being sought from two other NW systems

5. Diagnostics

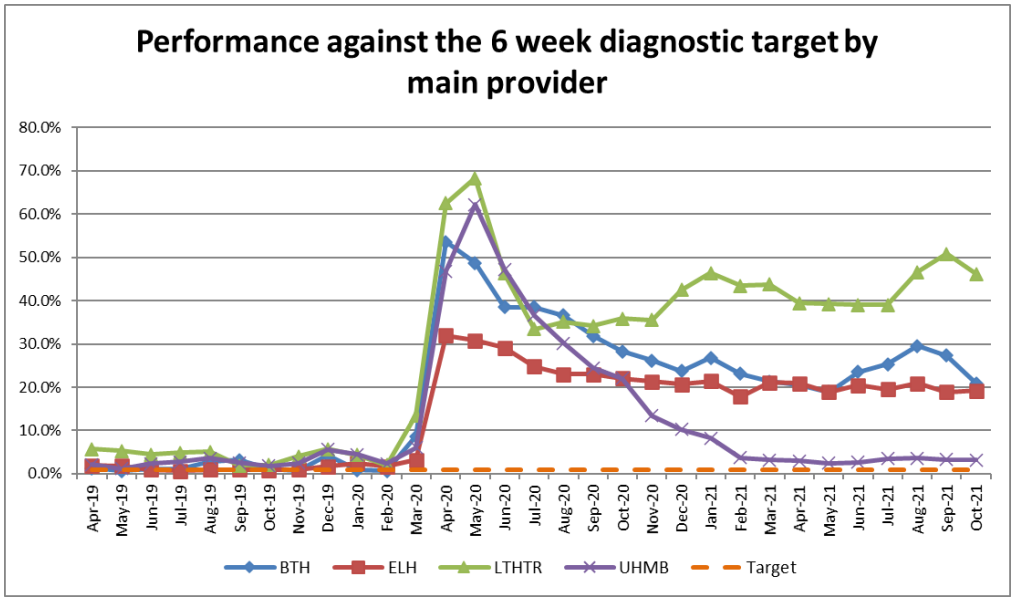
5.1. Overview of Diagnostic Performance

There has been a fall in the number of patients waiting for a diagnostic test in October 2021 from the September 2021 position, mainly driven by a fall in the list at LTHT and UHMB. This fall in the number of patients waiting has also resulted in an improvement in the overall performance against diagnostic indicator in L&SC.



5.2. Overview of Performance at Provider Level

The information at provider level shows improving performance for LTHT and a significant improvement at BTHT. The performance at ELHT remains flat albeit from a lower base, whereas UHMB continue their strong performance.



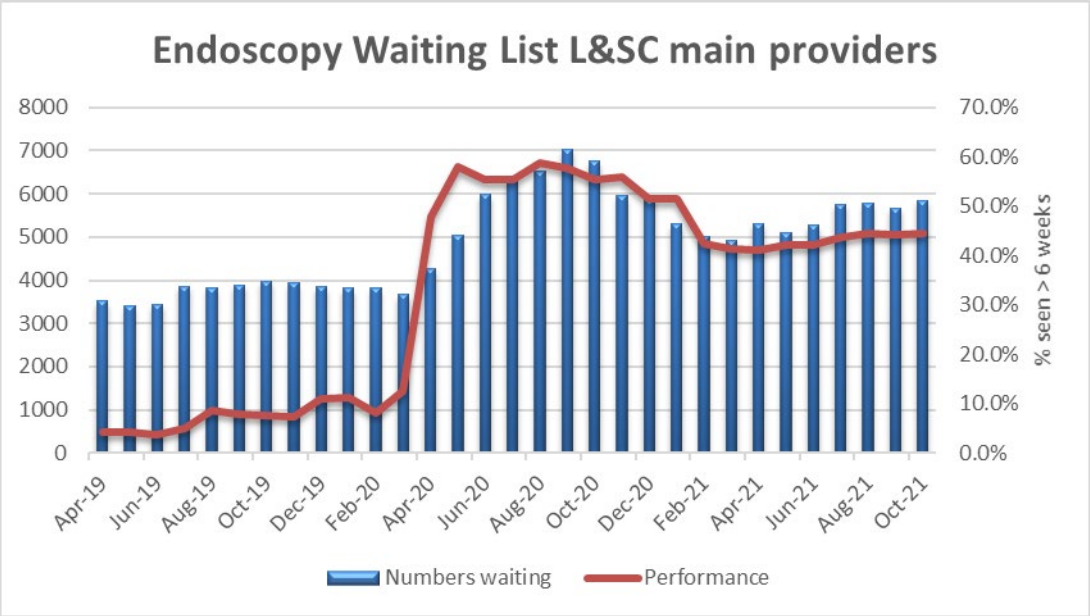
5.3. Performance at Procedure Level

The split for Endoscopy and Non Endoscopy shows improvements across all providers, particularly in BTHT and to a lesser extent with LTHT. The overall performance at UHMB continues to be strong across both Endoscopy and Non Endoscopy diagnostics. There is only Endoscopy performance at ELHT which has worsened on the previous month.

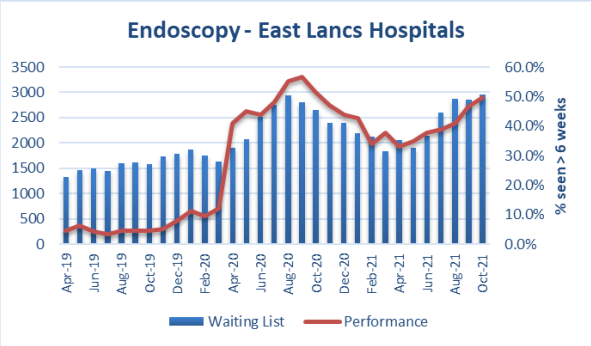
	% of patients waiting over 6 weeks (Oct 21)		
Provider	Endoscopy	Non Endoscopy	All Diagnostic Tests
BTHT	42% ↓	12% ↓	21% ↓
ELHT	50% ↑	11% ↓	19% ↔
LTHT	57% ↓	45% ↓	46% ↓
UHMB	2% ↔	3% ↔	3% ↔

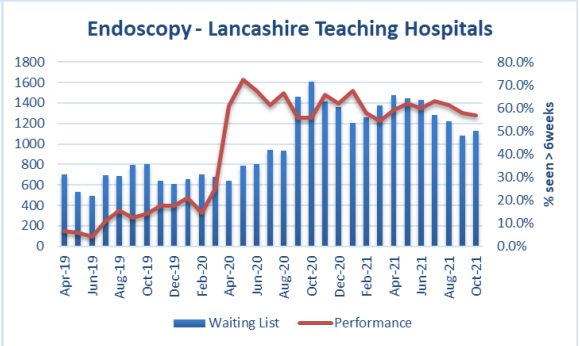
5.4. Endoscopy

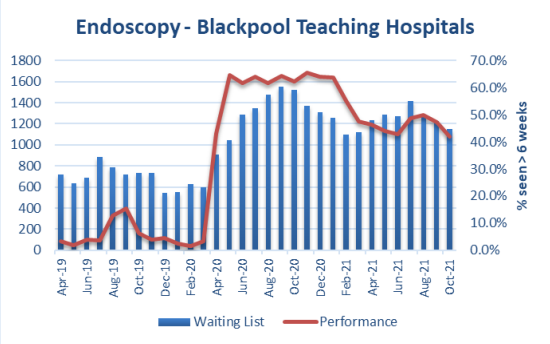
5.4.1. There has been an increase in the number of people on a waiting list for Endoscopy in October 2021 from the previous month. Performance against for diagnostics in Endoscopy has remained flat on the previous month. There are differences between the providers performance on Endoscopy, with UHMB continuing to have strong performance, LTHT has improved in the month but still has the worst performance across the main acute providers, BTHT have improved significantly in the month and ELHT has worsened in the month.

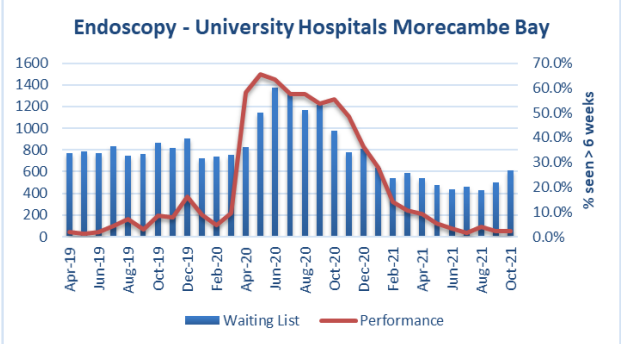


5.4.2. The information by providers highlights the issues with Endoscopy, with all but BTHT showing an increase in the number of patients waiting for a diagnostic endoscopy. There is a worsening trend in performance at ELHT from April 2021 which has continued in October 2021. The performance at LTHT has been consistently over target and has been around 60% for the past 6 months. The performance at BTHT is continuing on an improved trend since June 2021 which has correlated with falling waiting lists, UHMB continues with strong performance, although there is a rising trend in the waiting list.

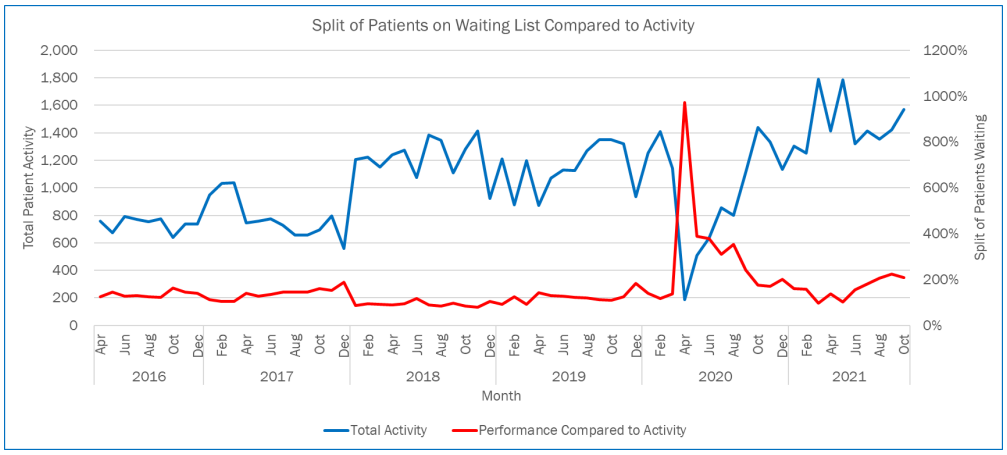








5.4.3. The activity for ELHT in Endoscopy shows that it is above pre pandemic levels, however with rising waiting lists, there is an assumption that demand for diagnostic endoscopy services in ELHT has increased significantly.

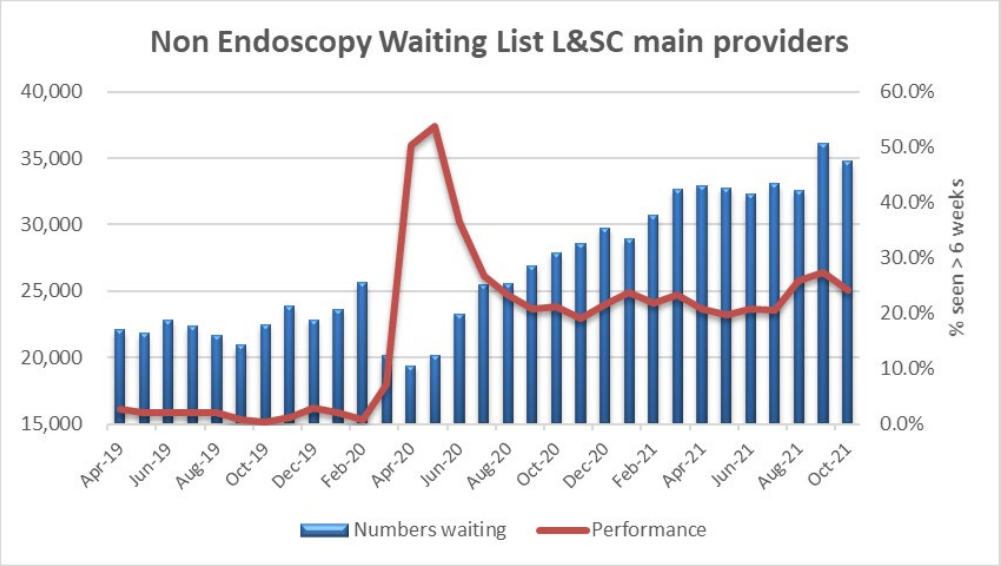


5.4.4. The L&SC Endoscopy Transformation Programme continues to work on several key areas to increase capacity and increase efficiency within endoscopy. These key areas of include:

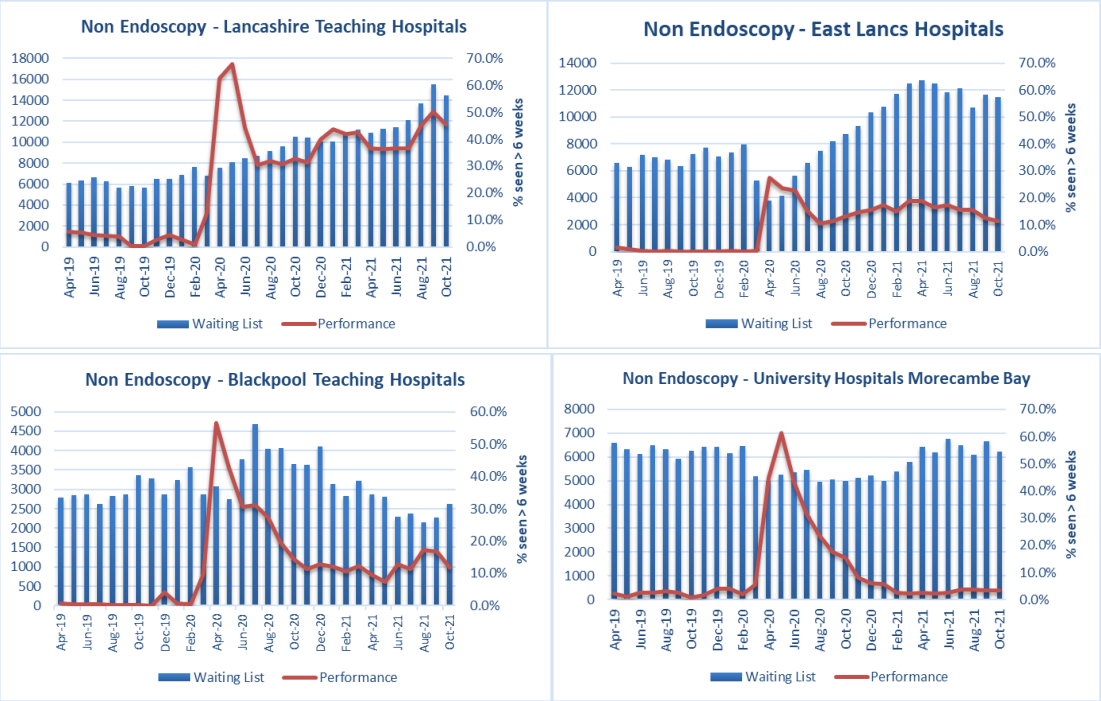
- Substantial monies for the NW Endoscopy Academy, co-ordinated through a hub and spoke model. Training for all aspect of Endoscopy including for Nurses and Clinical and Medical Endoscopists. UHMB are co-ordinating training for nurses, endoscopists training venues now being mobilised in Blackburn, Blackpool and Chorley. Major set up and impact is likely to be in 2022/23.
- Innovations – Bid for Cytosponge delivery in Community Diagnostic Centres and Primary care Hubs. A NHSE stage II pilot for Cytosponge at LTHT as well as a NHSE pilot for Colon Capsule Endoscopy and bowel distribution through community pharmacy. CDC are now open with activity mainly in MRI scans and Non Obstetric Ultrasound. From January 2022 there is extra capacity in CT scanning too. Year 2 funding and planning is to be developed.
- L&SC is unique in using double FIT testing across all trusts.
- Increasing capacity through 4th room at Burnley, improving the recovery areas at Blackpool Chorley and Preston and improving patient flow at Lancaster. The addition of Cytosponge and Colon Capsule Endoscopy into community diagnostic centre, subject to funding.
- Additional monies for Bowel Cancer Screening for uplift in activity to insource at LTHT. Impact is likely to start in quarter 4 of 2021/22.

5.5. Non Endoscopy

5.5.1. The data for October 2021 shows a significant fall in the Non Endoscopy waiting list plus an improvement in performance from the previous month.



5.5.2. The improvement in performance is seen across all providers within L&SC. As predicted there has been an improvement in LTHT with a fall in their waiting list, despite significant numbers on the list at ELHT their performance continues to improve. Performance at BTHT has improved significantly in the month despite an increasing waiting list and performance at UHMB continues to be strong.



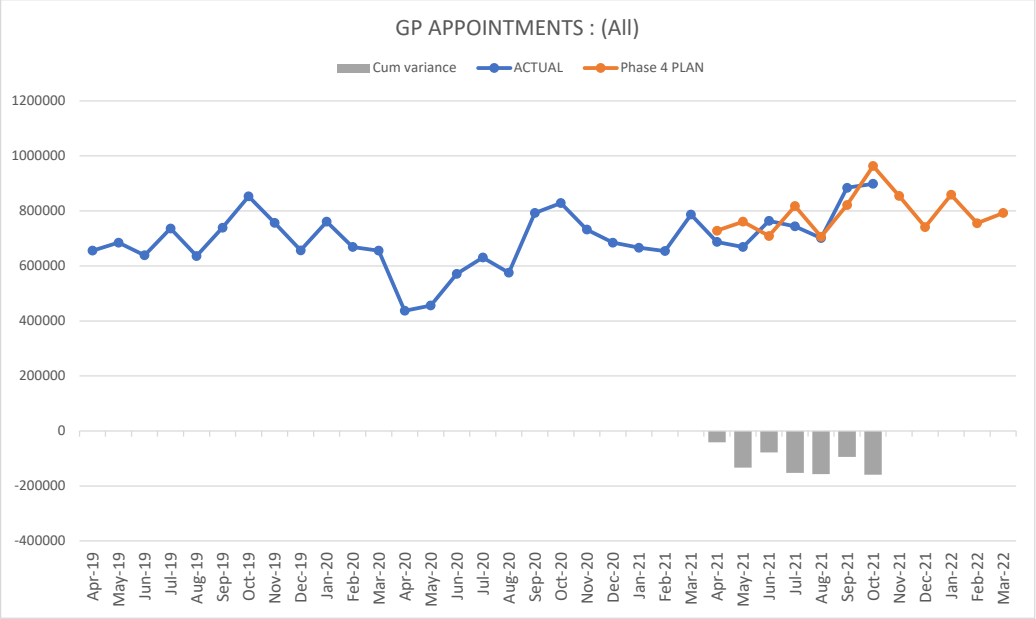
5.5.3. Across the ICS for all providers the activity data suggests that performance will remain stable or improve slightly in November 2021. There is variation between providers which will affect their individual performance and waiting list level. The Community Diagnostic Centres continue to provide extra capacity for non endoscopic procedures which will ease pressure on performance.

6. Elective Care

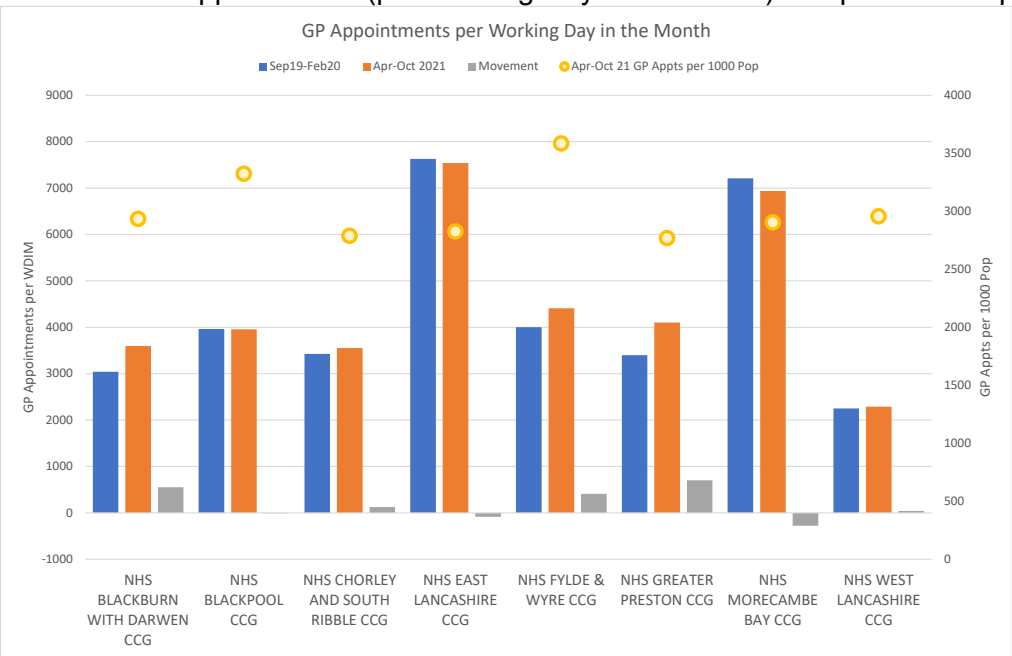
6.1. Demand

6.1.1. Appointment demand and activity per working day in the month within GP practices has returned to levels seen in the September 2019 – February 2020 (pre-COVID) period (Chart 1) with October 2021 having the most appointments available (per working day in the month) in the last 31 months. However, there are variations underneath this at CCG level with both BwD CCG and GP CCG seeing clear increases in GP appointments reported per working day in the month compared to pre-pandemic levels (in excess of 10% higher). When the number of GP appointments per 1000 population is reviewed then practices within the Fylde Coast ICP offer the greatest number of appointments per 1000 population.
[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 / H2 (provisional) plan



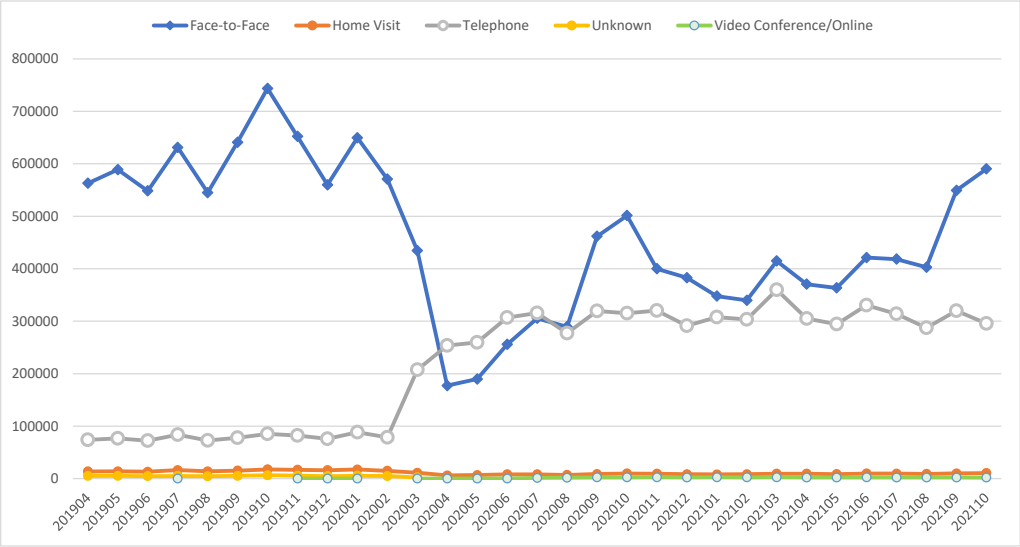
6.1.3. Chart 2 – GP Appointments (per Working Day in the Month) and per 1000 Population



6.1.4. The 'type' of appointment has changed during the pandemic with reductions in face-to-face appointments and increases in telephone and video appointments. However, face to face appointment numbers have started to increase from September 2021 while telephone appointments have been maintained therefore contributing to the overall increase in appointment numbers.

