Strategic Commissioning Committee (Formal)
10 March 2022, 1 pm – 3.00 pm
via MS Teams Videoconference

Agenda

Item	Description	Owner	Action	Format
1.	Welcome and introductions to the Strategic Commissioning Committee	Chair	Note	Verbal
2.	Apologies for absence	Chair	Note	Verbal
3.	Declarations of interest relating to items on the agenda	Chair	Note	Verbal
4.	Minutes of the previous formal meeting held on 13 January 2022, matters arising and actions to agree	Chair	Approve	Attached
5.	Key Messages	Andrew Bennett	Discuss	Verbal
Building the system for 2022/23 and beyond				
6.	New Hospitals Programme - Quarter 3 Report - Shortlist of Options	Jerry Hawker	Discuss / Note Approve	Attached Presentation
7.	CCG Closedown / Transition to ICB	Helen Curtis	Discuss / Note	Attached
8.	Delegation of NHS England's Commissioning Functions	Peter Tinson	Discuss / Note	To Follow
Managing 2021/22				
9.	Quality and Performance Report	Kathryn Lord/ Roger Parr	Discuss / Note	Attached
10.	Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions	Brent Horrell	Approve	Attached
11.	Development of Lancashire and South Cumbria Clinical Commissioning Group Policies - Sacral Neuromodulation Policy	Brent Horrell	Approve	Attached
Reports from Sub-Committees				
12.	CCG Transition Board	Andrew Bennett	Note	Attached
13.	Quality and Performance Sub-Committee	Kathryn Lord	Note	Attached
14.	Collaborative Commissioning Advisory Group	Peter Tinson	Note	Attached
Any Other Business				
15.	Any Other Business	Chair	Note	Verbal

Next meeting of the Strategic Commissioning Committee: Thursday 14 April 2022, 1 pm – 3 pm, MS Teams (Informal meeting) Thursday 12 May 2022, 1pm – 3pm, MS Teams (Formal meeting				

Development of the Integrated Care System Glossary of key terminology and 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 3

Subject to ratification at the next meeting

Draft Strategic Commissioning Committee

Minutes of Meeting	
Date and time	13 January 2022, 1.30 pm – 2.30 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
Paul Kingan	Chief Finance Officer	NHS West Lancashire CCG
Beth Goodman	Deputy Director of Commissioning (attending for Blackpool/Fylde and Wyre CCGs AO)	NHS Blackpool and NHS Fylde and Wyre CCGs
Denis Gizzi	CCG Chief Officer/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
Andrew Bennett	Interim ICS Chief Officer	Lancashire and South Cumbria ICS
Gary Raphael	ICS Executive Director	Lancashire and South Cumbria ICS
Sam Proffitt	ICS Director of Finance and Provider Sustainability	Lancashire and South Cumbria ICS
Andy Curran	ICS Medical Director	Lancashire and South Cumbria ICS
Sarah Sheppard	Interim ICS Director of HR and OD	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
Helen Curtis	Deputy Accountable Officer	Chorley and South Ribble CCG

Roger Parr	Interim Director of Performance	Lancashire and South Cumbria ICS
Zoe Richards	Senior Manager, SEND	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
Becky Higgs	Business Manager	Lancashire and South Cumbria ICS
Pam Bowling	Corporate Office Team Leader	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Office Co-Ordinator (minute taker)	Lancashire and South Cumbria ICS
Public Attendees		
3 members of the public were present		

1. Welcome and Introductions

The Chair welcomed all to the formal meeting of the Lancashire and South Cumbria (L&SC) Strategic Commissioning Committee (SCC), held virtually via Microsoft Teams. Attendees were made aware that the meeting was being recorded.

2. Apologies for absence

Apologies were noted from Jane Scattergood, Sumantra Mukerji and Linda Riley.

The Chair highlighted the pressure that services across the health and care system were currently experiencing and that the response from all parts of the sector had been remarkable. In response to current pressures, regular meetings were focussing on essential business and reduced in length where possible. The implementation date for the establishment of the new Integrated Care Board had been extended to 1 July 2022. Existing statutory and organisational structures would continue until the end of June and the role of the SCC would be vital to ensure the safe and secure management of existing services operating throughout this extended period.

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 11 November 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 11 November 2021 were approved as a correct record.