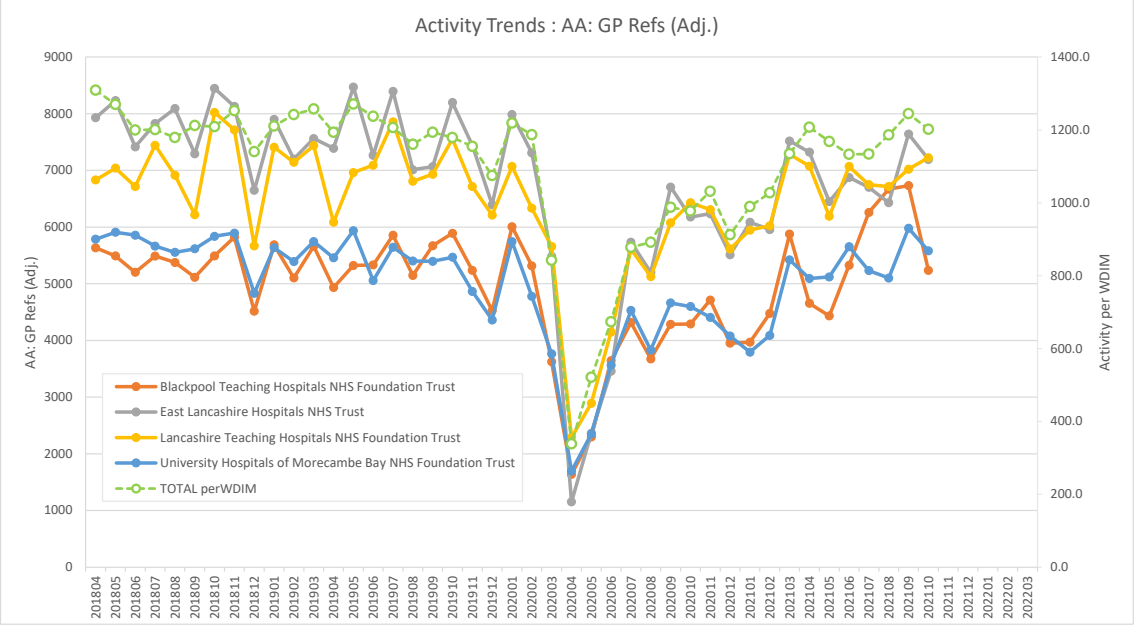
Period	% Face to Face Appointments	% Telephone Appointments
April-Oct 2019	86.2%	11.0%
April-Oct 2021	58.3%	40.2%

6.1.5. Chart 3 – Shift in 'Type' of appointment over time – 8 x CCGs (L&SC)



6.1.6. Chart 4 below shows GP referrals to the four main ICS acute hospitals. GP referrals have continued to recover back towards historic levels with the April - October 2021 activity across the 4 x L&SC providers (adjusted for working days in the month) was 96.9% of the GP referral activity in April - Oct 2019 [though the October 2021 referrals in isolation were 1.9% higher than October 19]

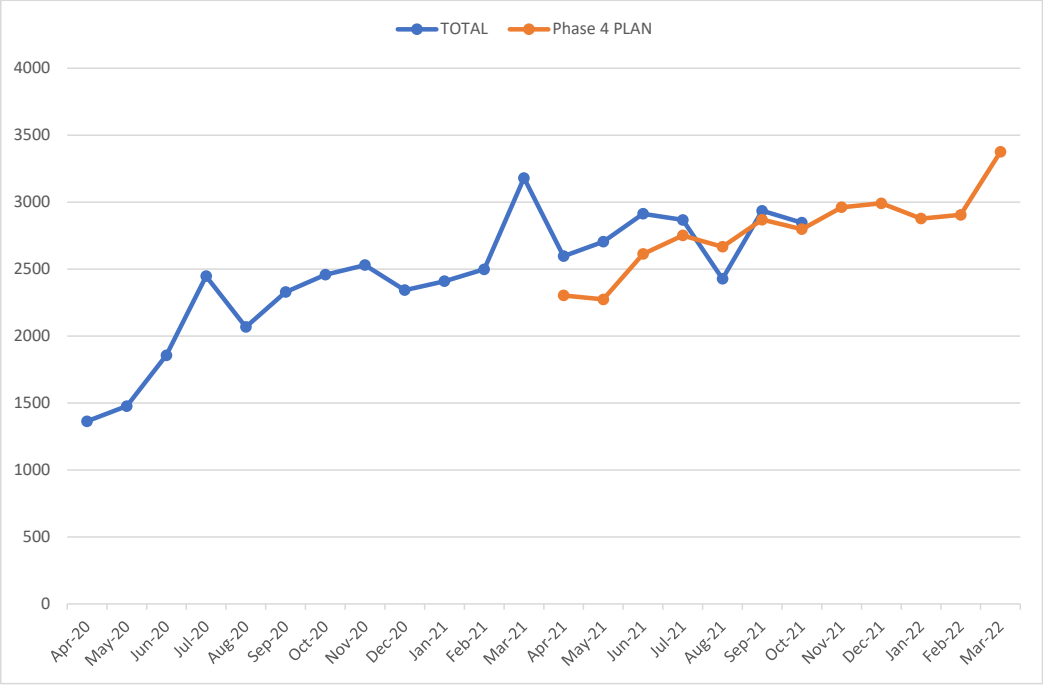
6.1.7. Chart 4 – GP referrals into the 4 main acute hospitals across L&SC



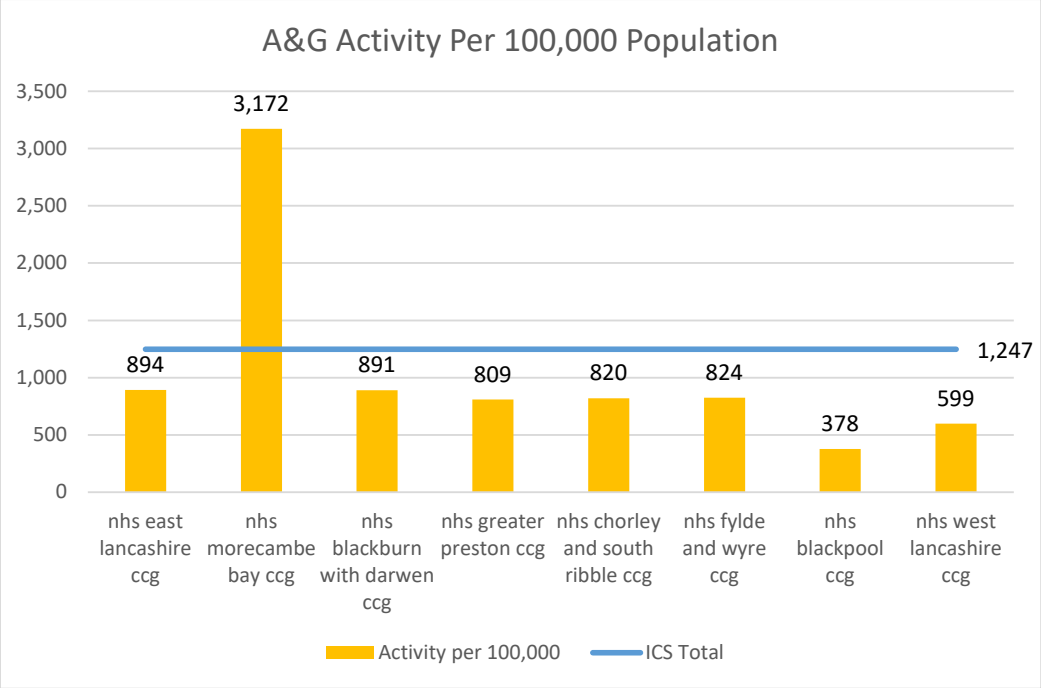
6.1.8. One approach being utilised across L&SC to support management of demand into the acute system has been the implementation of Advice and Guidance (based on the Morecambe Bay system [Except West Lancs which uses consultant connect]). The use of this system has been steadily increasing, and it is expected that this will continue [Chart 5]. The H2 planning submission target identified via the ECRG is that a minimum of 12 A&G requests should be delivered per 100 outpatient first attendances or equivalent via other triage approaches by Mar 2022. Current performance reported via the ECRG identifies that in October 2021 the system is currently at 5.2%.

6.1.9. Figures presented to the L&SC Advice and Guidance working group indicate that across the 8 x L&SC CCGs, around 91.6% of all A&G activity is through the UHMB system, with around 6.5% via the ERS system and the small remainder via 'Consultant Connect' in West Lancashire CCG. The volume of advice and guidance requests (across all 3 of these systems) has been above the H1 and H2 plans. Morecambe Bay CCG (early adopter) accounts for half of all advice and guidance requests and has a much higher utilisation rate per 100,000 population than any other CCG.

6.1.10. Chart 5 – Advice and Guidance requests against H1 Plan and H2 (provisional) plan



6.1.11. Actual A&G activity per 100,000 population (all systems) by CCG [April – October 2021]



6.1.12. 88.1% of all Advice and Guidance requests in April - November 2021 through the UHMB system were responded to within 2 days while initial referrals to outpatients were effectively halved (Table 1)

6.1.13. Table 1 – Pre and Post- Advice and Guidance outcomes Apr-Nov 2021 [UHMB system]

Treatment Plan (Apr-Nov)	BEFORE	AFTER A&G	MOVEMENT	% SHIFT
Admit	2470	2294	-176	-7.1%
Carry out further investigations	1055	2030	975	92.4%
Forced Closure		813	813	
Manage patient's care myself	1234	6039	4805	389.4%
Other	1366	1969	603	44.1%
Radiology test sanctioned by radiologist		769	769	
Refer to outpatients	8969	4558	-4411	-49.2%
Seek advice from another source	3247	682	-2565	-79.0%
(blank)	2076	1263	-813	-39.2%
TOTAL	**20417**	**20417**	**0**	**0.0%**

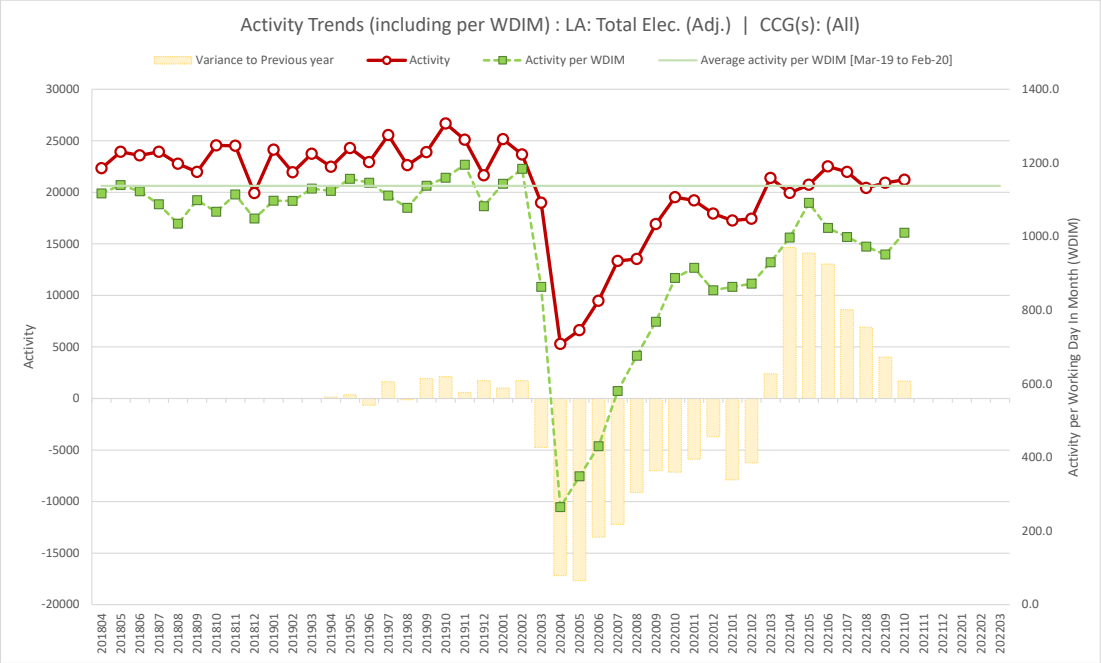
6.1.14. Radiology, Dermatology, Cardiology and Clinical Haematology are the 4 specialties that receive the greatest number of Advice and Guidance requests (34% of all A&G requests in April - November 2021). Work is ongoing to track the changes in demand by speciality and population group to ensure that recovery actions are equitable and that low presenting patient groups are targeted for support. In line with the planning guidance, specific consideration will be given to variation in access by ethnicity and deprivation.

6.2. Activity

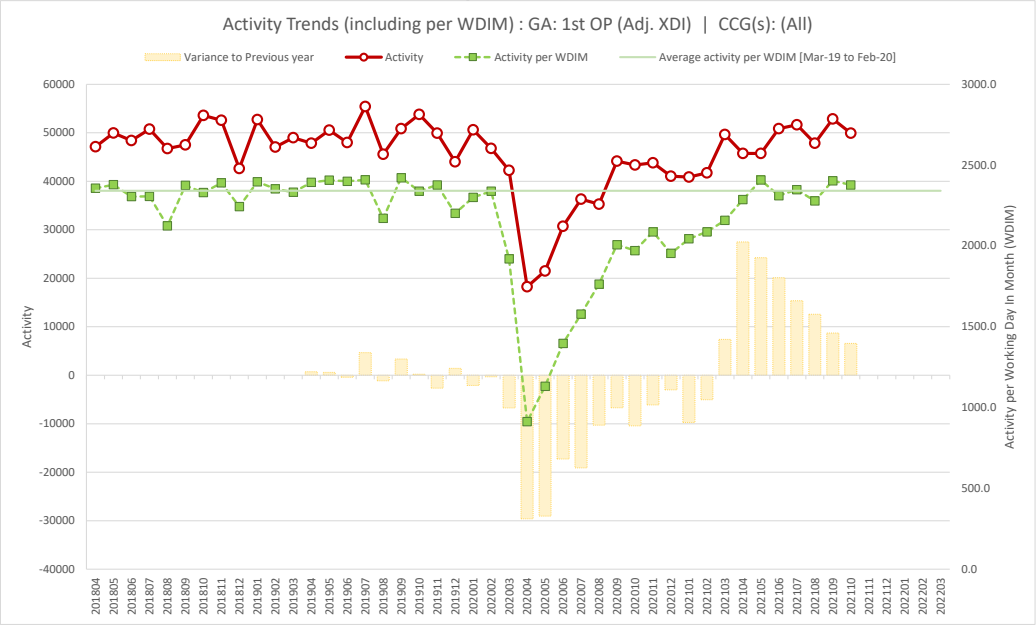
6.2.1. Activity trends based on the national dataset for CCGs (across all providers) indicates that recovery is not yet back to 2019-20 levels for the totality of electives activity. Outpatient activity (first and follow-up) is largely back to historic levels, though there are still some month on month and provider variations.

Activity Type	Oct 2019 (Activity per WDIM)	Oct 2021 (Activity per WDIM)	Oct 21 Indicative Recovery %
Total Elective (EL+DC)	1159.6	1010.3	87.13%
First Outpatients	2338.8	2377.4	101.65%
Follow-Up Outpatients	4702.8	4573.0	97.24%

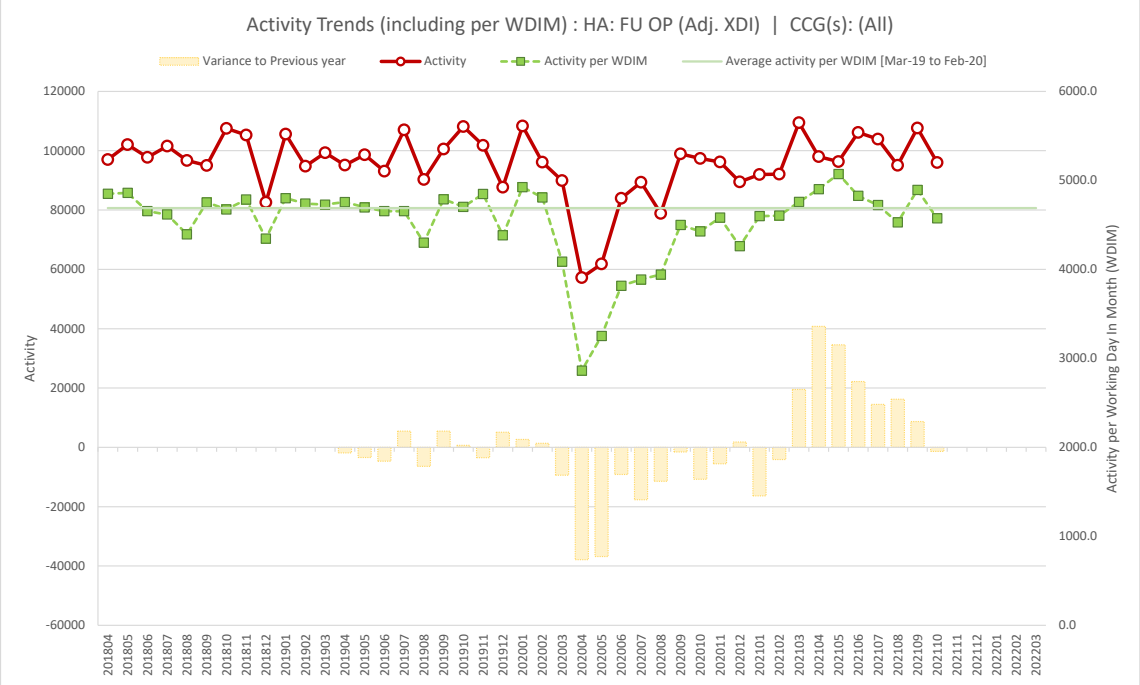
6.2.2. Chart – Total Elective Activity Trends – L&SC CCGs



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



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



6.2.5. Weekly Activity Return (WAR) information has been reviewed across the North West, and for the week to 12th December 2021, the total elective recovery position (elective ordinary and daycases) was strongest in Greater Manchester, closely followed by L&SC. There is variation at provider level underneath this L&SC position.

6.2.6. Recovery – Elective activity and daycases (w/e 12th December 2021) – ICS Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
North West	22,510	19,306	3,204	85.8 %
C&M	8,635	7,167	1,468	83 %
GM	8,921	7,816	1,105	87.6 %
L&SC	4,954	4,323	631	87.3 %

6.2.7. Recovery – Elective activity and daycases (w/e 12th December 2021) – Provider Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
L&SC	4,954	4,323	631	87.3 %
Blackpool Teaching	1,160	1,041	119	89.7 %
East Lancashire	1,377	1,262	115	91.6 %
Lancashire Teaching	1,462	1,172	290	80.2 %
Morecambe Bay	955	848	107	88.8 %

6.2.8. In terms of outpatient activity (first and follow-up), L&SC is showing recovery back to historic levels for first outpatients, but has not fully recovered follow-ups.

6.2.9. Recovery – Outpatient (First) (w/e 12th December 2021) – ICS Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
North West	54,100	51,729	2,371	95.6 %
C&M	21,412	20,149	1,263	94.1 %
GM	22,689	21,591	1,098	95.2 %
L&SC	9,999	9,989	10	99.9 %

6.2.10. Recovery – Outpatient (Follow-up) (w/e 12th December 2021) – ICS Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
North West	131,097	131,066	31	100 %
C&M	53,344	53,361	-17	100 %
GM	55,618	56,414	-796	101.4 %
L&SC	22,135	21,291	844	96.2 %

6.2.11. The Elective Care Recovery Group are leading on the development and implementation of elective restoration plans. Progress is monitored regularly through the ECRG. These plans include:

Elective Hub	• Transformation Actions including: A&A Theatres: 24 hr Joints, Consistent IPC, standardisation of lists, Theatre Lite, Maximising Day Case activity • Establishing surgical hubs • Co-ordinated waiting list (inc. IS) & protocol to determine system wide priorities • Oversight clinical validation of waiting lists • Managed system view of EBIs & implementation of clinical policies • System wide surgical prioritisation committee
Outpatients	• Increased use of Patient Initiated Follow Ups (PIFUs) • Increased use of Advice and Guidance • Increased volume of Virtual Consultations • Clinical pathway redesign: MSK & dermatology to reduce attendances
Diagnostic Imaging	• Securing additional imaging capacity • Establishing Provider Collaborative Diagnostics Imaging Network • Implementing Community Diagnostic Hubs
Diagnostics Endoscopy	• Establishing Endoscopy Hub and manage at system level Mobile scanner utilisation rates • Workforce capacity, staffing models & skills
Independent Sector	• Contract negotiation, mobilisation & monitoring CCGs & Trusts • Referral & demand management, triage, clinical prioritisation & use of eRS • IS NHS patients incorporated into single system waiting list
Critical Care	• Project plan to address; • Efficient use of critical care beds/ enhanced care within the estate • Workforce: staffing models, attrition, education, well being & skill sets • Patient pathways and interdependencies • Effective and efficient system working

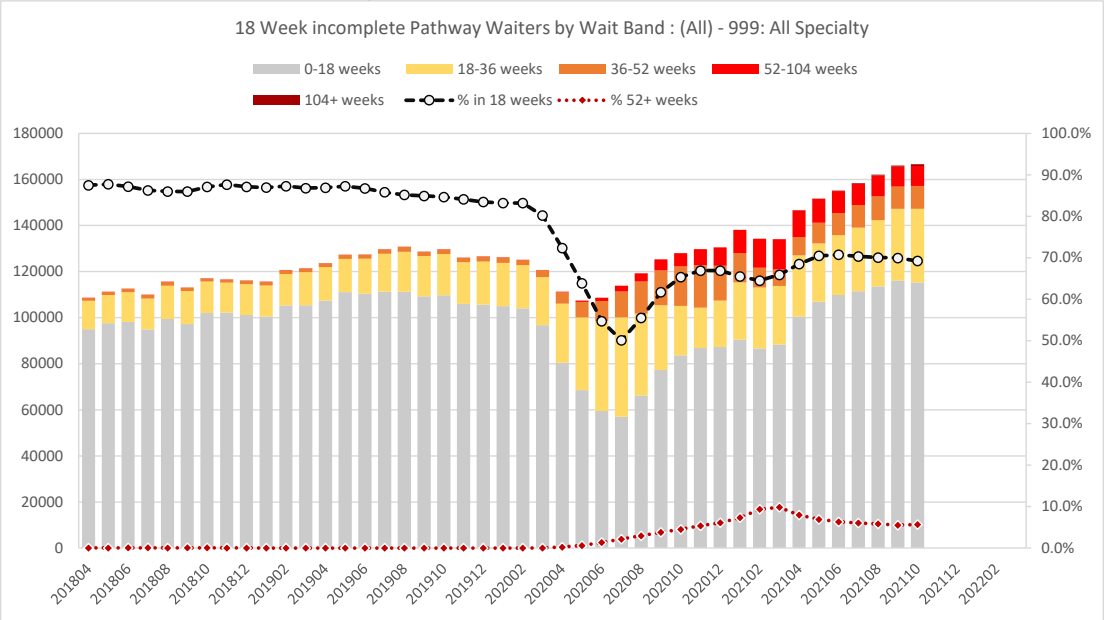
6.3. <u>18 Weeks Referral to Treatment Target / Incomplete Pathways / 52+ Week Waiters</u>

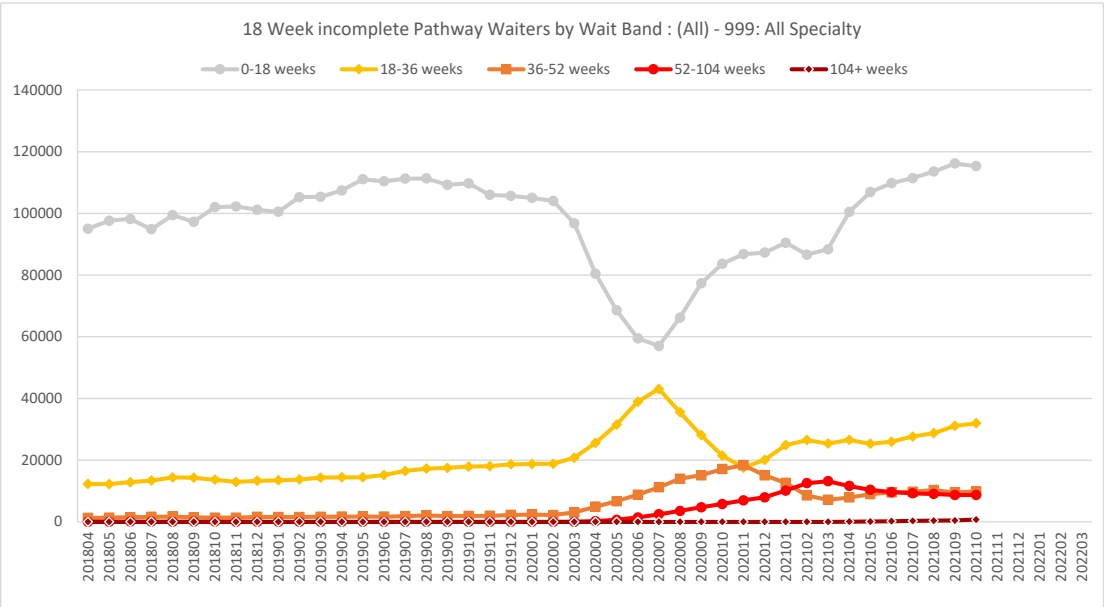
6.3.1. There are 3 key measures associated with referral to treatment times:

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

6.3.2. The chart below shows the ICS performance (aggregated for the 8 x CCGs) against these 3 measures. Prior to the COVID pandemic, the total number of patients waiting to start treatment had stabilised and was showing signs that it was starting to reduce. 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 October 2021 the total number of patients waiting to start treatment has increased to 166,597, performance against the 18-week standard was 69.2%, and there were 9,442 over 52-week waiters (5.7%) of which 753 had been waiting in excess of 104 days.

6.3.3. 18 week Incomplete Pathway Waiters – L&SC





6.3.5. The slow decrease in the number of over 52 week waiters appears to have stalled in October 2021 although the 104+ week waiter numbers are still growing. The 0-18 band number of waiters has reduced this month for the first time during this financial year.

6.3.6. Within the October 2021 return, 753 patients across L&SC had been waiting in excess of 104 weeks. Half of these 104+ week waiters are reported to be waiting at LTHT, with a further 28.2% at UHMB. The specialty breakdown of these workers has shifted significantly this month due to increasing use of the X0* codes following the national guidance for mapping specialties to RTT codes.

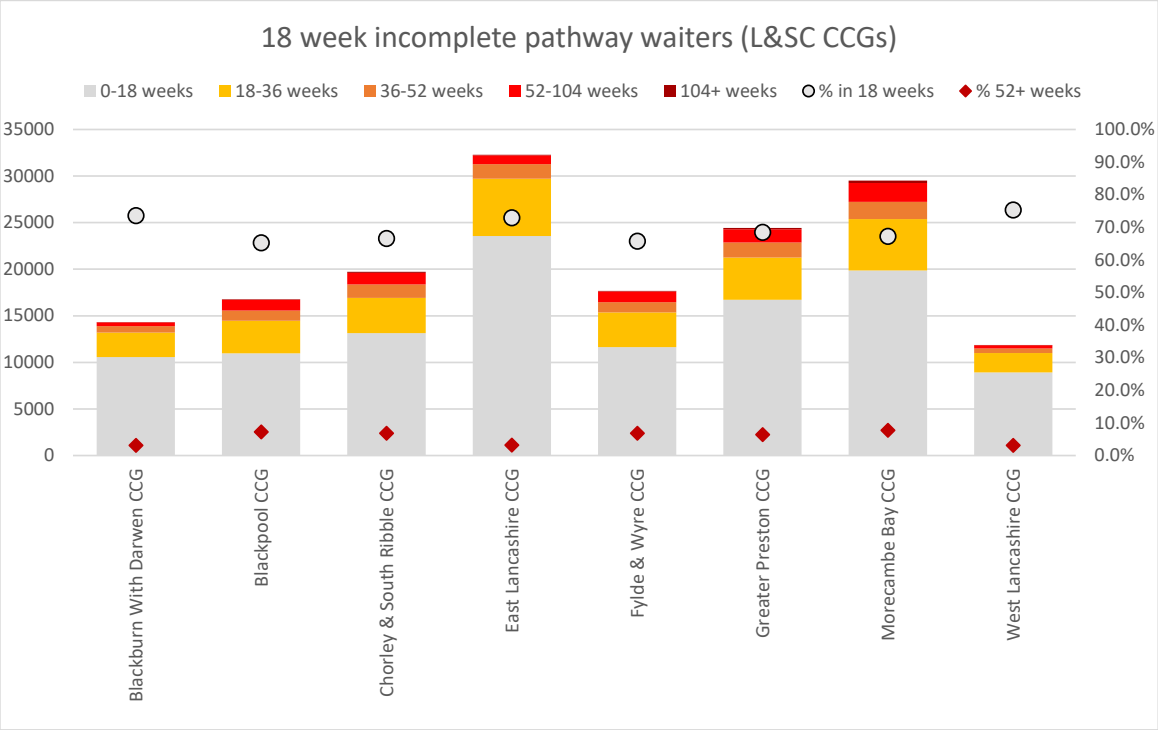
6.3.7. Table – 104+ week waiters by provider and specialty (October 2021)

PROVIDER	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	SPIRE FYLDE COAST HOSPITAL	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	ALL OTHER	TOTAL	% TOTAL
100: GENERAL SURGERY	5	47	5	2	11	1	7	78	10.4%
101: UROLOGY	31	10	4	0	7	0	1	53	7.0%
110: TRAUMA & ORTHOPAEDICS	21	101	1	22	2	3	11	161	21.4%
120: ENT	85	13	8	2	0	2	1	111	14.7%
130: OPHTHALMOLOGY	24	16	7	0	0	0	0	47	6.2%
160: PLASTIC SURGERY	67	0	0	0	0	0	3	70	9.3%
300: GENERAL MEDICINE	13	0	0	0	0	0	0	13	1.7%
400: NEUROLOGY	42	0	0	0	0	0	0	42	5.6%
502: GYNAECOLOGY	8	3	12	4	2	0	1	30	4.0%
X05: All other TREATMENT FUNCTIONS in the Surgical group nc	89	10	3	0	4	2	5	113	15.0%
X04: All other TREATMENT FUNCTIONS in the Paediatric group	0	1	9	0	0	0	0	10	1.3%
X02: All other TREATMENT FUNCTIONS in the Medical Services	11	11	0	0	0	0	1	23	3.1%
Grand Total	**396**	**212**	**49**	**30**	**27**	**8**	**31**	**753**	**100.0%**
% TOTAL	52.6%	28.2%	6.5%	4.0%	3.6%	1.1%	4.1%	**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 October 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 the greatest pressure now appears to be in Morecambe Bay where 7.7% of patients were waiting 52+ weeks at the end of October 2021.

6.3.9. Table - Waiting list variation between CCGs (October 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	10555	2629	702	420	29	14335	73.6%	3.1%
Blackpool CCG	10959	3501	1101	1152	67	16780	65.3%	7.3%
Chorley & South Ribble CCG	13123	3804	1452	1229	110	19718	66.6%	6.8%
East Lancashire CCG	23558	6176	1535	967	53	32289	73.0%	3.2%
Fylde & Wyre CCG	11630	3733	1106	1140	67	17676	65.8%	6.8%
Greater Preston CCG	16720	4524	1618	1416	145	24423	68.5%	6.4%
Morecambe Bay CCG	19867	5511	1870	2013	269	29530	67.3%	7.7%
West Lancashire CCG	8921	2088	472	352	13	11846	75.3%	3.1%
Grand Total	**115333**	**31966**	**9856**	**8689**	**753**	**166597**	**69.2%**	**5.7%**



6.3.11. 79.8% of all over 52-week waiters for the CCGs are at the four main providers in the ICS, with 46.2% at LTHT (See Appendix 1).

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 (2,010) with 90.2% 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]

7. COVID-19 Nosocomial Infections

7.1. As some of the information contained in the report was out of date due current system pressures, a verbal positional update was given at the Sub-Committee meeting as follows:

7.1.1. Secondary and Primary Care

- The Omicron wave has hit L&SC hard over the last two weeks. Positive tests in 7 days to Monday 3rd January 2022 were 2,171 per 100,000 by far the highest of the pandemic and 70% higher than the previous week.
- There is a risk that the rapid rise in the over 60's cohort will lead to further hospital admissions.
- Cases now stand at 2,171 per 100,000 population across L&SC.
- The number of patients in hospital beds across L&SC now stands at 403.
- It was noted that the North West now has the second highest number of patients occupying hospital beds in the country with London having the highest.
- Attendances to ED continue to increase. Length of Stays over seven days are also increasing which places intense pressure on ED.
- All Acute Trusts have experienced immense pressure over recent weeks with Morecambe Bay declaring an internal major incident.
- Staff sickness in the Acute Trusts is running at 10-11% with 5% being COVID related. Total staff absence on 31st December 2021 was 3,528 almost 50% higher than two weeks earlier.
- Primary Care are also undergoing pressure due to staff sickness with a high percentage being covid related.
- NWAS has reported that staff sickness is at 36% which is placing particular pressure on ambulance crews at night.

7.1.2. Mitigations

- As pressure has increased with regard to testing, PCR testing has been stepped down to try to ease this.
- There are plans for a surge facility of an additional 100 beds to serve the North West, however, staffing will remain an issue.
- There has been a review of the use of Oximetry at home in order to prevent hospital admissions.
- Plans are in place in Trusts (Perfect Week) to move forward with delayed discharges.
- Non-emergency meetings have been stepped down.

7.1.3. Regulated Care

- There are currently 198 outbreaks across L&SC together with 66 incidents which may lead to further outbreaks; 60% of Regulated Care is now in outbreak impacting on hospital admissions, discharge and packages of care.
- 36% of staff are in isolation. 21 homes have been rated as red. Support is being given via CCGs, however, internal resources are diminishing.

- 36 homes are currently not in outbreak.

7.1.4. Mitigations

- ICP huddles take place thrice weekly.
- The In Hospital Cell and the Out of Hospital Cell has now joined to get an overview.
- Sit rep has been re-established for Primary Care.
- The outbreak system has been re-established.
- Contingency plans are being developed with a 3 stage approach to multi care home pressures.
- Staffing is reviewed across all sectors constantly, and staff are being flexible to support.
- Testing deliveries have been ring fenced for care homes.

7.2. Overview

7.2.1. As of Thursday 16th December 2021, the number of positive tests per 100,000 of the population has reduced across every area from 360 to 274 per 100,000 of the population from Monday 13th December 2021. This is mirrored by the those aged 60, dropping from 113.6 to 87.7 per 100,000 per population.

7.2.2. The number of COVID-19 positive in-patients has risen slightly since Monday 13th December 2021 from 113 to 117, with the biggest increase being experienced at ELHT rising from 22 to 27 in the same timeframe.

7.2.3. Although the younger age bands remain the highest number of positive tests per 100,000 both 5-10s and 11-15s have reduced significantly since Monday 13th December 2021 indicating just under a 40% change from the previous 7 days.

7.2.4. COVID-19 related staff absences have started to see some increase in the last 3 days to 470, the highest since 23rd October 2021. ELHT and LTHT have absorbed the biggest share of this with 134 and 156 respectively, levels not seen at either Trust since late July 2021.

7.3. Outbreaks

7.3.1. LTHT currently have 4 active outbreaks at the trust. One of the wards has been identified as omicron related which has involved five staff and three patients testing positive. Issues highlighted in the post infection review include the ward being cluttered, staff sickness and patient adherence to IPC measures. A deep clean has been completed and the ward will be closed for 2 weeks. Full patient and staff screening undertaken and no further cases identified. COVID typing has been undertaken for the other 3 outbreaks, awaiting results. All wards have had IPC input and support for audits, education and advice.

7.3.2. ELHT currently have 5 active outbreaks across the trust. The Infection Prevention Control Team have carried out hand hygiene, PPE, environmental and social distancing audits, and post infection reviews on the first 2 positive cases in each outbreak to identify any immediate learning. Audit findings were fed back to the ward managers at the time of the audit. Matrons and Divisional Directors of Nursing were alerted in order to oversee any necessary actions.

7.3.3. LSCFT MH Services In-patient ward at Pendle View currently have 3 active outbreaks with a total of 20 positive cases. Awaiting confirmation whether any of the cases are omicron variant of concern.

7.3.4. UHMB currently have 5 wards in incident at Royal Lancaster Infirmary due to COVID-19, and only 1 incident at Furness General Hospital. All the wards remain open, with only a low number of positive cases identified, these patients have been cohorted into isolation rooms.

7.3.5. A number of IPC exceptional reports have been completed recently due to capacity concerns within the UHMBT and the difficulties maintaining COVID-19 colour streams. Executive teams and IPC are monitoring on a daily basis, risk assessments are completed, and additional measures are implemented to support i.e. split staffing and additional cleaning.

7.3.6. Themes highlighted from reviews are cleanliness where audit results do not reflect the cleaning standards, storage remains an issue, estate issues throughout, ageing ventilation and a lack of single room facilities, PPE storage concerns for visors and masks, patients walking with purpose unable to comply with social distancing, staffing issues identified in most areas, vast amount of wards with 'supervision 1:1' bays and delays in discharges.

7.3.7. Communications from Post Infection Reviews and outbreak meetings are sent out in the weekly COVID-19 messaging and 'back to basics' IPC training is being provided to wards of concern.

7.3.8. BTHT is currently reporting 1 live COVID-19 outbreak, this being on the Clifton Hospital site. The outbreak initially linked 2 HOCI cases and 1 staff member; 3 more patients have tested positive over recent weeks through routine screening. Investigations and staff screening continues. Visiting has ceased on the affected ward with patients noted to be fully vaccinated and asymptomatic.

7.3.9. Lessons learned from these incidents include failures in some patient screening requirements which divisions continue to work to resolve. The other key factor is the fact that some exposed/contact patients go on to test positive themselves. Additional challenges in relation to the current context where there is unrelenting pressure on NHS hospital services to maintain a zero tolerance to the mixing of COVID-19 pathways on the same ward as is the case for Clifton Ward 3.

7.3.10. All trusts are collating vaccination status for all COVID-19 inpatient positive cases, to understand epidemiology of spread and severity.

7.3.11. All trusts are reporting the majority of positive cases are identified through routine testing- they are asymptomatic or have mild symptoms and the vaccination status varies between fully (including booster) to unvaccinated.

7.4. Regulated Care

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 13th December

CCG	Care Homes in Outbreak	Care Homes in Incident
Morecambe Bay CCG	5	4
Central Lancashire CCG	7	4
Blackpool CCG	-[1]	-
West Lancashire CCG	2	0
East Lancashire CCG	2	4
Blackburn with Darwen CCG	1	1

7.5. General Trends & Themes

[1] Data unavailable at time of reporting

7.5.1. The homes in outbreaks and incidents are continuing to manage well due to previous experience of COVID-19 outbreaks.

7.5.2. The majority of the positive cases are asymptomatic or have very mild cold-like symptoms, and are being identified through routine testing. There is no particularly trend, with a mixture of both staff and residents affected.

7.5.3. Regular IPC visits continue to all homes of concern, by the Local Authority IPC team. These are completed on an ad-hoc basis and all findings are shared with the local CCGs via the monthly HCAI report or escalated immediately if required.

7.5.4. The COVID-19 booster programme has been offered to all residents in all care homes with uptake being reported as good. However, as this data is inputted directly onto the Care Home Capacity Tracker by the care homes staff, data is not always inputted in a timely manner.

7.5.5. Concerns around the uptake of boosters for care homes staff, is indicating that staff are refusing for a number of reasons: high number of staff with on-going side effects, concerns about being unwell following the booster, staff don't want to keep having vaccines, and the fact that it is not mandated. Work is being done locally and nationally to address this including education, messaging and access to reliable information and data on vaccine.

7.5.6. Care Homes are struggling to access the appropriate test kits, which is resulting in care home staff having to isolate; this has been escalated to the Testing Cell. Concerns amongst professionals as we approach the festive period in relation to health and social care settings will already be working with skeleton staff. Homes have been encouraged to update contingency plans as a matter of urgency.

7.6. Updated guidance published 15/12/21 Important changes

7.6.1. Exemptions from self-isolation if a staff member is fully vaccinated and is identified as a contact of a case.

7.6.2. Staff members notified that they are a contact of a COVID-19 case are not required to self-isolate if they are fully vaccinated. They should inform their line manager or employer immediately if they are required to work in the 10 days following their last contact with a COVID-19 case. Additional recommendations are identified. [COVID-19: management of staff and exposed patients or residents in health and social care settings]

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 November 2021 for L&SC CCGs regarding CHC services. It must be noted that whilst the majority of services are commissioned from MLCSU and Blackpool 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.

8.1.3. Blackpool CCG data in is only partly included in the majority of this report, it is being received (6 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 section do include data/input from Blackpool 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 ↑ 60%.

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 ↑ 22%. A review is being undertaken for the reason behind the increase with more focus being given to EL CCG as they receive a high proportion of the total of Fast Tracks received.

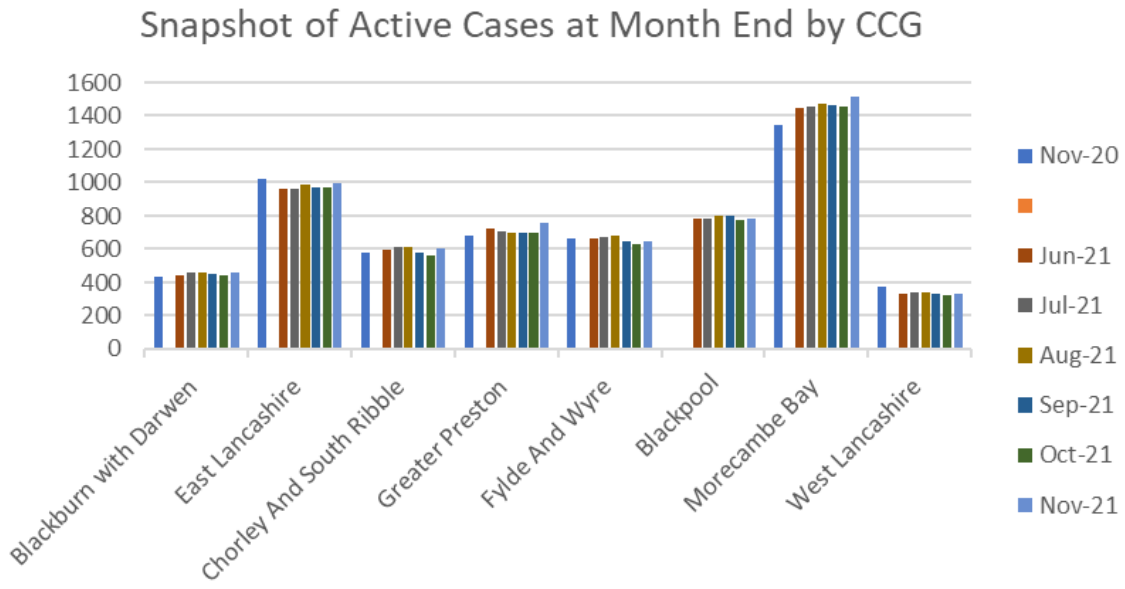
8.2.3. Incomplete Referrals – there are 74 ICRs (as at 30/11/21) in the system. These are being monitored in weekly reports against a trajectory that was submitted to NHSE/I. There is currently ↓ 228 case decrease from the end of June 2021. An additional 5 staff have been retained from the 'recovery project' to support the service whilst recruitment has been undertaken for the new ICS funded posts; this and a thorough data quality cleanse led to a decrease in September 2021. This reduction highlights the improvement in performance due to the increase in staff. The number against the trajectory is levelling out with individual cases now being reviewed to understand the reason for the delay in the assessment being undertaken.

8.2.4. Quality Premium - All CCGs are falling short of the Quarterly Quality Premium Target of completing over 80% of eligibility decisions within 28 days of the referral being made. A trajectory has been submitted to NHS E/I in line with the ICR trajectory with a target of all CCGs meeting the QP by the end of Q4 2021/22. Currently 6 of the 8 CCGs are behind trajectory and have had to complete an assurance plan. All CCGs are meeting the QP 'Less than 15% of all NHS CHC assessments take place in Acute Hospital Setting'; the ICS as a whole is reporting between 0-2% month on month.

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 provided in future reports.

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

CCG	Nov-20	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	1 Month Movement		12 Month Movement	
Blackburn with Darwen	431	440	456	459	454	445	459	**3.1%**	**14**	**6.5%**	**28**
East Lancashire	1022	963	965	989	972	974	999	**2.6%**	**25**	**-2.3%**	**-23**
Chorley & South Ribble	580	593	611	610	579	565	605	**7.1%**	**40**	**4.3%**	**25**
Greater Preston	678	723	708	697	695	700	756	**8.0%**	**56**	**11.5%**	**78**
Fylde And Wyre	664	665	676	679	650	631	649	**2.9%**	**18**	**-2.3%**	**-15**
Blackpool	n/a	779	779	798	796	778	779	**0.1%**	**1**	**n/a**	**n/a**
Morecambe Bay	1344	1446	1459	1471	1468	1457	1516	**4.0%**	**59**	**12.8%**	**172**
West Lancashire	373	332	343	338	333	319	332	**4.1%**	**13**	**-11.0%**	**-41**
ICS Total (exc Blackpool)	**5092**	**5162**	**5218**	**5243**	**5151**	**5091**	**5316**	**4.4%**	**225**	**4.4%**	**224**



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. November 2021 has stopped the trend of the September and October 2021 of the total number of packages reducing month on month. The 4.4% increase from October to November 2021 is the highest monthly increase of this financial year. This increase is identical to the 12 month increase (notably because October 2021 was one package less than November 2020). The total increase in packages from August 2021 to November 2021 (73) is back in line with the expected 3 month increase.