Action log – All actions were accepted as closed.

5. Key Messages

Andrew Bennett (AB) reported that in mid-December 2021, the UK Covid-19 alert level had returned to a Level 4 national incident. AB paid tribute to CCG and CSU staff for their continued contribution to the response to the pandemic. A multi-agency exercise was taking place this week to maximise flow of patients through the system. Since the start of this exercise, improvement had been seen in ambulance delays, reduction in bed occupancy, reduction in long waits in emergency departments and hospitals discharging more people than those admitted. Risks were being mitigated as services remained under significant

pressure. Communication with the public continued around the broader range of services that remained open and available.

Building the system for 2021/22 and beyond

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

Brent Horrell (BH) presented the report and apprised the Committee of the work undertaken by the Lancashire and South Cumbria Medicines Management Group (LSCMMG) to develop commissioning recommendations relating to the following: two local policy positions where there were queries regarding the cohort of patients that should have access; the removal of one policy position due to the medicine's license removal; and two NICE technology appraisals.

In response to a request for clarification, it was explained that patient engagement was not required in relation to all recommendations. If the policy was expected to have a significant impact or be detrimental to the patient population, there would be a public engagement process, via CCGs. Opening access to new medicines would not usually require routine public engagement unless it was realised this could prove a significant impact on initial screen. To ensure a better understanding, future reports would include reference to whether it was deemed relevant to seek patient and public engagement.

ACTION: Brent Horrell

RESOLVED: The SCC ratified 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 glycemic control despite optimal insulin therapy**
- **NICE Technology Appraisals (October-November 2021).**

7. Development of Lancashire and South Cumbria (L&SC) Clinical Commissioning Group Policies

Brent Horrell (BH) presented the following policies developed by the L&SC Commissioning Policy Development and Implementation Working Group (CPDIG):

- Endoscopic Procedures on the Knee Joint Cavity - an update to the pre-existing policy.
- Cystoscopy in uncomplicated Lower Urinary Tracts Symptoms in Males - a new policy position based on the Evidence-based Interventions national phase 2 recommendations
- Surgical Intervention for Benign Prostatic Hyperplasia - a new policy position based on the Evidence -based Interventions national phase 2 recommendations
- Male Circumcision - a minor change to wording in a recently approved policy.

It was confirmed that all the above policies had been through a clinician engagement process and a public consultation process with no significant changes required.

Andy Curran, Chair of the Lancashire and South Cumbria Medicines Management Group, explained the consultation process for medicines and confirmed that it included extensive consultation via CCGs and Trusts and from patients and specific user groups. Dr Curran also provided assurance that relevant experts and non-experts were consulted during the process for development of Commissioning Policies.

Andrew Bennett confirmed that in order to maintain a common suite of consistent clinical approaches to this range of issues, he would work with Andy Curran and Brent Horrell in making the transition from a library of CCG policies to a library of ICB policies, early in the new financial year.

ACTION: Andrew Bennett

Brent confirmed that as part of the process of developing both medicines and commissioning policies, work was undertaken across other neighbouring areas in the North West to align policies wherever possible to minimise cross border issues. Dr Curran added that whilst commissioning decisions were made for the local population many policies were based on best practice and evidence so may come to similar outcomes.

Geoff Jolliffe asked what mechanisms the ICB would have in place to ensure policies were applied correctly. Dr Curran responded that the Clinical Policy Implementation Group had a role in following up on the application of policies. A benefit for the ICS was being able to do this once across the system and to be able to hold each other to account in 'place'.

Nicola Adamson highlighted that over the next 12 months, the Committee would need to consider the governance of clinical policies for specialised services coming to the ICS and other commissioned services within primary care and work was taking place in preparation for this.

RESOLVED: The SCC ratified the 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.**

Managing 2021/22

8. CCG Closedown Report

Denis Gizzi (DG) updated members on CCG closedown and highlighted NHSE/I's announcement, in December 2021, of the delay in the establishment of the Integrated Care Board to a new target date of 1 July 2022 and to key changes to the programme.

The primary objective was now to ensure as many features of the programme as possible be approved by 1 April in order that the ICB was in a state of readiness and CCGs were able to safely transfer many undertakings by 1 April, albeit some statutory features would be contingent on the formal closedown date. The current structured closedown programme and handover plan would therefore continue and this was supported by ICS leadership.