8.3.3. All 8 CCGs reported an increase in November 2021 with Greater Preston (8%) and Chorley & South Ribble (7.1%) showing the highest increase.

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

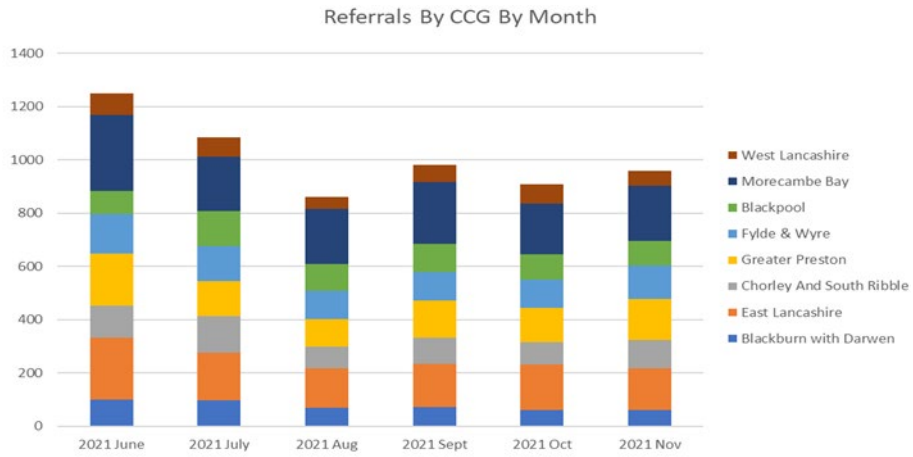
8.3.5. Review on the exceptions noted above will be investigated and provided in future reports.

8.4. Referrals Received

CCG	2021 June	2021 July	2021 Aug	2021 Sept	2021 Oct	2021 Nov		6 Month Average	2019-20 Monthly Average	Monthly Movement	
Blackburn with Darwen	99	98	70	71	62	61		77	54	-1	-2%
East Lancashire	234	178	147	162	168	155		174	146	-13	-8%
Chorley & South Ribble	120	138	82	99	84	108		105	89	24	29%
Greater Preston	195	130	104	141	130	153		142	111	23	18%
Fylde & Wyre	148	133	105	104	106	126		120	111	20	19%
Blackpool	86	129	101	107	94	93		102	n/a	-1	-1%
Morecambe Bay	287	204	206	232	190	207		221	171	17	9%
West Lancashire	81	73	46	65	73	56		66	54	-17	-23%
ICS Total	**1164**	**954**	**760**	**874**	**813**	**866**		**905**	**734**	**53**	**7%**

Referral Type	2021 June	2021 July	2021 Aug	2021 Sept	2021 Oct	2021 Nov		6 Month Average	2019-20 Monthly Average	Monthly Movement	
Checklist	87	60	89	84	83	105		85	167	22	27%
Initial DST	172	101	74	97	111	129		114	36	18	16%
Fast Track	361	361	336	396	343	333		355	292	-10	-3%
D2A	86	66	70	73	85	70		75	47	-15	-18%
FNC Referral	7	7	3	8	7	9		7	28	2	29%
Funding Request Form (non CHC)	451	355	177	189	178	210		260	158	32	18%
CYP Checklist		4	11	27	6	6		11	0	0	0%
PUPOC						4		4	0	4	N/A
Total	**1164**	**954**	**760**	**874**	**813**	**866**		**905**	**734**	**53**	**7%**

ICS total and referral type breakdown above both exclude Blackpool



8.4.1. The average number of referrals over the last 6 months remains around 25% higher than the 2019-20 average, with significant increases in Fast Track (22%), Discharge to Assess (59%), Funding Requests and DST referrals.

8.4.2. Changes in process have led to an increase in initial DST referrals and a decrease in checklist referrals (linked to D2A recording process) t he increase is evenly split across the 7 CCGs.

8.4.3. Month on month activity is up 7% with the main reason the number of Checklist referrals up 27% and 25% higher than the 6month average.

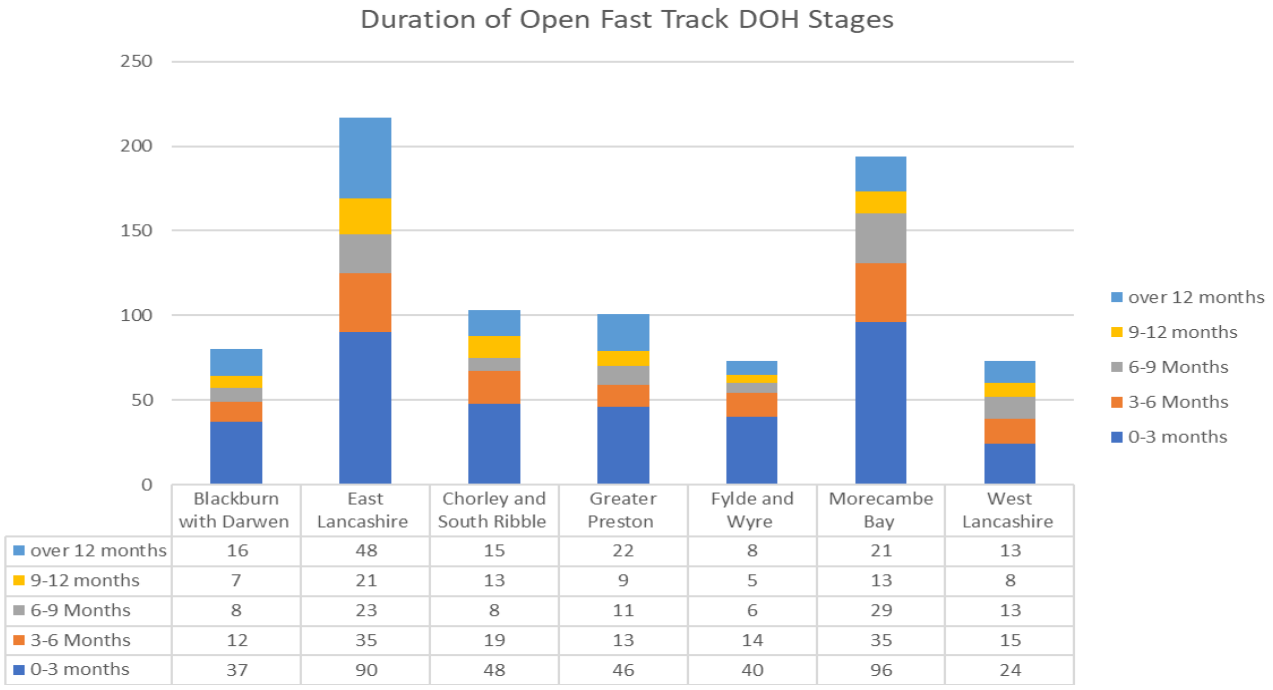
8.4.4. N.B. Data for Month 3 of the Quarter (June) includes a balance for late entered data for the previous 2 months, to allow consistency in line with Quarterly NHS submissions, so month 3 will tend to be higher than months 1 & 2.

8.4.5. 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
Jun-21	395	876	49%
Jul-21	403	909	49%
Aug-21	360	822	55%
Sep-21	429	735	52%
Oct-21	380	713	54%
Nov-21	333	802	55%

CCG	0-3 months	3-6 Months	6-9 Months	9-12 months	over 12 months	Grand Total		% FT over 3 months
Blackburn with Darwen	37	12	8	7	16	80		54%
East Lancashire	90	35	23	21	48	217		59%
Chorley and South Ribble	48	19	8	13	15	103		53%
Greater Preston	46	13	11	9	22	101		54%
Fylde and Wyre	40	14	6	5	8	73		45%
Morecambe Bay	96	35	29	13	21	194		51%
West Lancashire	24	15	13	8	13	73		67%
Grand Total	**381**	**143**	**98**	**76**	**143**	**841**		**55%**



	Blackburn with Darwen	East Lancashire	Chorley and South Ribble	Greater Preston	Fylde and Wyre	Morecambe Bay	West Lancashire
over 12 months	16	48	15	22	8	21	13
9-12 months	7	21	13	9	5	13	8
6-9 Months	8	23	8	11	6	29	13
3-6 Months	12	35	19	13	14	35	15
0-3 months	37	90	48	46	40	96	24

8.5.1. Section 8.4.1 shows a 25% increase in the 6 month average of Fast Track referrals (355) compared to 2019-20 (292).

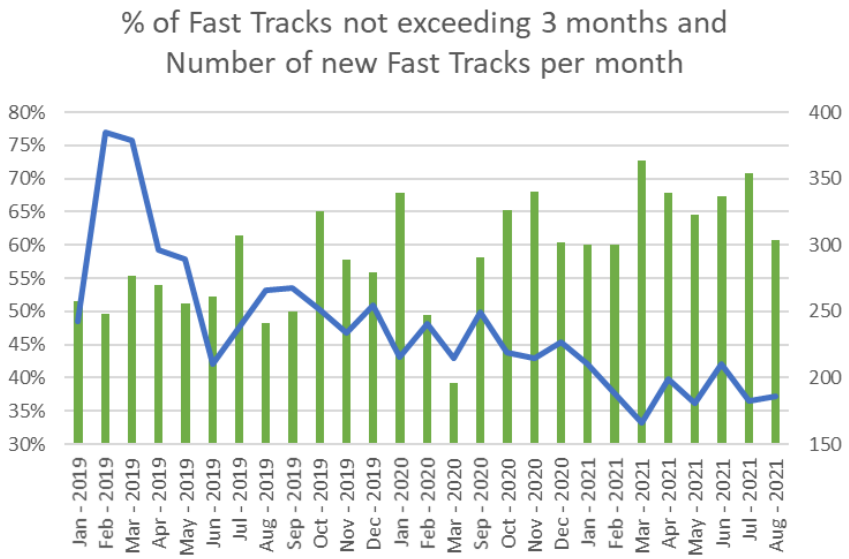
8.5.2. The percentage of Fast Track patients with a package > 3 months continues to remain high (55%), until the 3 months reviews are completed it is hard to determine if this is because the referrals should not have been Fast Track referrals; a quality review of a sample of Fast Track referrals is being undertaken.

8.5.3. EL CCG has the largest number of patients with a stage > 12 months (48 patients which is 22% of East Lancashire Fast Track packages).

8.5.4. Reviews are being undertaken by Community providers, but further work needs to be undertaken as these reviews are ensuring the patient has the correct care but they are not being followed by a DST and therefore remain with Fast Track packages and not CHC packages.

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%	1%	52%	326
Nov - 2020	43%	3%	1%	1%	52%	340
Dec - 2020	45%	2%	1%	51%	0%	302
Jan - 2021	42%	4%	2%	53%	0%	300
Feb - 2021	38%	5%	2%	56%	0%	300
Mar - 2021	33%	2%	54%	10%	0%	364
Apr - 2021	40%	4%	56%	0%	0%	339
May - 2021	36%	2%	62%	0%	0%	323
Jun - 2021	42%	52%	6%	0%	0%	337
Jul - 2021	36%	64%	0%	0%	0%	354
Aug - 2021	37%	63%	0%	0%	0%	304



8.6.1. Since the reintroduction of the CHC Framework in September 2020 there has been a 25% 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 355 (as noted on the last slide this matches the 6month average increase).

8.6.2. The table and graph above detail the number of Fast Tracks received each month from January 2019 – August 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 and 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 Settings.

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

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Initial DST Assessments	243	94	161	152	132	134
Initial DST Assessments carried out in Acute Settings	1	2	1	1	0	3
Quality Premium %	0%	2%	1%	1%	0%	2%

8.7.2. In November 2021, a total of 134 DSTs were completed (Inc. Blackpool CCG). Of these 3 were completed in an acute setting meaning the QP was met for the ICS as a whole as well as each of the individual 8 CCGs. As the table shows this QP has now been met for each CCG for the last 6 months.

8.7.3. This QP performance has significantly improved from 2019/20 where on average 14% of DSTs were completed in an 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	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Blackburn with Darwen	41%	33%	23%	33%	0%	75%
East Lancashire	22%	5%	29%	25%	53%	62%
Chorley And South Ribble	22%	10%	36%	27%	62%	45%
Greater Preston	16%	36%	27%	53%	87%	79%
Fylde & Wyre	66%	45%	52%	50%	61%	62%
Blackpool	85%	85%	77%	83%	75%	68%
Morecambe Bay	64%	64%	65%	79%	61%	77%
West Lancashire	14%	29%	30%	75%	67%	67%
ICS Total	**49%**	**50%**	**40%**	**61%**	**65%**	**70%**

8.7.5. None of the 8 CCGs met the QP target of completing over 80% of eligibility decisions within 28 days of the referral being made, in November 2021, including Blackpool CCG who have now not met the QP in 3 of the last 4 months and continues to decrease.

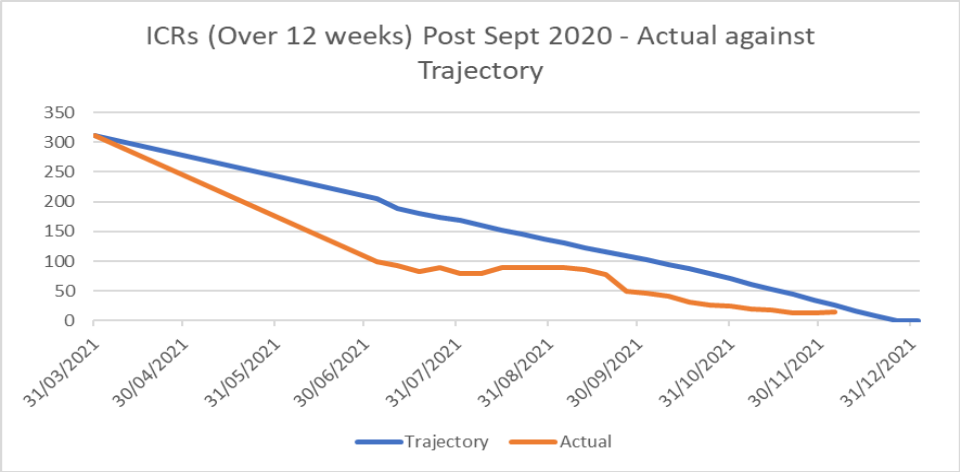
8.7.6. Whilst failure to meet this requirement was commonplace in 2019-20, the performance has been significantly impacted by the current Incomplete Referrals Project, (further detail is provided in section 8.8), which in turn has meant that 5 CCGs have fallen behind the 28 day trajectory, as shown below.

8.7.7. The numbers are however consistent with those reported in 19/20.

	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								
Q3 21/23	Trajectory	≥65% to 69.9%	≥60% to 64.9%	>80%	≥70% to 74.9%	≥65% to 69.9%	≥40% to 49.9%	≥75% to 77.9%	≥65% to 69.9%
	Actual (2 months)	38	58	72	61	54	83	69	67
Dec 2021 to be added	Comparison								

8.8. <u>Incomplete Referrals over 28 days (data from w/c 5th December 2021)</u>

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	2	0	3	0	0	5
East Lancashire	0	5	8	3	1	17
Chorley and South Ribble	1	0	3	0	0	4
Greater Preston	1	1	4	0	0	6
Blackpool	4	4	2	2	0	12
Fylde and Wyre	1	2	4	1	2	10
Morecambe Bay	2	5	5	2	2	16
West Lancashire	0	1	1	1	1	4
Total	**11**	**18**	**30**	**9**	**6**	**74**



8.8.1. The ICR Project, targeted at clearing all incomplete referrals received prior to March 2020, is close to completion with 1 case now awaiting a decision from Dispute.

8.8.2. The focus is now on CHC referrals received post September 2020. There is currently a backlog of 74 ICRs in the system that have breached 28 days. This is a reduction from the 92 that was reported in October 2021. This number hasn't reduced as much as the trajectory, this is due to an increase in those breaching by 2 weeks, and highlights that the BAU capacity is not enough to meet demand.

8.8.3. The teams are constantly monitoring the ICRs on an individual patient level ensuring that assessments are booked and any cases that are deferred are escalated and processed efficiently. An issue that is being seen at the moment is that a number of assessments are being booked but cancelled at the last minute. Further details on this will be added in future reports.

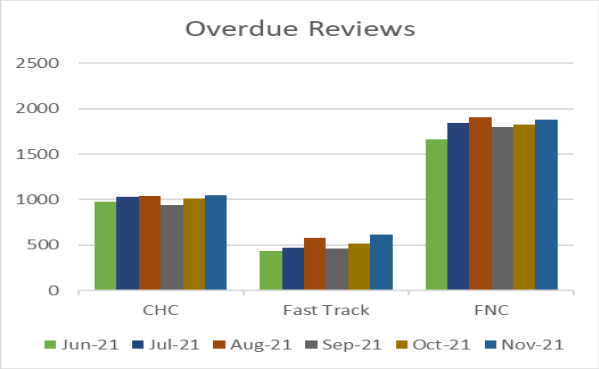
8.8.4. In June 2021 a trajectory for 2021/22 was submitted to NHS E/I of the predicted number of referrals breaching 28 days (per quarter) and the predicted Quality Premium – DSTs completed within 28 days. At that stage there were 311 ICRs and was increasing on average by 7-9 referrals per week; additional funding was agreed in June 2021 for 5 additional clinicians. Whilst these staff are recruited, 5 clinicians have been retained from the COVID Deferred Assessments Recovery Team and have supported the BAU working solely on ICRs built up from 1st September 2020. A s is noted above they have helped to improve the position of ICRs in the system. To assist in monitoring this, detailed weekly reports are being submitted to the system, which will enable the ICS Leadership to act if the trajectory is not being met.

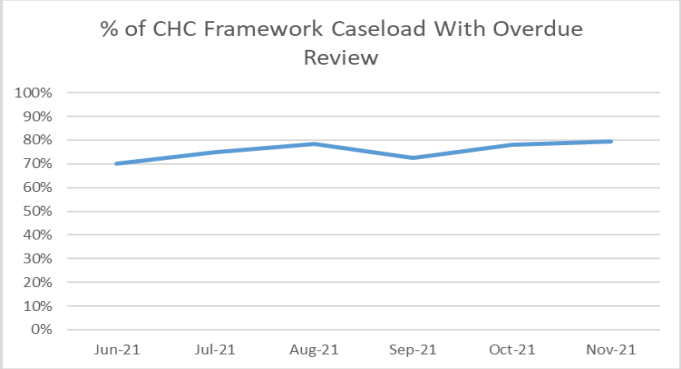
8.8.5. The trajectory submitted to NHS E/I was based on ICRs that have already breached the 28 day period by 12 weeks. The graph above highlights that we are ahead of trajectory as an ICS with 15 ICRs over 12 weeks. This has again reduced from 19 reported in the September 2021 report.

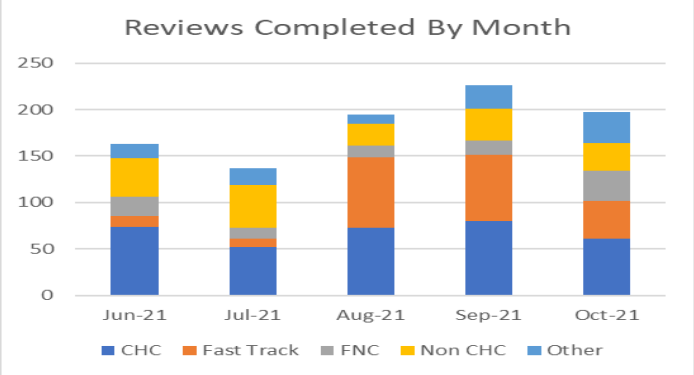
8.9. <u>CHC Framework Overdue Reviews</u>

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Monthly Movement	% Change
CHC	977	1027	1040	941	1016	1049	33	3.2%
Fast Track	431	471	579	461	520	614	94	18.1%
FNC	1661	1842	1908	1799	1828	1877	49	2.7%
Total	**2701**	**3340**	**3527**	**3201**	**3364**	**3540**	176	5.2%

% of CHC Framework Review Caseload	**70%**	**75%**	**78%**	**73%**	**78%**	**80%**





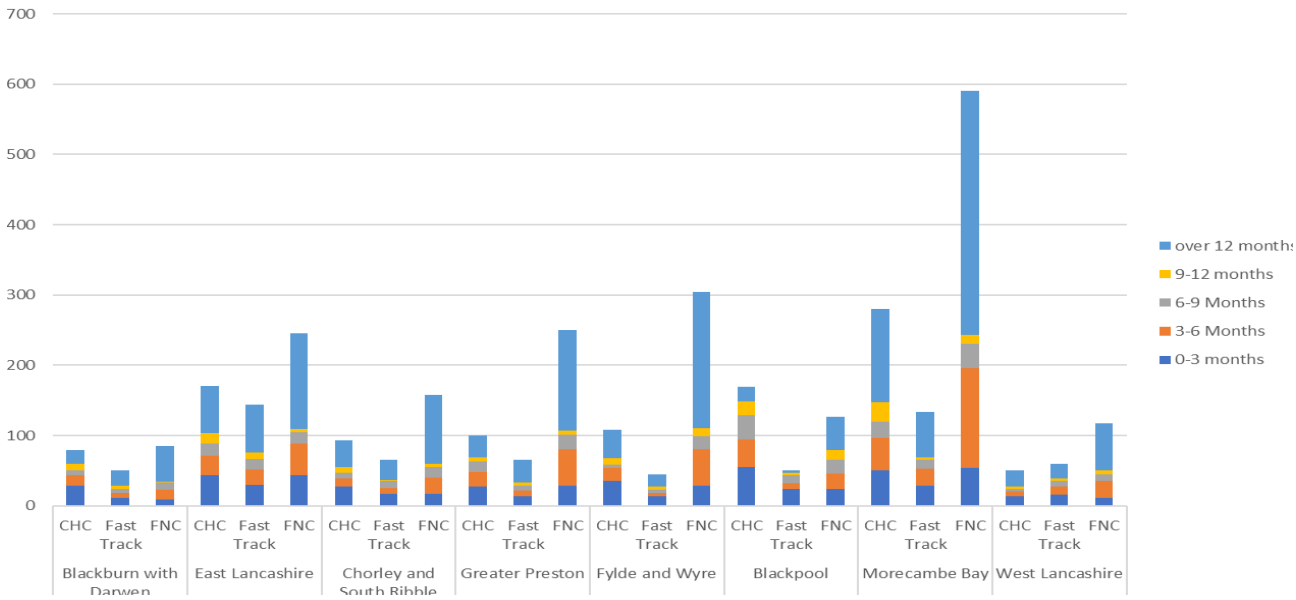


8.9.1. There has been a monthly increase in the number of CHC Framework reviews that are overdue. This percentage will continue to rise in the coming months as clearing the backlog of ICRs has led to an increase in the number of CHC and FNC packages that will require their 3 month reviews as they become due; 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, September and October 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 c280 ODRs, this project is due to start in December 2021.

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	281	187	114	96	371	1049
Fast Track	154	93	74	35	258	614
FNC	217	373	144	59	1084	1877
Grand Total	**652**	**653**	**332**	**190**	**1713**	**3540**

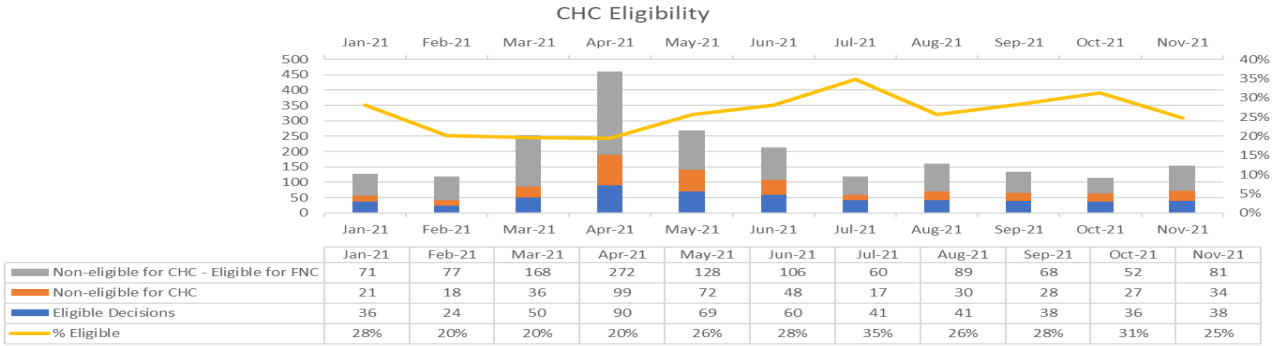


8.10.1. The pattern is the same across all CCGs with over 50% of overdue reviews being more than 12 months past the review due date, particularly FNC patients where the figure is over 60%.

8.10.2. The larger CCGs of Morecambe Bay and East Lancashire also show particularly high levels of CHC patients with overdue reviews.

8.11. <u>CHC Eligibility</u>

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Blackburn with Darwen	25%	11%	38%	48%	57%	28%	57%	43%	44%	0%	50%
East Lancashire	30%	22%	16%	19%	22%	25%	29%	13%	36%	20%	19%
Chorley & South Ribble	20%	13%	6%	27%	13%	21%	56%	18%	25%	62%	36%
Greater Preston	19%	17%	29%	18%	21%	9%	29%	35%	16%	47%	11%
Fylde And Wyre	50%	14%	15%	15%	29%	32%	29%	21%	13%	17%	17%
Blackpool	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Morecambe Bay	34%	27%	18%	16%	27%	35%	35%	24%	31%	25%	30%
West Lancashire	10%	22%	25%	22%	15%	29%	29%	40%	33%	44%	25%



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Non-eligible for CHC - Eligible for FNC	71	77	168	272	128	106	60	89	68	52	81
Non-eligible for CHC	21	18	36	99	72	48	17	30	28	27	34
Eligible Decisions	36	24	50	90	69	60	41	41	38	36	38
% Eligible	28%	20%	20%	20%	26%	28%	35%	26%	28%	31%	25%

8.11.1. The table and graph above detail the eligibility rates for the ICS as a whole following a DST. Through January 2021 – April 2021 the system was clearing the backlog of ICRs from post the COVID period along with deferred COVID cases. This gives an indication that the long

running ICRs have a lower eligibility rate than average. May 2021 – October 2021 eligibility rates are in line with those recorded before COVID.

8.11.2. Future reports will break down the data into individual CCGs, which will enable us to look at if different processes in different areas impact eligibility rates. BwD CCG have higher than the ICS average eligibility rate for 6 out of the 11 months in 2021, the other CCGs eligibility rates fluctuate month on month.

9. Safeguarding

9.1. Items to be escalated to SCC:

NHS readiness for Liberty Protection Safeguards (LPS)

The system awaits the LPS Code of Practice from DHSC, *expected April 2022.* Collective partnership preparation is progressing and includes:

- Implementation planning
- Leadership
- LPS workforce planning
- LPS data set
- Delayed DoLs and performance improvement
- Resource planning

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

9.2.1. Resource Implication - Implementation of Liberty Protection Safeguards

Financial and resource implications are not yet known; theCode is due April 2022 and is expected to outline these. There are potential cost implications relating to leadership e.g. Mental Capacity Lead, digital solutions, training.

A recent national briefing has indicated that Commissioning and Provider Contracting Leads to discuss optimising the 2022 and 2023 1.25% baseline budget for LPS implementation (as an innovation) for the coming 18 months. The Directors of Finance have been informed.

9.2.2. Delayed DoLs - *Deprivation of Liberty Applications*

The Q3 2021/22 position of delayed DoLs is being collated. The CCGs collectively (ICS) have an active improvement plan. Blackpool delays are being picked up via a directly commissioning service and pan-Lancashire is being picked up via MLCSU.

From January 2022, performance will be monitored via IPA reporting structures.

9.2.3. Service Pressure

North Cumbria Integrated Care (NCIC) have advised that the Strengthening Families Team are currently in Business Continuity for the East and West teams in Cumbria.

Whilst the South team (South Lakes, Barrow in Furness) is not directly affected currently, the south team workforce are supporting the other areas in terms of clinical leadership.

Both NCCCG and MBCCG have received a priority work plan detailing the scaling back of some services, including the Children Looked After functions. The plan will be reviewed twice

a week during the period of business continuity, and going forward, will be amended to reflect improved capacity across the service as and when that takes place.

MBCCG Executive Team have been made aware of the capacity and delivery issues and are looking at next steps to further support.

9.3. Current area of focus:

Maintaining Safeguarding Statutory functions

The ongoing impact of COVID presents many variables across Safeguarding. The teams continue to flex and respond, working with organisations, partners, individuals and communities.

9.4. Successes:

The LSC System held a Safeguarding Leads Learning Event. With funding from region, the safeguarding leads alongside the theatre company 'Afta Thought' produced a training film illustrating the narrative of 'Myth of Invisible Men' (national publication). Utilising an appreciative enquiry approach this film facilitates our workforce to confidently 'include', 'think' about the importance of father and male involvement in care of infants. We had national speaker involvement and the film has been shared with national networks and will be made available on NHS Future platforms accessible to all practitioners nationally.

10. Adult Mental Health, Children and Young People and, Learning Disabilities and Autism Data

NATIONAL DATA (North West Region)	IAPT Access	IAPT Access	IAPT Recovery Rate	IAPT 6 Week Wait	IAPT 18 Week Wait	IAPT 1st to 2nd Treatment >90 days	CYP Access (1+ Contacts)	CYP Eating Disorder Waiting time - Urgent	CYP Eating Disorder Waiting time - Routine	OAP bed days (inapp)	Dementia Diagnosis Rate	EIP Waiting Times	SMI Physical Health Checks	Perinatal Access (No of Women)	Community MH Access (2+ contacts)	Discharges Follow Up within 72 hours	Admissions with No Prior Contact (All Patients)
	Monthly	Rolling Quarter	Monthly	Monthly	Monthly	Monthly	Rolling 12 Months	Rolling 12 Months/Qtr*	Rolling 12 Months/Qtr*	Rolling Quarter	Monthly	Rolling Quarter	Rolling 12 Months	Rolling 12 Months	Rolling 12 Months	Monthly	Rolling Quarter
	Sep-21	Sep-21	Sep-21	Sep-21	Sep-21	Sep-21	Sep-21	Sep-21	Sep-21	Sep-21	Oct-21	Sep-21	Q2 21/22	Sep-21	Sep-21	Sep-21	Sep-21
Cheshire and Merseyside	4,653	12,480	45.0%	90.0%	96.0%	31.0%	29,985	85.5%	87.8%	1,660	62.7%	71.3%	6,990	945	15,670	78.0%	12.0%
Greater Manchester Health & Social Care Partnership	6,835	19,715	47.0%	78.0%	98.0%	20.0%	39,650	94.3%	92.3%	2,330	68.3%	79.5%	10,381	1,390	20,730	79.0%	15.0%
Healthier Lancashire & South Cumbria	2,885	8,580	52.00%	92.0%	100.0%	19.0%	21,100	59.4%	82.7%	8,230	67.5%	21.7%	4,986	1,000	10,515	62.0%	11.0%
North West	14,355	40,775	48.0%	85.0%	98.0%	24.0%	90,390	81.9%	83.9%	12,220	65.9%	60.7%	22,357	3,330	46,730	75.0%	13.0%
England	102,252	300,425	49.9%	91.2%	98.7%	18.0%	628,454	62.6%	64.8%	58,905	61.9%	69.4%	156,690	27,284	493,892	77.0%	15.0%
Target / Ceiling	4,303	12,910	> 50%	> 75%	> 95%	< 10.00%	20,419	> 95%	> 95%	0	> 66.7%	> 60%	> 6,917	> 807	No Target	> 80%	No Target

Healthier LSC Specific Target / Ceiling

LOCAL DATA (Lancashire & South Cumbria)	⚠ IAPT Access	⚠ IAPT Access	IAPT Recovery Rate	IAPT 6 Week Wait	IAPT 18 Week Wait	⚠ IAPT 1st to 2nd Treatment >90 days	CYP Access (Minimum 1 Contact)	CYP Eating Disorder Waiting time - Urgent	⚠ CYP Eating Disorder Waiting time - Routine	⚠ OAP bed days (inapp)	⚠ Dementia Diagnosis Rate	EIP Waiting Times	⚠ SMI Physical Health Checks	Perinatal Access (No of Women)	Community MH Access (2+ contacts)	Discharges Follow Up within 72 hours	Admissions with No Prior Contact (All Patients)	Learning Disability - Annual Health Checks
	Monthly	Rolling Quarter (target)	Monthly	Monthly	Monthly	Monthly	Rolling 12 Months	Rolling 12 Months/Qtr*	Rolling 12 Months/Qtr*	Rolling Quarter	Monthly	Rolling Quarter	Rolling 12 Months	Rolling 12 Months	Rolling 12 Months	Monthly	Rolling Quarter	Year to date
	Oct-21	Q2	Q2 21/22	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Sep-21	Oct-21	Sep-21	Nov-21
Blackburn with Darwen CCG	239	821	49.0%	92.26%	100.00%	8.25%	2,023	100.0%	0.0%	–	–	–	430	–	–	–	–	184
Blackpool CCG	360	991	60.0%	96.30%	99.47%	5.36%	2,215	–	–	–	–	–	488	–	–	–	–	204
Chorley and South Ribble CCG	264	798	48.0%	71.76%	96.95%	24.00%	1,779	100.0%	67.0%	–	–	–	266	–	–	–	–	271
East Lancashire CCG	643	1976	59.0%	95.40%	100.00%	24.42%	3,438	–	75.0%	–	–	–	649	–	–	–	–	328
Fylde and Wyre CCG	296	843	52.0%	86.30%	98.00%	29.01%	1,520	100.0%	100.0%	–	–	–	398	–	–	–	–	131
Greater Preston CCG	344	1073	51.0%	80.30%	98.73%	37.66%	1,506	–	0.0%	–	–	–	421	–	–	–	–	286
Morecambe Bay CCG	475	1439	57.0%	77.90%	100.00%	16.40%	3,208	–	100.0%	–	–	–	–	–	–	–	–	–
West Lancashire CCG	181	644	60.0%	90.30%	100.00%	16.98%	1,079	–	–	–	–	–	184	–	–	–	–	75
Lancashire and South Cumbria	2,802	8,585	55.0%	86.00%	99.29%	20.64%	16,768	100.0%	76.0%	1,294	63.1%	67.70%	2,836	1,320	–	89.40%	–	1,479
Target / Ceiling			> 50%	> 75%	> 95%	< 10.00%		> 95%	> 95%	< 1110	> 66.7%	> 60%	9,112			> 80%		

Total number of checks required to hit 60% compliance

⚠ Under target / concern

⚠ Under target / not a concern

11. 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 NHS E/HEE recommended figures have been supported in 2021/2022.
- National NHS E lead attended delivery meeting and has provided a list of high impact actions to support delivery.
- National IAPT expert to support review within 1 IAPT provider and share findings recommendations

11.2. Out of Area Placements – whilst nationally the OAP has remained relatively stable, several factors have led to an increase in OAPs 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

11.4. 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

12. Learning Disability and 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	57	49	+8
Secure In-Patients	38	39	-1
Total	**95**	**88**	+7

12.1.1. The position as at 13th December 2021 is that there are currently 57 CCG inpatients, against a Q3 trajectory of 49 (+8). 31 of these inpatients are placed outside of L&SC. Secure position in Q3 is 38, against a Q3 trajectory of 39 (-1).

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

Admissions	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021
CCG Inpatients	5	8	14	11	18	18	9
Secure Inpatients	1	4	2	1	0	0	0

12.1.2. There have been 8 people with a Learning Disability and/or Autism admitted into a LSCFT inpatient bed during Q3 and 1 person admitted out of area into an independent hospital bed.

Table 4: Discharges of Lancashire and South Cumbria Adult inpatients since Q1 2020

Discharges	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021
CCG Inpatients	16	8	11	16	11	10	13
Secure Inpatients	1	2	6	3	6	0	0

12.1.3. There have been 13 CCG patients with a Learning Disability and/or Autism discharged into the community during Q3, and no secure inpatients discharged.

12.1.4. Discharge Facilitation Meetings are now in place and meeting bi-weekly chaired by Fleur Carney. The aim of the meeting is to review all in-patients and identify actions required to enable discharges and identify any barriers.

12.1.5. Themes identified so far are:

- Secure EDD's listed but actually transfers to another hospital – not actual discharge
- Delays with building works impacting on the discharge date
- Staff recruitment is taking longer for some, reduced number of applicants
- Multiple assessments taking place followed by BI meetings

12.1.6. Suitable provision for Children and Young People – ASD and LD – there is a growing issue impacting Paediatric wards and Emergency departments

- 2 presenting issues
  - Identification of suitable community provision for CYP not meeting threshold for T4 admission – impacting ED and Paediatric Wards
  - Long waits for CYP in assessed as requiring a Tier 4 bed
- Repeated MDT/Leap and escalation meetings are failing to find solutions
- Lack of suitable community provision
- Co-morbidities such as Eating Disorder, Emotional Dysfunction, Social Emotional and Mental Health Needs further impact the successful search for suitable community placement with therapeutic input

- Action – a review of cases over the past 3 months to further understand the issues

12.2. Safe and Wellbeing Checks

12.2.1. CCG Reviews
- 56 Safe and Well-being Reviews to be completed
- 39 reviews completed as at 13th December 2021
- 9 dates yet to be confirmed / rescheduled due to sickness
- 2 cancelled as the people have been discharged into the community
- Aim to complete all CCG reviews by mid-January 2022

12.2.2. Specialised Commissioning Reviews
- 40 to be completed
- Responsibility is with Specialised Commissioning to arrange and facilitate the reviews

12.2.3. ICS Panel reviews
- ICS Panels weekly – 5 undertaken to date
- 16 Review documents now reviewed
- Process in place to either seek further clarity or by agreement of the panel an escalation meeting takes place
- 11 reviews have resulted in escalation to date
- Tracker mechanism in place to review further clarifications and minutes from escalation meetings – sign off on concerns then agreed by the panel

12.2.4. Key concerns from the ICS Panel
- Physical health checks
  - No identified support for weight management yet high BMI recorded, oral health lack of recoding and no dentist intervention, specialist medical intervention not followed up, recording of sleep patterns, lack of prescription glasses, access to SLT, follow up from physical health checks and recording of when these took place
- No clear advocate or lack of advocate involvement
- Queries as to whether the patient has capacity
- High numbers of episodes of restraint – no clarity on why
- Frequent use of PRN medication which no clarity as to why
- Parent dissatisfied with the hospital, activity levels and medication
- No discharge plan in place, delays in developing ISP
- Lack of clarity on the treatment plan
- Concerns regarding transition plans to support discharge

13. Recommendation

The Committee is asked to note the contents of this report.

Roger Parr
Deputy Chief Officer / CFO from Pennine Lancashire CCGs

Kathryn Lord
Director of Quality and Chief Nurse from Pennine Lancashire CCGs

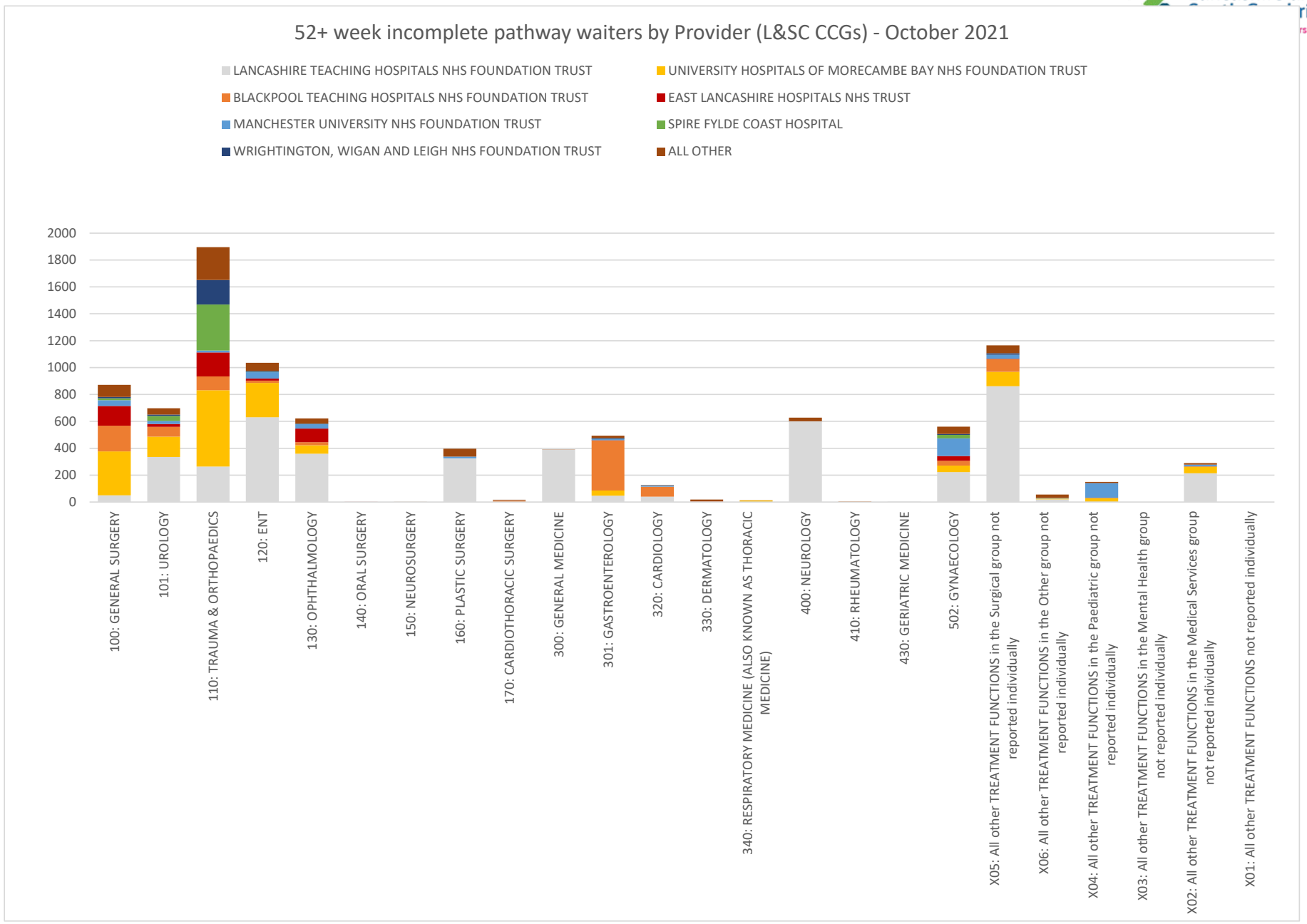
Glossary

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
AZ	AstraZeneca	IPC	Infection Prevention and Control
B CCG	Blackpool Clinical Commissioning Group	LAMP	Loop Mediated Isothermal Amplification
BGH	Burnley General Hospital	L&SC	Lancashire and South Cumbria
BI	Business Intelligence	LeDeR	Learning Disabilities Mortality Review
BSI	Blood Stream Infections	LOS	Length of Stay
BTHT	Blackpool Teaching Hospitals Trust	LSCFT	Lancashire South Cumbria Foundation Trust
BVH	Blackpool Victoria Hospital	LTHT	Lancashire Teaching Hospital Trust
BwD	Blackburn with Darwen	MAS	Memory Assessment Service
C&M	Cheshire and Mersey	MB CCG	Morecambe Bay Clinical Commissioning Group
CAMHS	Children and Adolescent Mental Health Service	MCFT	Mersey Care Foundation Trust
CBT	Cognitive Behavioural Therapy	MDT	Multidisciplinary Team
CCG	Clinical Commissioning Group	MH	Mental Health
CDI	Clostridioides Difficile Infections	MHDS	Mental Health Services Data Set
CHC	Continuing Health Care	MHLT	Mental Health Liaison Team
CYPEWMH	Children and Young People's Emotional Wellbeing and Mental Health	MHST	Mental Health Support Teams
CHR	Clinical harm review	MLCSU	Midlands and Lancashire Commissioning Support Unit
CoP	Court of Protection	MRI	Magnetic Resonance Imaging
CPA	Care Programme Approach	MRSA	Meticillin resistant Staphylococcus Aureus
CRG	Clinical Reference Groups	MSSA	Meticillin Sensitive Staphylococcus Aureus
CSR	Chorley and South Ribble	MSK	Musculoskeletal
CT	Computerized Tomography scan	NHSE	National Health Service England
CTR	Care and Treatment Review	NHSI	National Health Service Improvement
CYP	Children and Young People	NW	North West
D2A	Discharge to assess	NWAS	North West Ambulance Service
DA	Domestic Abuse	OAP	Out of Area Placement
DCA	Double-crewed Ambulance	PALS	Patient Advice and Liaison Service
DH&SC	Department of Health and Social Care	PCN	Primary Care Network
DNA	Did not attend	PHE	Public Health England
DTA	Decision to Admit	PHOM	Population Health Operating Model
ECDS	Emergency Care Dataset	PICU	Psychiatric Intensive Care Unit
E. coli	Escherichia coli	PIR	Post Incident Review
ECRG	Elective Care Recovery Group	PPE	Personal Protective Equipment
ED	Emergency Department	QP	Quality Premium
EDi	Eating Disorders	Q&P	Quality and Performance
EIP	Early Intervention Psychosis	RBH	Royal Blackburn Hospital
EL	East Lancashire	RDC	Rapid Diagnostic Centre
ELCAS	East Lancashire Child and Adolescent Services	RLI	Royal Lancaster Hospital

ELHT	East Lancashire Hospitals Trust	RPH	Royal Preston Hospital
EMHPs	Education Mental Health Practitioners	RTA	Referral to Assessment
EOIs	Expression of Interests	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	SJR	Structured Judgement Reviews
G&A	General and Acute	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.
GP	Greater Preston	UCC	Urgent Care Centre
GM	Greater Manchester	UEC	Urgent and Emergency Care
HCAIs	Healthcare Associated Infections	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
HLSC	Healthier Lancashire and South Cumbria	WL	West Lancashire
HOCI	Healthcare onset COVID-19 infection	WLIs	Waiting List Initiatives
IAPT	Improving Access to Psychological Therapies		