A full reconciliation of the current action and programme plan would now be undertaken and the Risk Register refreshed. The need to ensure continued communication with staff, Executive and Governing Body colleagues was highlighted. It was also suggested that clarity was required on how the system will operate between April and July 2022 and the delegation and leadership arrangements between the designate ICB executive and designate Place executive teams.

NHSE/I was currently refreshing the national closedown critical path which would be shared in order for the recalibration exercise to be undertaken. Jane Cass, NHSE/I, had endorsed the opinion that the primary objective should be to continue with the closedown programme for 1 April 2022.

Helen Curtis added that the Governance Working Group, which included Heads of Corporate Service representatives from each of the CCGs, was committed to continue to take this work forward as planned mindful of the impact the delay was having on the resilience of staff. It was also suggested that thought be given to bringing some groups of staff together to ensure success in both the closedown of CCGs and the establishment of the ICB.

Paul Kingan advised that discussions were taking place nationally about the impact of the extension on financial issues, both the audit of accounts from April to June 2022 and the allocation of resource to the ICB.

Debbie Corcoran highlighted the importance of clear communication during this period of change, not only for staff but also members of the public and other stakeholders and suggested that an enhanced report be provided to CCG Governing Bodies on the changes and implications to support consistent messaging in the public domain.

Andrew Bennett confirmed there was a restructured programme in place and that the change in timeline brought complexity and risk which would be worked through over the course of the next few weeks. Additional guidance was expected which would inform dialogue with Governing Body members. The SCC would be used as a forum for progressing collective decision making over this period, both in terms of reporting progress, managing risk, and assisting the ICB to work in shadow form and then as a statutory body.

Andrew endorsed the comments about communication and confirmed that an initial briefing for stakeholders had been prepared and that the value of sharing this report with Governing Bodies would be considered. Two staff briefing sessions had been arranged for the following week, which would include an opportunity for staff to ask questions.

Roy Fisher confirmed that in December 2021, the CCG Transition Board had asked that reports be prepared for CCG Governing Bodies on both the current position regarding the establishment of the ICB and on closedown of CCGs and this was in hand.

RESOLVED: The Strategic Commissioning Committee noted the CCG Closedown report.

9. Quality and Performance Report

Roger Parr presented the report and highlighted the following key issues.

A&E performance against the 4-hour target was at 78.7% with acuity numbers remaining high in November alongside a high number of 12-hour waits reflecting current pressures. Cancer referrals remained above pre-pandemic levels, with a deterioration in performance against the 2-week target. In October, diagnostic performance showed a more positive position across providers with waiting lists having reduced. Appointment demand within GP practices had returned to pre-pandemic levels with October 2021 having the most appointments available per working day in the last 31 months and an increase in face-to-face appointments. As of October 2021, the number of patients waiting to start treatment was at over 166,000 and performance against the 18-week standard was 69% and there were 9,442 over 52-week waiters.

Kathryn Lord explained that pressures due to staff absence had continued across all sectors. The Local Authority regulated care sector was under significant pressure and work was taking place to ensure care was maintained in care settings at a level appropriate, and admissions kept to a minimum. The vaccination programme continued and thanks were extended to staff who stepped into different roles pre-Christmas to offer their support. The mandate for health and social care staff to be fully vaccinated by 1st April presented a risk and work was underway across the system to gather data, ensuring any hotspots were known with a view to mitigating any risks prior to deadlines.

With regard to Safeguarding the following item was escalated for the attention of the Committee: NHS readiness for Liberty Protection Safeguards (LPS) and it was noted that collective partnership was progressing. Other emerging items that may require future escalation included Resource Implication – implementation of Liberty Protection Safeguards, Delayed Deprivation of Liberty Applications and Service Pressures.

Nicola Adamson reported that she was currently acting as the Director of Vaccine Inequalities for Lancashire and South Cumbria, whilst still representing NHSE commissioning on the Committee, and emphasised the focus of the Vaccination Programme on equalities to ensure that everyone is protected and hospital admissions due to Covid are reduced.