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

Specialty	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	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	SPIRE FYLDE COAST HOSPITAL	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	ALL OTHER	TOTAL	% TOTAL
100: GENERAL SURGERY	50	327	191	147	42	14	10	91	872	9.2%
101: UROLOGY	335	152	72	21	23	37	11	47	698	7.4%
110: TRAUMA & ORTHOPAEDICS	264	568	102	179	14	342	182	244	1895	20.1%
120: ENT	630	256	17	15	47	3	7	60	1035	11.0%
130: OPHTHALMOLOGY	360	62	23	102	32	1	3	39	622	6.6%
140: ORAL SURGERY	0	0	0	2	0	0	0	0	2	0.0%
150: NEUROSURGERY	0	0	0	0	0	0	0	1	1	0.0%
160: PLASTIC SURGERY	325	0	0	0	13	0	0	58	396	4.2%
170: CARDIOTHORACIC SURGERY	0	0	12	0	2	0	0	4	18	0.2%
300: GENERAL MEDICINE	391	0	0	0	0	0	0	1	392	4.2%
301: GASTROENTEROLOGY	48	38	373	1	9	1	6	18	494	5.2%
320: CARDIOLOGY	40	0	75	0	9	0	0	3	127	1.3%
330: DERMATOLOGY	2	0	2	1	0	0	0	14	19	0.2%
340: RESPIRATORY MEDICINE (ALSO KNOWN AS THORACIC MEDICINE)	0	12	0	0	0	0	0	1	13	0.1%
400: NEUROLOGY	600	0	0	0	0	0	0	28	628	6.7%
410: RHEUMATOLOGY	0	0	5	0	0	0	0	1	6	0.1%
430: GERIATRIC MEDICINE	3	0	0	0	0	0	0	0	3	0.0%
502: GYNAECOLOGY	222	49	36	36	131	26	7	54	561	5.9%
X05: All other TREATMENT FUNCTIONS in the Surgical group not reported individual	862	106	94	4	29	0	12	58	1165	12.3%
X06: All other TREATMENT FUNCTIONS in the Other group not reported individually	20	6	0	0	4	0	0	26	56	0.6%
X04: All other TREATMENT FUNCTIONS in the Paediatric group not reported individu	0	28	4	0	108	0	1	9	150	1.6%
X03: All other TREATMENT FUNCTIONS in the Mental Health group not reported ind	0	0	0	0	0	0	0	0	0	0.0%
X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported i	214	50	0	2	12	0	0	11	289	3.1%
X01: All other TREATMENT FUNCTIONS not reported individually	0	0	0	0	0	0	0	0	0	0.0%
Grand Total	**4366**	**1654**	**1006**	**510**	**475**	**424**	**239**	**768**	**9442**	**100.0%**
% TOTAL	46.2%	17.5%	10.7%	5.4%	5.0%	4.5%	2.5%	8.1%	**100.0%**	


52+ week incomplete pathway waiters by Provider (L&SC CCGs) - October 2021
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
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
SPIRE FYLDE COAST HOSPITAL
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
ALL OTHER
2000
1800
1600
1400
1200
1000
800
600
400
200
0
100: GENERAL SURGERY
101: UROLOGY
110: TRAUMA & ORTHOPAEDICS
120: ENT
130: OPHTHALMOLOGY
140: ORAL SURGERY
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
X03: All other TREATMENT FUNCTIONS in the Mental Health group not reported individually
X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported individually
X01: All other TREATMENT FUNCTIONS not reported individually

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

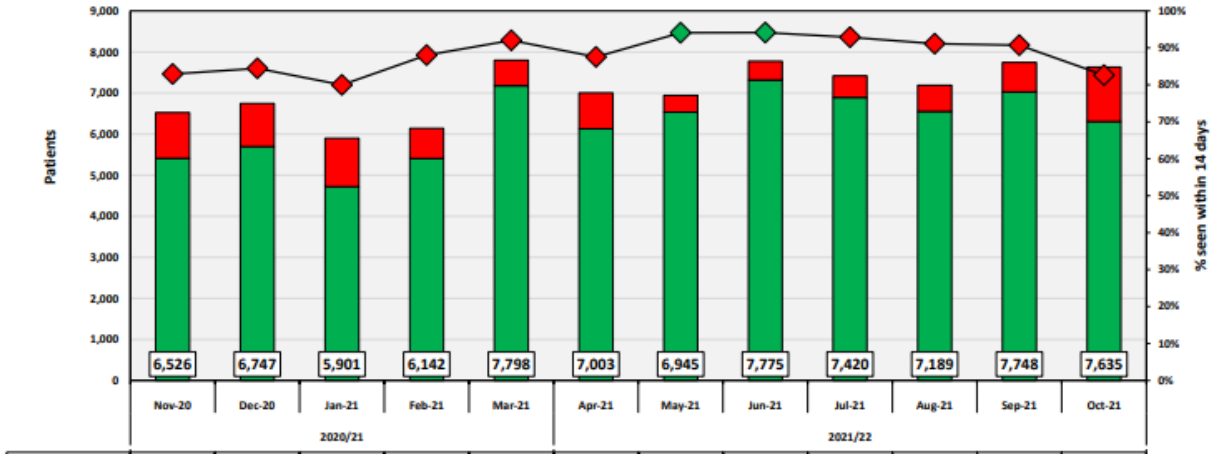
Treatment Function	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	EAST LANCASHIRE HOSPITALS NHS TRUST	TOTAL	% TOTAL
Oral Surgery Service	1814	37	13	146	2010	19.2%
Trauma and Orthopaedic Service	307	597	105	182	1191	11.4%
Other - Surgical Services	923	115	94	6	1138	10.9%
Ear Nose and Throat Service	660	267	18	15	960	9.2%
General Surgery Service	54	343	197	150	744	7.1%
Neurology Service	613	0	0	0	613	5.9%
Urology Service	358	156	74	22	610	5.8%
Ophthalmology Service	368	66	23	102	559	5.4%
Neurosurgical Service	519	0	0	0	519	5.0%
Gastroenterology Service	51	38	378	1	468	4.5%
General Internal Medicine Service	413	0	0	0	413	4.0%
Gynaecology Service	241	52	36	36	365	3.5%
Plastic Surgery Service	338	0	0	0	338	3.2%
Other - Medical Services	235	55	0	2	292	2.8%
Cardiology Service	41	0	84	0	125	1.2%
Other - Paediatric Services	0	29	4	0	33	0.3%
Other - Other Services	21	6	0	0	27	0.3%
Respiratory Medicine Service	0	14	0	0	14	0.1%
Cardiothoracic Surgery Service	0	0	13	0	13	0.1%
Dermatology Service	2	0	2	1	5	0.0%
Rheumatology Service	0	0	5	0	5	0.0%
Elderly Medicine Service	3	0	0	0	3	0.0%
Other - Mental Health Services	0	0	0	0	0	0.0%
TOTAL	**6961**	**1775**	**1046**	**663**	**10445**	**100.0%**
% TOTAL	66.6%	17.0%	10.0%	6.3%	**100.0%**	

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

% 2 Weeks Cancer – Urgent GP Referral – October 21

2 Week Wait Referrals (93% Standard)

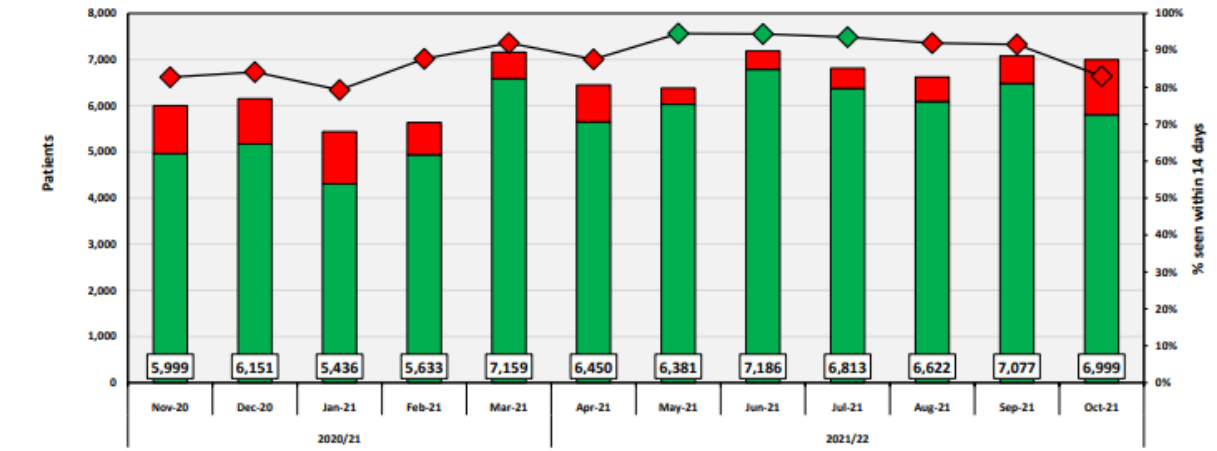
Cancer Alliance CCGs (Nov-20 to Oct-21)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	1,115	1,050	1,181	735	622	873	410	455	528	638	720	1,327
Within 14 Days	5,411	5,697	4,720	5,407	7,176	6,130	6,535	7,320	6,892	6,551	7,028	6,308
Seen	6,526	6,747	5,901	6,142	7,798	7,003	6,945	7,775	7,420	7,189	7,748	7,635
Performance	82.91%	84.44%	79.99%	88.03%	92.02%	87.53%	94.10%	94.15%	92.88%	91.13%	90.71%	82.62%

CCG	Oct-21			Nov-20 to Oct-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	528	93	82.39%	6,033	479	92.06%
BCCG	701	86	87.73%	8,030	583	92.74%
CSRCCG	809	174	78.49%	9,054	1,084	88.03%
ELCCG	1,420	235	83.45%	15,763	1,176	92.54%
FWCCG	1,003	130	87.04%	11,164	880	92.12%
GPCCG	939	176	81.26%	11,299	1,296	88.53%
MBCCG	1,652	301	81.78%	17,042	3,215	81.13%
WLCCG	583	132	77.36%	6,444	941	85.40%
CA CCGs	7,635	1,327	82.62%	84,829	9,654	88.62%

Cancer Alliance Providers (Nov-20 to Oct-21)



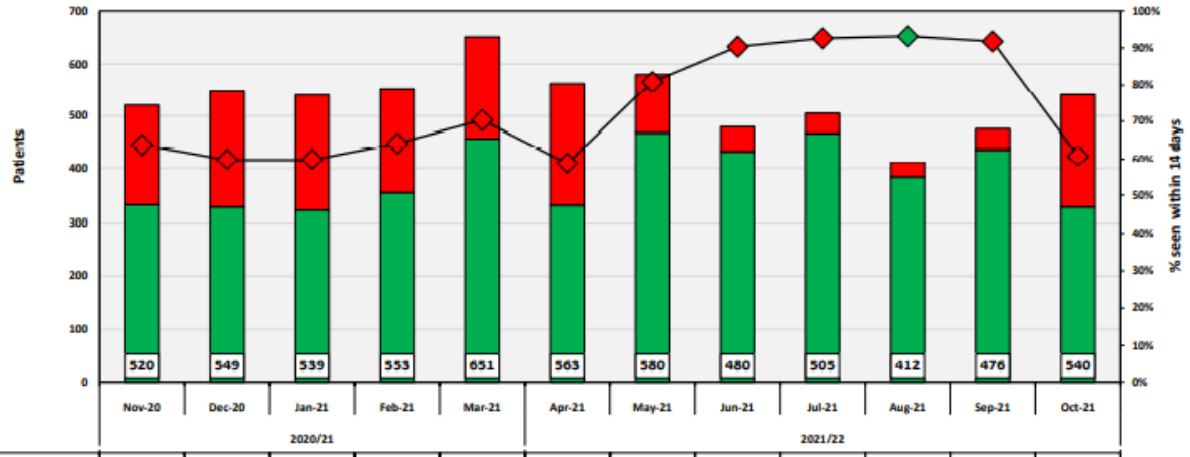
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	1,036	978	1,127	693	575	802	348	400	439	532	595	1,191
Within 14 Days	4,963	5,173	4,309	4,940	6,584	5,648	6,033	6,786	6,374	6,090	6,482	5,808
Seen	5,999	6,151	5,436	5,633	7,159	6,450	6,381	7,186	6,813	6,622	7,077	6,999
Performance	82.73%	84.10%	79.27%	87.70%	91.97%	87.57%	94.55%	94.43%	93.56%	91.97%	91.59%	82.98%

Provider	Oct-21			Nov-20 to Oct-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	1,498	177	88.18%	16,999	1,139	93.30%
ELHT	1,866	310	83.39%	20,697	1,511	92.70%
LTH	1,893	390	79.40%	22,057	2,617	88.14%
UHMB	1,742	314	81.97%	18,152	3,449	81.00%
CA Providers	6,999	1,191	82.98%	77,905	8,716	88.81%

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

2 Week Wait Breast Symptomatic Referrals (93% Standard)

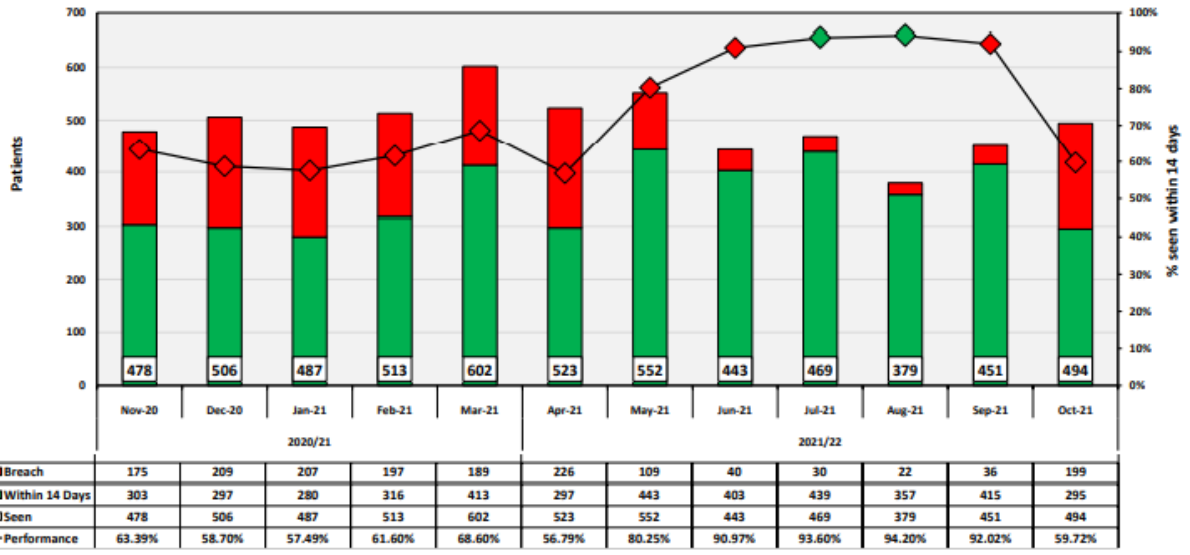
Cancer Alliance CCGs (Nov-20 to Oct-21)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	188	221	217	198	193	232	111	46	37	28	39	212
Within 14 Days	332	328	322	355	458	331	469	434	468	384	437	328
Seen	520	549	539	553	651	563	580	480	505	412	476	540
Performance	63.85%	59.74%	59.74%	64.20%	70.35%	58.79%	80.86%	90.42%	92.67%	93.20%	91.81%	60.74%

CCG	Oct-21			Nov-20 to Oct-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	46	15	67.39%	667	65	90.25%
BCCG	76	7	90.79%	783	135	82.76%
CSRCCG	54	46	14.81%	722	331	54.16%
ELCCG	133	45	66.17%	1,479	150	89.86%
FWCCG	54	11	79.63%	650	139	78.62%
GPCCG	64	47	26.56%	836	383	54.19%
MBCCG	77	32	58.44%	874	458	47.60%
WLCCG	36	9	75.00%	357	61	82.91%
CA CCGs	540	212	60.74%	6,368	1,722	72.96%

Cancer Alliance Providers (Nov-20 to Oct-21)



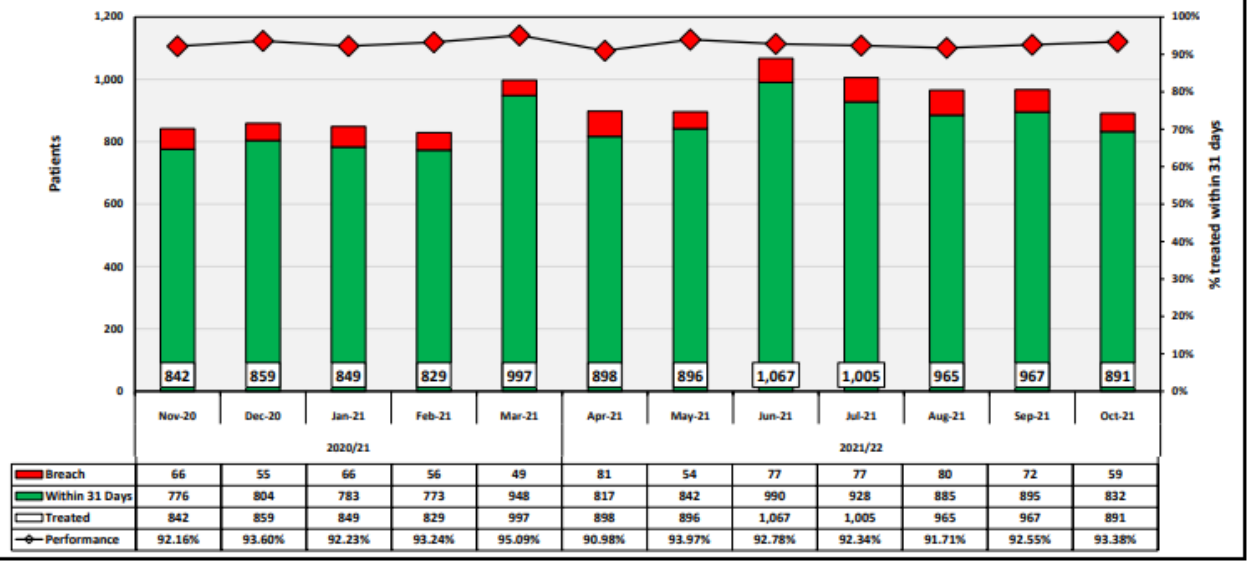
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	175	209	207	197	189	226	109	40	30	22	36	199
Within 14 Days	303	297	280	316	413	297	443	403	439	357	415	295
Seen	478	506	487	513	602	523	552	443	469	379	451	494
Performance	63.39%	58.70%	57.49%	61.60%	68.60%	56.79%	80.25%	90.97%	93.60%	94.20%	92.02%	59.72%

Provider	Oct-21			Nov-20 to Oct-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	123	12	90.24%	1,335	220	83.52%
ELHT	169	55	67.46%	2,027	180	91.12%
LTH	122	96	21.31%	1,607	743	53.76%
UHMB	80	36	55.00%	928	496	46.55%
CA Providers	494	199	59.72%	5,897	1,639	72.21%

% 31 Day Cancer – Definitive Treatment – October 21

31 Day First Treatment (96% Standard)

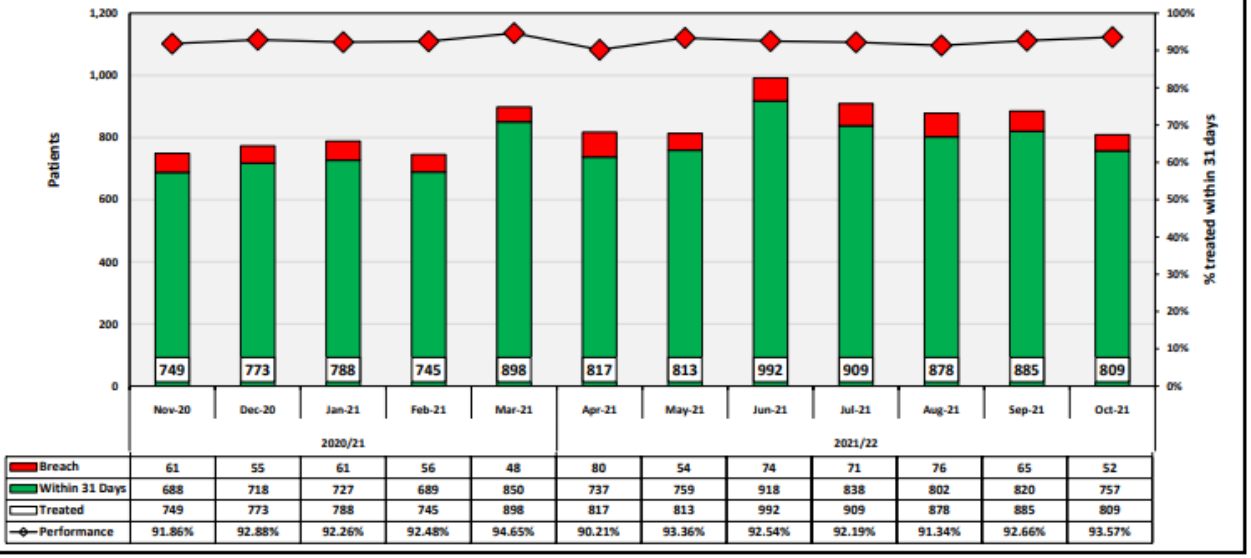
Cancer Alliance CCGs (Nov-20 to Oct-21)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	66	55	66	56	49	81	54	77	77	80	72	59
Within 31 Days	776	804	783	773	948	817	842	990	928	885	895	832
Treated	842	859	849	829	997	898	896	1,067	1,005	965	967	891
Performance	92.16%	93.60%	92.23%	93.24%	95.09%	90.98%	93.97%	92.78%	92.34%	91.71%	92.55%	93.38%

CCG	Oct-21			Nov-20 to Oct-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	62	5	91.94%	751	51	93.21%
BCCG	92	3	96.74%	1,233	65	94.73%
CSRCCG	113	7	93.81%	1,181	111	90.60%
ELCCG	185	10	94.59%	2,126	130	93.89%
FWCCG	104	6	94.23%	1,596	98	93.86%
GPCCG	95	4	95.79%	1,084	99	90.87%
MBCCG	171	18	89.47%	2,305	209	90.93%
WLCCG	69	6	91.30%	789	29	96.32%
CA CCGs	891	59	93.38%	11,065	792	92.84%

Cancer Alliance Providers (Nov-20 to Oct-21)



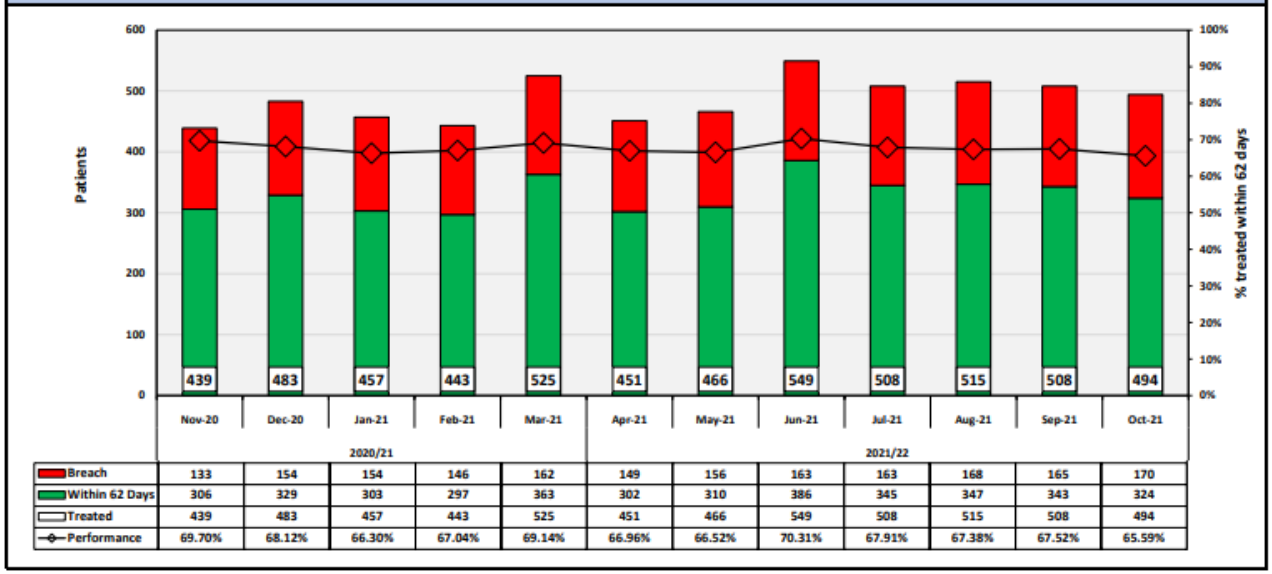
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	61	55	61	56	48	80	54	74	71	76	65	52
Within 31 Days	688	718	727	689	850	737	759	918	838	802	820	757
Treated	749	773	788	745	898	817	813	992	909	878	885	809
Performance	91.86%	92.88%	92.26%	92.48%	94.65%	90.21%	93.36%	92.54%	92.19%	91.34%	92.66%	93.57%

Provider	Oct-21			Nov-20 to Oct-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	167	3	98.20%	2,345	43	98.17%
ELHT	221	15	93.21%	2,446	133	94.56%
LTH	278	24	91.37%	3,357	438	86.95%
UHMB	143	10	93.01%	1,908	139	92.71%
CA Providers	809	52	93.57%	10,056	753	92.51%

% 62 Day Cancer – October 21

62 Day Classic Performance (85% Standard)

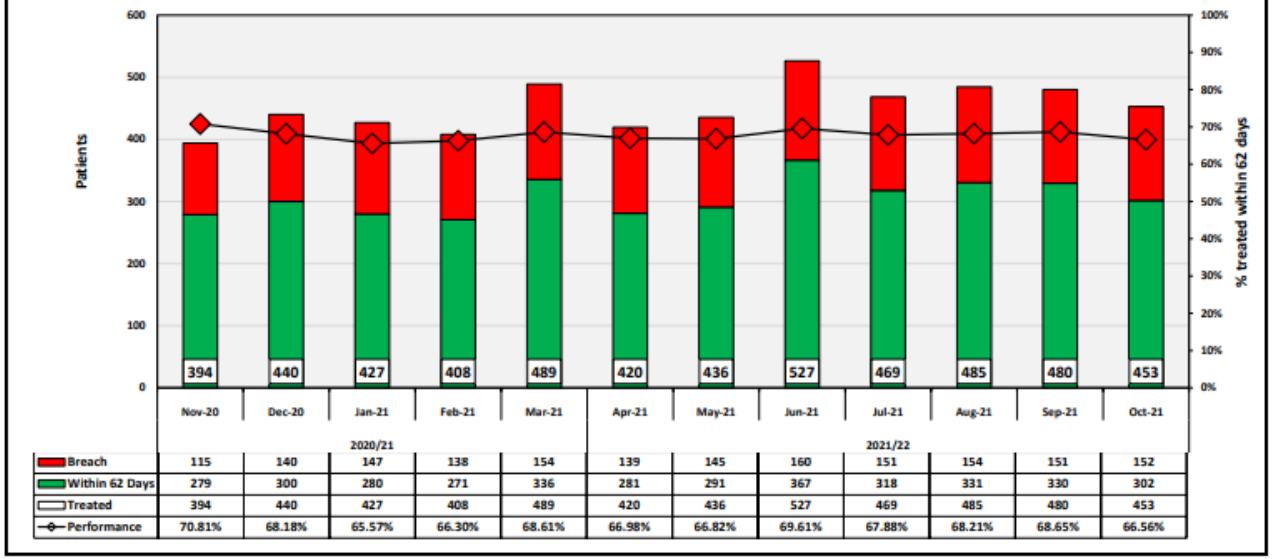
Cancer Alliance CCGs (Nov-20 to Oct-21)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	133	154	154	146	162	149	156	163	163	168	165	170
Within 62 Days	306	329	303	297	363	302	310	386	345	347	343	324
Treated	439	483	457	443	525	451	466	549	508	515	508	494
Performance	69.70%	68.12%	66.30%	67.04%	69.14%	66.96%	66.52%	70.31%	67.91%	67.38%	67.52%	65.59%

CCG	Oct-21			Nov-20 to Oct-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	33.0	9.0	72.73%	372.0	104.0	72.04%
BCCG	52.0	22.0	57.69%	623.0	187.0	69.98%
CSRCCG	58.0	12.0	79.31%	673.0	227.0	66.27%
ELCCG	104.0	32.0	69.23%	1,115.0	305.0	72.65%
FWCCG	57.0	14.0	75.44%	865.0	235.0	72.83%
GPCCG	67.0	21.0	68.66%	614.0	227.0	63.03%
MBCCG	82.0	41.0	50.00%	1,188.0	464.0	60.94%
WLCCG	41.0	19.0	53.66%	388.0	134.0	65.46%
CA CCGs	494.0	170.0	65.59%	5,838.0	1,883.0	67.75%

Cancer Alliance Providers (Nov-20 to Oct-21)



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Breach	115	140	147	138	154	139	145	160	151	154	151	152
Within 62 Days	279	300	280	271	336	281	291	367	318	331	330	302
Treated	394	440	427	408	489	420	436	527	469	485	480	453
Performance	70.81%	68.18%	65.57%	66.30%	68.61%	66.98%	66.82%	69.61%	67.88%	68.21%	68.65%	66.56%

Provider	Oct-21			Nov-20 to Oct-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	99.5	29.0	70.85%	1,323.5	331.5	74.95%
ELHT	129.5	36.0	72.20%	1,356.5	362.0	73.31%
LTH	146.5	49.0	66.55%	1,601.0	630.5	60.62%
UHMB	77.5	37.5	51.61%	1,144.5	418.5	63.43%
CA Providers	453.0	151.5	66.56%	5,425.5	1,742.5	67.88%

% 6 Week Diagnostic Waiters –October 21

ICS Level: Lancashire & South Cumbria

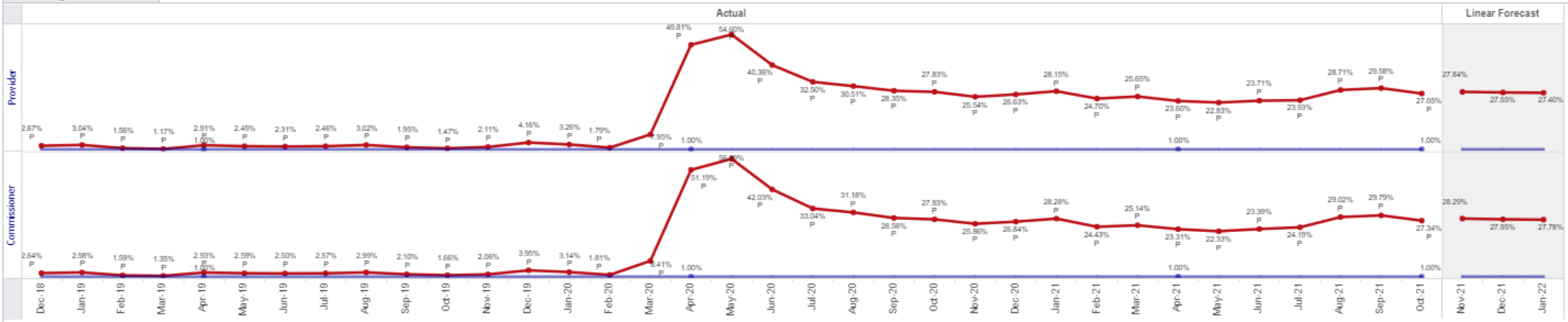
% of patients waiting 6 weeks or more for a diagnostic test

	Provider		YTD
Value	Oct-21	27.05%	25.70%
Target	Oct-21	1.00%	1.00%
Forecast	Nov-21	27.84%	25.70%

	Commissioner		YTD
Value	Oct-21	27.34%	25.79%
Target	Oct-21	1.00%	1.00%
Forecast	Nov-21	28.29%	25.79%

% Waiters 6 Wks Diagnostics

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

% Incomplete 18 weeks RTT – October 21

ICS Level: Lancashire & South Cumbria

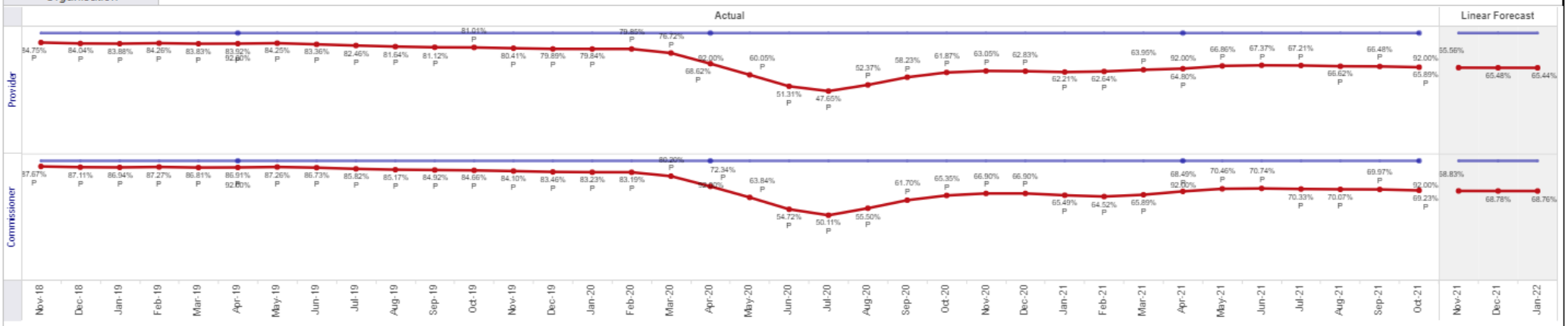
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

	Provider		YTD
Value	Oct-21	65.89%	66.47%
Target	Oct-21	92.00%	92.00%
Forecast	Nov-21	65.56%	66.47%

	Commissioner		YTD
Value	Oct-21	69.23%	69.90%
Target	Oct-21	92.00%	92.00%
Forecast	Nov-21	68.83%	69.90%

% Incomplete 18 Wks RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Total number of Incompletes RTT –October 21

ICS Level: Lancashire & South Cumbria

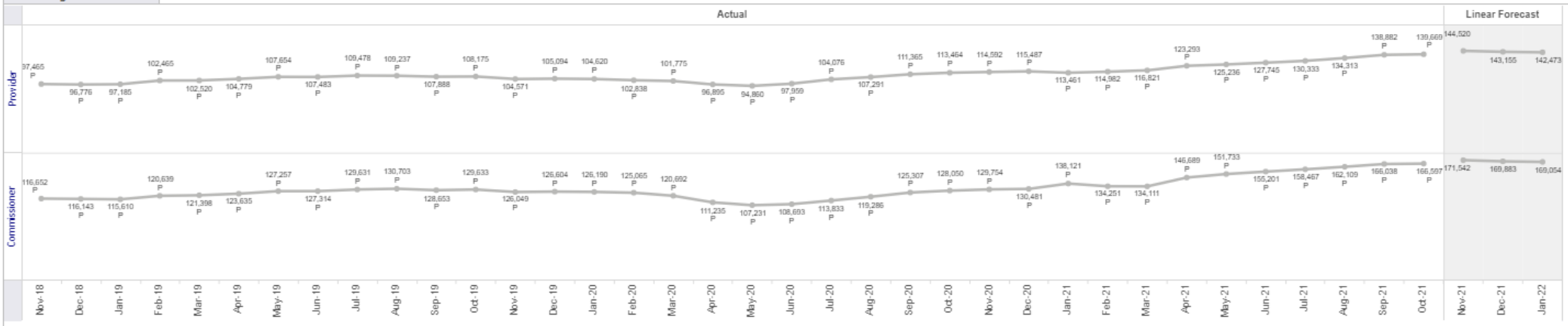
Total Number of Incompletes under and above 18 weeks RTT

Provider		
Value	Oct-21	139,669
Target	Oct-21	
Forecast	Nov-21	144,520

Commissioner		
Value	Oct-21	166,597
Target	Oct-21	
Forecast	Nov-21	171,542

Total no. of Incompletes RTT

Organisation



ICS | Integrated Care Partnerships \ Integrated Care Organisations

Lancashire & South Cumbria

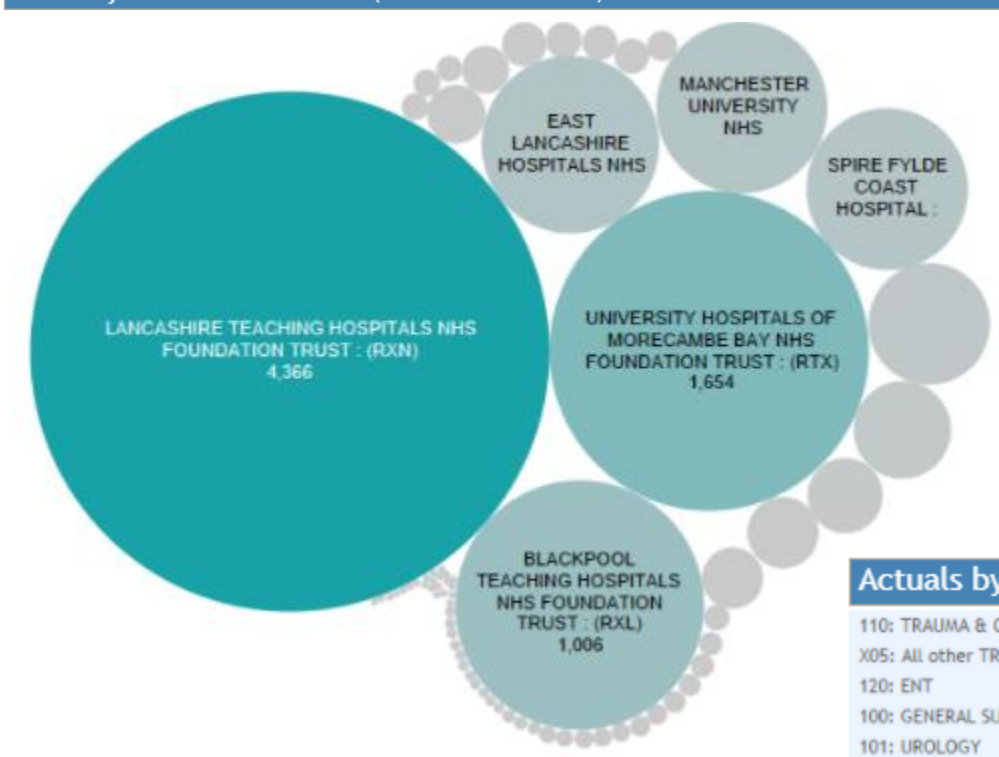
	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire	West Lancashire
Commissioner	25,091 Oct-21	56,393 Oct-21	23,066 Oct-21	35,119 Oct-21	11,846 Oct-21
Commissioner	29,530 Oct-21	44,141 Oct-21	34,456 Oct-21	46,624 Oct-21	

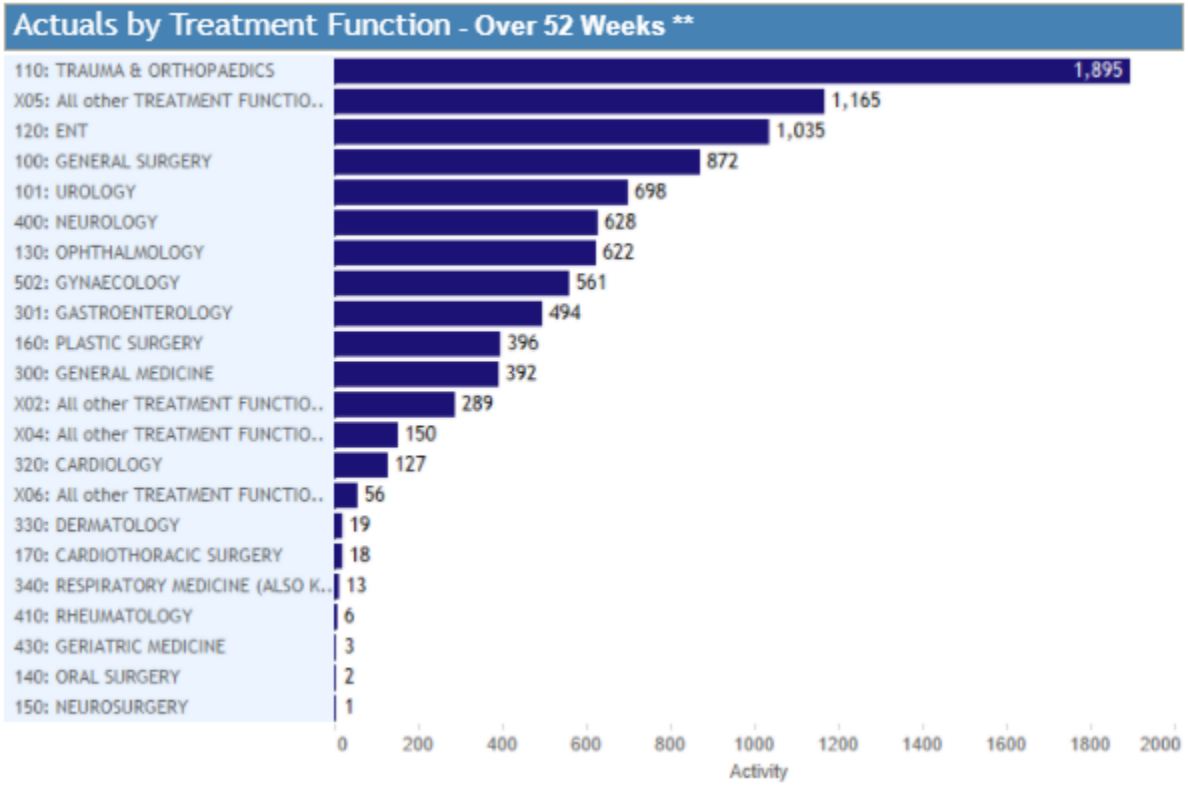
Commissioner: 166,597 Oct-21

	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
	Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	29,530 Oct-21	25,091 Oct-21	19,718 Oct-21	24,423 Oct-21	56,393 Oct-21	16,780 Oct-21	17,676 Oct-21	23,066 Oct-21	14,335 Oct-21	32,289 Oct-21	35,119 Oct-21	11,846 Oct-21

Provider: 139,669 Oct-21

Over 52 week waiters – October 21





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

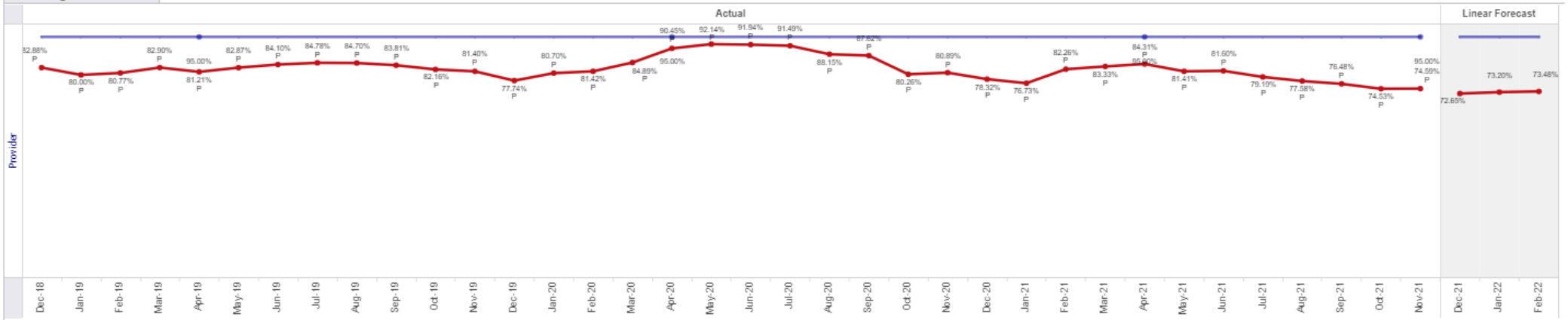
ICS Level: Lancashire & South Cumbria

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

	Provider		YTD
Value	Nov-21	74.59%	78.66%
Target	Nov-21	95.00%	95.00%
Forecast	Dec-21	72.65%	78.66%

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

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations			
	Bay Health & Care Partners Provider	Central Lancashire Provider	Fylde Coast Provider	Pennine Lancashire Provider
Lancashire & South Cumbria	75.01% Nov-21	75.69% Nov-21	80.18% Nov-21	66.99% Nov-21
Provider	Bay Health & Care Partners	Central Lancashire	Fylde Coast	Pennine Lancashire
74.59% Nov-21	UHMB	LTH	BTH	ELHT
	75.01% Nov-21	75.69% Nov-21	80.18% Nov-21	66.99% Nov-21

Strategic Commissioning Committee

Date of meeting	13 January 2022
Title of paper	SEND Update
Presented by	Hilary Fordham, Chief Operating Officer MBCCG, and Senior Responsible Officer for SEND for the Integrated Care System (ICS)
Author	Zoe Richards, Senior Manager for SEND for the ICS
Agenda item	10
Confidential	No

Purpose of the paper

To update Strategic Commissioning Committee on the inspection positions for SEND

Executive summary

SEND inspections commenced in the Lancashire and South Cumbria Integrated Care System in November 2017 and progress with inspection positions has been reported to Strategic Commissioning Committee. This paper provides the latest update position.

Lancashire had an inspection revisit in March 2020 which resulted in an Accelerated Progress Plan (APP) covering 5 areas of significant concern. The APP has been closely monitored by Department for Education (DfE) and NHS England (NHSE) since September 2020. This report provides Strategic Commissioning Committee with an update following the 12 month monitoring session held by DfE and NHSE at the end of September 2021. Additionally,

Additionally, there are immediate commissioning needs that require support in both H2 and in 2022/23, and these are covered within the report.

Recommendations

The SCC is asked to:

- Note the outcome of the Lancashire Accelerated Progress Plan monitoring meeting.
- Continue to support the funding request for:
  - Second part of the ASD waiting list management
  - Specialist community nursing (as outlined in the supplementary paper presented to CCAG in July 2021) including Special School Nursing and Bladder and Bowel services.
- Recognise that further developments will be presented through CCAG over the next few months which may have funding implications for 2022/23. This includes neurodevelopmental pathway and therapies.
- Continue the commitment to support the ongoing programme management of SEND and recognise the need to marry ICB and Local Authority level responsibilities as the structures develop.