Debbie Corcoran sought further information and assurance regarding the following matters covered in the report: The Friends and Family Test and RPH being an outlier; Advice and Guidance and how patient feedback is being gathered to influence and guide future use of the service; Access to CYP eating disorder services; and addressing access to services for people with autism – seeking assurance on the pace of improvement and impact of current interventions, and highlighting any recommended further commissioning decisions or considerations for the SCC to support securing improved patient experience and outcomes.

The Chair requested that these issues be considered outside the meeting and a response provided.

ACTION: Kathryn Lord/Roger Parr

RESOLVED: The Committee noted the content of the Quality and Performance Report.

10. SEND Update

Julie Higgins (JH) introduced the report and advised members that SEND inspections had commenced in the L&SC ICS in November 2017 and progress had been reported to the SCC. The report provided the latest position.

Nicola Adamson commented that whilst not a conflict of interest, she had a personal interest relating to SEN, so would refrain from commenting on this item.

Lancashire had an inspection revisit in March 2020 which resulted in an Accelerated Progress Plan (APP) covering 5 areas of significant concern. The APP had been closely monitored by Department for Education (DfE) and NHS England (NHSE) since September 2020 and at the end of September 2021 a 12-month monitoring session took place. The outcome of the monitoring was that the DfE and NHSE were satisfied that sufficient progress had been made and the local area had demonstrated clear and sustained progress, resulting in the ending of continued formal monitoring. The monitors noted that this positive result came as a result of a great deal of commitment and hard work on the part of the Local Authority, CCGs, families and front-line staff across education, health and social care. Dr Higgins acknowledged the work of the SEND Board partners and the leadership of Edwina Grant, Hilary Fordham and Zoe Richards. Commissioning intentions had been put in place for the oversight process and were required to continue to deliver the SEND plan.

Zoe Richards continued that 'SEND news' was now being shared monthly to provide an update on SEND across the ICS. Maturity matrix were required by NHS England and the Quarter 3 return had been submitted. Feedback received from the first return identified Lancashire as being one of the few areas in the country rated as 'green'.

It was noted that Blackburn with Darwen had continued to progress well with ongoing improvements and had agreed to be a test area for methodology testing for a new SEND Inspection Framework that was expected to come into effect in April 2022. Blackpool was expecting its initial SEND inspection based on the original Inspection Framework prior to April 2022. Cumbria was previously inspected in 2019 and was anticipating an inspection revisit in early 2022.

In July 2021, the Collaborative Commissioning Advisory Group (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 supporting the ICS in meeting its statutory duties. CCAG supported that these should be put forward for the H2 and 2022/23 planning process.

Andrew Bennett confirmed that this would be picked up formally as part of the 2022/23 planning process and that he would liaise with colleagues to ensure that the issues raised were clearly understood and factored in the planning process.

RESOLVED:
The Committee:

- **Noted the outcome of the Lancashire Accelerated Progress Plan monitoring meeting.**
- **Supported 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**
- **Recognised that further developments would be presented through CCAG over the next few months which may have funding implications for 2022/23. This included neurodevelopmental pathway and therapies**
- **Continued the commitment to support the ongoing programme management of SEND and recognised the need to marry ICB and Local Authority level responsibilities as the structures developed.**

Reports from Sub-Committees

13. CCG Transition Board

RESOLVED: Members of the Committee acknowledged the report.

14. Quality and Performance Sub-Committee

RESOLVED: Members of the Committee acknowledged the report.

15. Any Other Business

No other business was raised.

Next formal meeting:
10 March 2022, 1 pm – 3 pm, MS Teams

Strategic Commissioning Committee

Formal Action Log

Updated 25 February 2022

Item Code	Action	Responsible Lead	Status	Due Date	Progress Update
2022-01-13 Item 6	**LSC Medicines Management Group Commissioning Policy Positions** Future reports to include reference to whether it was deemed relevant to seek patient and public engagement.	Brent Horrell	**Closed**	10.03.22	
2022-01-13 Item 9	**Quality and Performance** To provide further information and assurance on the following issues: (1) Friends and Family Test – RPH being an outlier (2) Advice and Guidance – how is patient feedback being gathered to influence and guide future use of the service. (3) Access to CYP eating disorder services (section 11.4 in the Quality and Performance Report) and also addressing access to services for people with autism (section 12.1.6) – assurance on the pace of improvement and impact of current interventions and highlighting of any recommended further commissioning	Roger Parr Kathryn Lord Fleur Carney	**Closed**	10.03.22	Kathryn Lord and Fleur Carney met with Debbie Corcoran on 11 February to provide the additional information and assurance on the issues.