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

Meeting	Date	Outcomes
Collaborative Commissioning Advisory Group	9th November 2021	Approved recommendations

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:	Collaborative Commissioning Advisory Group

SEND Update December 2021

1. **Background**

SEND inspections commenced in the Lancashire and South Cumbria Integrated Care System in November 2017 when Lancashire SEND Partnership, covering the Lancashire County Council local area, underwent a joint Ofsted / Care Quality Commission inspection. The inspections ensure that a local area, based on a local authority footprint, is delivering its statutory duties, and includes the voices of children and young people and their families through co-production and meaningful feedback.

Since 2017, three of the local areas have gone through the inspection process, with Blackpool due to have an initial inspection early 2022. Cumbria was given a Written Statement of Action from its initial inspection, and is awaiting an inspection revisit to identify whether sufficient progress has been made.

Lancashire had an inspection revisit in March 2020 which resulted in an Accelerated Progress Plan (APP) covering 5 areas of significant concern. The APP was closely monitored by Department for Education (DfE) and NHS England (NHSE).

It should be noted that the responsibility for SEND across the ICS will transfer from CCGs to the ICB at its inception.

This report provides Strategic Commissioning Committee with an update position for SEND.

2. **Lancashire Accelerated Progress Plan**

Following an inspection revisit in March 2020, Lancashire local area was required to complete an Accelerated Progress Plan (APP) for 5 areas of significant concern that the

Ofsted and CQC inspectors deemed the partnership not to have made sufficient progress with. These were:

- Leaders' understanding of the local area
- Joint commissioning arrangements
- ASD waiting times
- Transitions in healthcare
- Local Offer improvements

Oversight of progress on delivery was delivered by a robust governance structure which included a Scrutiny Sub-Committee of the Lancashire Health and Wellbeing Board, with county councillors and 2 non-executive directors from CCGs within the Lancashire SEND Partnership local area.

Despite the pandemic and the difficulties that presented, the SEND Partnership delivered 97% of the sub-actions described in the APP. The sub-action that was not been delivered in full was the phase 2 roll-out of the transitions in healthcare pathway from healthcare providers to primary care. This was delayed due to capacity within primary care in the context of the vaccination programme. Action is ongoing for the full delivery of this sub-action.

A team of monitors from Department for Education (DfE) and NHS England (NHSE) reviewed an evidence pack that demonstrated the current position in relation to the 5 actions, and conducted a monitoring meeting with senior leaders of the local area. At that meeting the monitors highlighted the following points:

- Lancashire is a large local authority area that presents challenges, and has been hit particularly hard by Covid19, however it was welcomed that the SEND Partnership have found the opportunities for improvement.
- The local area has a clear and positive vision with Think SEND Think Voice, and with the aspiration to improve the lives of children and young people with SEND, and their families.
- The area knows itself well and what is required to deliver continuous improvement.
- There is evidence of good co-production, and there is more than a tokenistic approach to gathering feedback from children and young people, and from parent carers.
- There is a tangible reduction in waiting times for autism assessment.
- There is good evidence of work on transitions in healthcare.
- It was welcomed that the local area links the different aspects of improvement activity together, and uses work in one action to benefit delivery of other actions.
- The evidence pack was recognised by all monitors as clear and effective, and was referenced as a good example of how evidence should be presented in other areas of the country.

The concentration of questioning from the monitors was to the head teachers, healthcare provider, parent carer forum and children and young people's group, to understand the impact and effectiveness of the improvements that have been made or are planned as on-going activity.

The outcome of the monitoring is that the DfE and NHSE monitors are satisfied that sufficient progress has been made and that the local area has demonstrated clear and sustained progress, meaning that they do not need to continue formal monitoring. The monitors noted that this positive result comes as the result of a great deal of commitment and hard work on the part of the local authority, the Clinical Commissioning Groups (CCGs), families and front-line staff across education, health and social care.

It should be noted that updates on strands of activity in the APP may be requested by the DfE and NHSE, and should performance in relation to SEND change and the need arise due to lack of sustained progress, more regular and formal reviews may be reinstated. Furthermore, the local area can expect to be inspected under the new SEND inspection framework at any point after April 2022.

3. Cumbria Written Statement of Action - Progress

Cumbria underwent its initial inspection in 2019 and was given nine areas of significant weakness to address and asked to develop its Written Statement of Action. The area is now awaiting its inspection re-visit at any time and significant work is being undertaken in readiness for this. The SEND Partnership Board continues to develop and oversee the work to improve service provision and outcomes for young people.

Over the last three years, partners in Cumbria have undertaken a range of work to address issues raised, including:

- Understanding population need and service performance
- Planning and commissioning services jointly which meet need
- Improving access to and delivery of services and provision
- Engaging, involving, and communicating with parent carers and young people
- Improving system guidance, processes, and support

In recent months the Executive Team (accountable officers across Cumbria County Council, North Cumbria CCG and Morecambe Bay CCG) has been concerned that progress in some areas is not as great as it should be and so an 'accelerated progress plan' approach has been put in place to improve progress related to three areas, with plans overseen by the Partnership board:

- **Understanding strengths and weaknesses in performance** – performance in the completion of mandatory Health Visitor checks at 27 months and statutory Annual Reviews of Education Health and Care Plans (EHCPs), along with the limited impact of the extensive work on securing consistently high quality EHCPs.
- **Approach to ASD including social, emotional, and mental health** – accuracy of data on assessment and referral, access to the pathway for support and diagnosis, and a system-wide graduated response to need.
- **Systems for ensuring smooth transition** – accuracy of data on referrals, triaging of complex cases, and planning provision for young people as they transition from children's services to adult social care and health services.

Preparations for the expected revisit are underway with a detailed self-assessment in place. As with all areas, we do not know when the revisit will take place but is expected early in 2022.

4. **Immediate SEND Commissioning Needs**

In July 2021, CCAG received and approved a list of future commissioning needs, recognising that addressing these would improve the outcomes for children and young people whilst at the same time support the ICS in meeting its statutory duties as defined in the SEND Code of Practice. CCAG supported that these should be put forward for the H2 and 2022/23 planning process which was undertaken. The areas are as follows, and we await the outcome of the 2022/23 planning process:

Commissioning Need	Current position
Autism Assessment Pathway	Funding of £620,000 of the £1,220,000 requested was agreed in 2020/21 to address ASD waiting times. In order to address the on-going waiting list issues, the additional £600,000 is still required and is requested from 2022/23 funding. Waiting lists continue to grow with increases in referrals from parents, schools, GPs and healthcare practitioners. As a result, whilst waiting times are now fully understood, and there is a reduction in the longest waits, the overall numbers of CYP waiting has increased. An ICS-wide ASD Data Dashboard has been developed, and is increasing in robustness across providers, giving clarity of where the longest waits are in the ICS, the reasons for those longest waits, and what needs to be done to manage them. Additionally, there is clarity regarding the increased levels of referrals, which is currently more than 25% up on pre-pandemic levels. This increase means that the overall numbers of children and young people on the waiting list has increased, despite the increased activity over the last 12 months.
Neurodevelopmental (ND) Pathway	The ICS previously committed to moving to the ND Pathway, though this was paused due to instruction from inspectors as part of the re-visit of Lancashire in 2020, to allow for management of ASD waiting lists. Fylde Coast piloted the ND Pathway and this indicates the benefits of adopting the ND model. In moving to this sustainable approach of no wrong front door, along with supporting CYP through graduated responses appropriate to need, the pathway enables a join up of ASD, ADHD, SLT and other needs. There are financial implications, and an ICS-wide business case was due to be considered by CCAG in December 2021. This meeting was stood down due to Covid, and the business case has now been submitted to CCAG for the meeting in January 2022.
Specialist Community Nursing Services	CCAG received a paper in July 2021 outlining the funding requirements and project plan for managing the commissioning arrangements. It was agreed to support this work over the next 4 years, and a funding framework is to be developed to cover the cost implications of managing the commissioning needs. At this stage the framework is still required in order to proceed with most of this project.

Commissioning Need	Current position
Therapies	A number of therapy reviews are underway across the ICS to develop therapy services including speech, language and communication needs and other equipment provision, sensory support, occupational therapy including equipment, etc. A paper will be submitted to CCAG outlining the requirement from 2022/23.

5. Next Steps for SEND

Firstly, it should be noted that the responsibility for SEND across the ICS will transfer from CCGs to the ICB at its inception.

Secondly, in summer 2021 Ofsted announced a new SEND Inspection Framework that will come into effect in April 2022. Blackburn with Darwen (BwD) agreed to test the methodology for the new framework, and an inspection took place in November 2021. This resulted in significant learning for the ICS, particularly in relation to the move from the focus being on leadership and the strategic positioning of SEND to a setting-based approach and understanding the impact on the child or young person. For health, this focus is on the provider organisations that are likely to require support to improve their maturity for future SEND inspections. Despite being involved in the methodology testing, the BwD local area could still be subjected to a full inspection at any point from April 2022.

Blackpool is expecting its initial SEND inspection based on the original SEND Inspection Framework in early 2022, as Ofsted have indicated that all outstanding inspections will be carried out before the move to the new framework in April 2022. Cumbria is anticipating an inspection revisit in early 2022.

Alongside the new inspection framework, and as part of an assurance mechanism, NHSE has introduced a SEND Maturity Matrix for each Integrated Care System to implement and report on each quarter. It should be noted that whilst the Integrated Care Board (ICB) will take on the statutory role that CCGs have had on SEND, those roles will continue to be exercised via the SEND Partnership which align to each Local Authority, the basis on which inspections take place. It is therefore essential that the ICB recognises the need to blend the ICS role expected by NHSE with the statutory role which needs to be undertaken at Local Authority level.

Lancashire and South Cumbria has developed and strengthened the management and oversight of SEND at an ICS level over the last 18 months and blended the management at that level with addressing the needs at Local Authority level, this will need to continue and be recognised as the ICB develops its new statutory structures and the ICS develops its ways of working to become a mature system in relation to leadership, co-production, and partnership working on this agenda.

6. Recommendations

The SCC is asked to:

- Note the outcome of the Lancashire Accelerated Progress Plan monitoring meeting.
- Continue to support the funding request for:
    - Second part of the ASD waiting list management
    - Specialist community nursing (as outlined in the supplementary paper presented to CCAG in July 2021) including Special School Nursing and Bladder and Bowel services.
- Recognise that further developments will be presented through CCAG over the next few months which may have funding implications for 2022/23. This includes neurodevelopmental pathway and therapies.
- Continue the commitment to support the ongoing programme management of SEND and recognise the need to marry ICB and Local Authority level responsibilities as the structures develop.

Hilary Fordham
Chief Operating Officer for MBCCG
SRO for SEND

Julie Higgins
Joint Chief Officer for Pennine Lancs CCGs
AO for SEND

December 2021

Issue 1: January 2022

SEND News

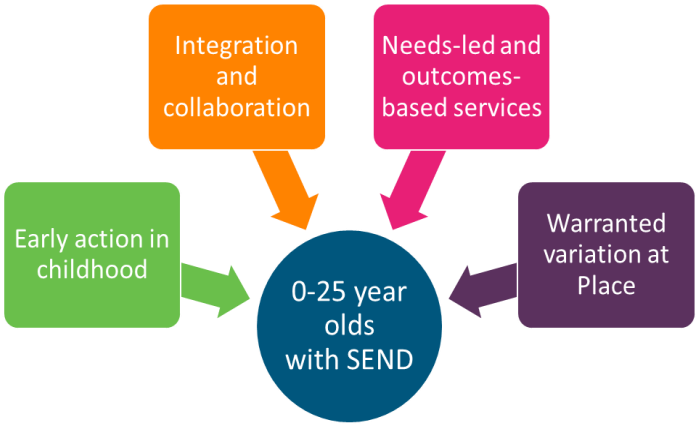
Lancashire and South Cumbria
Health and Care Partnership

Your 7 Point Briefing with Updates on SEND in health in Lancashire and South Cumbria
This month, all the background information you need about SEND in health

1 SEND Vision: Lancashire and South Cumbria ICS

SEND (Special Educational Needs and/or Disabilities) affects children and young people from birth to 25 years of age. Every local area has statutory duties covered by the SEND Code of Practice, and is subject to inspection across a local authority footprint.

In Lancashire and South Cumbria Integrated Care System (ICS), we have four local authorities, and the ICS has a vision for SEND to improve services for all children and young people with SEND from birth into adulthood. With this vision in mind, we encourage everyone to know about SEND and how we all impact on the lived experience of children and young people with SEND.



2 SEND Principles and the Key Priorities for 2022

The ICS has approved four principles to underpin all of the work we do. These principles are to **take early action** in childhood to improve outcomes later in life; **integrate and collaborate** in the work that we do; ensure there are **needs-led and outcomes-based** services, and reduce health inequalities, ensuring there is only **warranted variation at Place**.

There is a lot of work to do, and we cannot address everything at the same time. As a result, key priorities have been selected for the next 12-18 months:

- **Data**: improving the information we collect and use for decision-making
- **Autism**: improving the referral and assessment processes, and ensuring support is available
- **Preparing for adulthood**, including supporting a seamless transition into adult health services
- **Waiting times** for autism assessments and access to therapies
- Identifying and addressing **commissioning gaps**

3 SEND Roadmap

In 2021 the ICS approved a roadmap for SEND to help us improve services for all children and young people with SEND from the earliest opportunity and into adulthood. The roadmap encourages us to think about the experience people have of health services, and how we can simplify service models from the point a need is identified, through referral and assessment to treatment and support. The diagram opposite shows the six parts to the Lancashire and South Cumbria SEND Roadmap.

4 Think SEND Think Voice

A key priority for SEND is including the voice of the child or young person, either directly from them, or through their parent or carer. We achieve this through Think SEND Think Voice, which has 3 levels:

⇒ At the individual point of care
⇒ At service level to help improve or redesign services
⇒ At strategic level to help direct the delivery of our

The ethos of Think SEND Think Voice is to encourage everyone to consider how we include the voice of the child or young person. This could be by asking them what they think or what their aspirations are, or could be about including children, young people and parent carers in engagement and co-production activities.

5 Briefings: SEND is Everyone's Business

It is important to the success of SEND improvements that everyone working in health knows and understands about SEND, statutory duties, SEND inspections, and the SEND priorities for the ICS. In 2021 nearly 1,000 people attended the SEND is Everyone's Business briefings. We are keen to continue delivering these short sessions across the ICS.

- Has your senior leadership team or your service had the SEND is Everyone's Business briefing?
- Would you like to book someone to attend one of your regular meetings to share the briefing?

Contact Zoe Richards to book a 15 minute briefing: z.richards1@nhs.net

Who's Who

ICS SEND Lead: Zoe Richards, Senior Manager, SEND
SEND Project Manager: Vacancy
Designated Clinical Officers: Anne Hardman for Central and West Lancashire; Alex Nancollis for Cumbria; Clair Martin for Fylde Coast and North Lancashire; Sue Mounsey for Pennine Lancashire

6 SEND in Partnership

Each local area has a SEND Partnership, with an improvement group or operational group overseeing the delivery of priorities. The partnerships are made up of the local authority, health (including Place and providers), schools, parent carers and young people.

Across the ICS there are quarterly Local Area Partnership meetings run by the Designated Clinical Officers where themes are discussed.

Provider organisations each have a SEND Champion who updates senior leaders and service managers on SEND. They are kept up to date at the monthly SEND Champions Network.

7 Get Involved

We need your help. In 2019 a major piece of work was carried out with parent carers to co-produce a referral form for the neurodevelopmental pathway. Although some practitioners were involved in this work, feedback shows that the referral process needs to be improved to help staff who make a referral.

- Are you a healthcare practitioner, clinician or GP who refers patients for an autism assessment?
- Would you like to be part of developing the new digital referral form for autism assessment?

Contact Helen Marsden for information on how to get involved: helen.marsden5@nhs.net

Local Offer Websites

Each local area has a local offer website that provides contact details, updates and information on SEND and services that can be accessed.

Blackburn with Darwen
Blackpool
Cumbria
Lancashire

There is also information about emotional health and wellbeing on the Lancashire and South Cumbria Healthy Young Minds website.

In Next Month's Issue

Issue 2 of SEND News will be out Monday 8th February 2022. You can read about the Autism in Schools Project, Transitions in Healthcare, and an update on the inspection positions for each local area.

Do you want to be added to the circulation list to receive the monthly SEND News?
Email z.richards1@nhs.net (please note, these contact details may change from 1st April 2022)

Strategic Commissioning Committee

Date of meeting	**13 January 2022**
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	**11**
Confidential	**No**

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

Executive summary
The purpose of the CCG Transition Board is to co-ordinate the planning and implementation of transitional commissioning arrangements for 2021/22 and the transactional arrangements to close down eight CCGs by June 2022. At the December meeting of the CCG Transition Board the agenda focussed on the following areas: 1. CCG Transition – sender and receiver update 2. HR and OD Workstream Update 3. Communications & Engagement Update In addition, CCG TB noted that once risk (R0055) had a post-mitigation scores of 16. This relates to staffing capacity to effectively complete the CCG closedown and transition. The attached highlight report summarises the progress against items 1-3, as reported at the Transition Board. It also sets out the escalated risks and the mitigating actions.

Recommendations
Strategic Commissioning Committee are asked to • **Note** the report

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

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

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			N/A	
Equality impact assessment completed	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. Progess on this has been very limited during November 2021 due to ongoing delays related to data sharing agreements; and delays in receiving narratives on 'what happens where' from functional leads.	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 Helen Curtis	Programme plan in place, agreed by Transition Board 05/10/21. Plan has been based on the DD checklist and is in line with all released guidance to date. Reporting, monitoring and assurance will now begin.	29/06/22	Complete

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 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. Endorsed next iteration of the strategic narrative agreed at ICS Development Oversight Group in November following recommendations from the Multi-Agency Communications and Engagement Review group. This will be shared with leaders and staff ahead wc 22/11/21. Work to develop a strategic narrative and messages for the Provider Collaboration Board has commenced and will be taken to a number of groups before being agreed and endorsed in January.	31/03/22	In Progress no issues/delays
G02	**Co ordinating communications and engagement plans for all stakeholders at system and place levels, including those staff who are affected by the transition of activities associated with the closedown of CCGs**	Neil Greaves 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. 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. Website information developed and Place-based partnerships have asked to be embedded on their websites. Social media schedule of sharing case studies commencing this week to highlight good practice examples and impact of new ways of working. Toolkit for line managers developed and shared to support conversations with staff with key messages. Presentation shared with Multi-Agency Communications and Engagement Review Group detailing approaches with staff communications and engagement. Recommendations shared with ICS Development Oversight Group and are being embedded into activities.	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 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. Delivered first Colleague briefing sessions in July and shared video of the sessions plus responses to staff questions raised. 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. Updates to the website including documents, materials, glossary, videos with leaders and case studies (Sept 2021). Survey launched within place-based partnerships to acquire greater understanding of awareness and involvement of staff across partners in relation to the partnership work at place level. Responses and results to shared with place-based partnerships and feeding into maturity matrix work.	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. 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) Close down activities are being planned and reported via the closedown group which reports into the CCG TB. 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. Workforce Due Diligence templates now available and have been included in overarching People Service Project Plan to manage workforce closedown and transition activity. HRRG TOR updated to reflect oversight needed on HR actions as part of closedown activity and key milestone reports to be provided on monthly basis to HRRG for review. Consideration at all LSC CCG Remuneration committee in respect of 'Board Level' colleagues (employed and non-employed) and agreement of next steps which will include formal consultation with employed colleagues and cessation of non-employed arrangements. Opportunities to be made available for clinicians to discuss any specific queries with regard to their arrangements.	31/03/22	In Progress no issues/delays
E04	**Recruitment into NHS LSC senior leadership team and associated governance arrangements**	Cath Owen	Chair confirmed and authorised by NHSEI subject to legislation being approved by parliament. CEO appointment likely to take place during September. Expected that national process will be issued for local implementation. 22/9 Chair appointed confirmed Chief Officer national advert published with selection process to take place in October. Preferred candidate will require national approval via established authorisation process. Further senior leadership posts and board posts will follow the Chief Officer appointment being confirmed. National position given on remuneration levels for senior posts. Chief Officer recruitment ongoing and to be confirmed by 15/11. NED recruitment pack issued nationally National role profiles provided for ICB statutory roles. Recruitment plan in draft Chief Officer appointed NED advertisements issued with closing date of 1st December, interview prior to Christmas. Recruitment plan and timescales for ICB Senior roles to be agreed with designate CEO W/c 22 November	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. 22/9 OD Programme for senior leadership developed nationally and regionally and continue to be expanded. 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). Sumary of support available for staff drafted and to be issued on approval from HRRG. Outplacement support to be considered by HRRG with potential to procure across all LSC CCGs.	31/03/22	In Progress no 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. Staff Side engaged and being regularly updated via establshed formal mechanisms. NW Social Partnership Forum updated on progress. 22/9 Further staff briefings have taken place with updated FAQs to be issued and regular system wide staff communication bulletin now agreed. 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. Key communications activities and messages outline and subject to C&E review within HRRG for the purposes of planning Ongoing staff engagement and liaison with TU colleagues. Request from TU to 'publish' information as to their role and support available - being progressed via C&E team.	31/03/22	In Progress no issues/delays

HIGHLIGHT_Risks & Issues_Transition Summary

Risk No	Risk or Issue	Risk / Issue Description	Date Added	Catagory of Risk/Issue	Mitigating actions	Residual Risk Score
R0055	Risk	There is a RISK that due to the uncertainty of the staffing structure in the new NHS LSC system, that current CCG staff leave to secure alternative employment, leaving insufficient staff to manage CCG closedown and transition, and to undertake the new responsibilities of the new system, and resulting in a loss of system knowledge and expertise.	23/08/21	Commissioning Reform	Chief Officer and Deputy Chief Officer NHS Chorley and South Ribble and NHS Greater Preston CCGs have been appointed to the roles of executive sponsor and executive programme director for closedown. All CCGs within NHS LSC providing staff with regular communications on system development NHS LSC communications have now been estabished to provide staff briefings across the system Human Resources Reference Group established to manage the HR requirements of transition NHS LSC recrtuitment protocol in place to ensure consistent approach across the system to recruitment throughout transition Secondment policy in place for all CCGs to ensure risk assessment and approval of line manager process before staff are seconded out of the CCG Staff well-being programmes in place, including regular sharing of well-being tools, regular survery to act as 'temperature check' Regular communicatons provided to staff via CCG and system newsletters and regular presentations by each executive team Transition including Staffing movement is reported into the Quality and Performance Committee Transition document being established to captue legacy information Regular assessment of resources available over the next quarter undertaken. National OD support offered to those posts identified as not covered by the Employment Commitment Ability to monitor staff leavers via ESR reporting to monitor workforce establishment. Executives group will monitor any issues with regards to sufficient workforce Staffing issues will be monitored via this risk which the executives group will receive at each meeting and report back to the Transition Board. With regards to functions separate groups will not be established to manage these functions to closedown, instead closedown has been added as an additional remit to the existing functions group to prevent duplication of work and meetings. The executives group have agreed that assurances to staff are important when this risk assessment was approved by the group in August. A further discussion is needed now that the HR framework is available as to how we continue to positively reinforce this with staff whilst recognising that there will be a management of change policy affecting all from April 2022. A meeting is taking place between the Executive Lead for Closedown and HR leads to ensure that all HR actions are factored into the programme plan.	16