Item Code	Action	Responsible Lead	Status	Due Date	Progress Update
	decisions or considerations for the SCC to support securing improved patient experience and outcomes.				
2022-01-13	To work with Andy Curran and Brent Horrell in making the transition from a library of CCG medicines and commissioning policies to a library of ICB policies, early in the new financial year.	Andrew Bennett	**Closed**		To be picked up as part of the Sender/Receiver work.

Strategic Commissioning Committee

Date of meeting	**10 March 2022**
Title of paper	**New Hospitals Programme Quarter 3 Board Report**
Presented by	**Jerry Hawker, Programme SRO**
Author	**Rebecca Malin, Programme Director** **Matthew Burrow, Project Manager**
Agenda item	**6**
Confidential	**No**

Purpose of the paper
For information.
Executive summary
The purpose of this report is to provide an update on the New Hospitals Programme for the quarter 3 period; October – December 2021. This quarterly report is presented to the following Boards; • University Hospitals of Morecambe Bay NHS Foundation Trust • Lancashire Teaching Hospitals NHS Foundation Trust • East Lancashire Hospitals NHS Trust • Blackpool Teaching Hospitals NHS Foundation Trust • Lancashire and South Cumbria NHS Foundation Trust • Lancashire and South Cumbria Integrated Care System (ICS) • Provider Collaborative And the Strategic Commissioning Committee.
Recommendations
It is recommended the Committee; • Note the progress undertaken in Q3. • Note the progress in developing key products to support business case (section 3). • Note the activities planned for the next period namely appraising the longlist to a shortlist of options.

Implications

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

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

Report authorised by:	Jerry Hawker

NEW HOSPITALS PROGRAMME Q3 BOARD REPORT

1. Introduction

1.1 This report is the 2021/22 Quarter 3 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the **'Our NHS buildings' website (opens in new window).**

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 This is a national programme, which continues to shape and develop. The national New Hospital Programme team continues to work with schemes to determine the best national and local approach to demand modelling, clinical vision and strategy, assessing benefits of new hospital facilities as well as understanding the most effective commercial framework that can be applied. The national team continue to visit schemes across the country and L&SC look forward to welcoming colleagues in the near future.

2.4 Whilst the L&SC programme and extended team work through the complexities that come with such a programme, it remains an exciting opportunity to secure significant investment in our ageing hospital facilities and region as a whole.

3 Progress against plan (for the period October – December 2021)

3.1 In Q3, ICS leaders and NHSEI met to discuss wider system delivery, focusing on achievement of sustained operational, quality and financial improvement. This has enabled the NHP to be firmly placed in the scope of longer term system improvement.

3.2 Given this context, the programme has provided input to the review led by the PCB Clinical Integration Group to develop a strawman Hospitals Clinical Strategy for 2030 and beyond. This is an item of significance for the NHP given the interdependency between hospital sites and services. This important work will continue to be led by our clinicians and is embedded in the vision for L&SC hospitals to work in a networked way, enabled by digital technologies. The NHP will receive ongoing updates throughout Q4 to ensure hospital facilities are designed in line with the Hospitals Clinical Strategy.

3.3 Our hospitals are just one part of a health and care system and can only provide high quality, efficient care in partnership with colleagues from across L&SC. As the NHP progresses the detail around the longlist of proposals - including the size of new hospital facilities, it is clear the hospitals can only be rightsized for future demand if our Primary and Community care services and infrastructure are developed in parallel. This is both an interdependency and risk for the NHP. An ICS primary and community strategy group has recently been established and will start to create a case for change and strategic plan during Q4.

3.4 **Key products to support business case development –** During Q3, a number of key products have been developed. These products represent key building blocks in the development of the business cases. The products are:

3.5 **Site solutions** – this has been an energetic and intensive period where our clinical, operational and estates/site professionals have worked together with architects and other technical experts to understand the art of the possible for rebuild/partial rebuild and refurbishment on the existing sites. This has resulted in realistic examples and designs of where and how the existing sites could be developed, grouping clinical services and buildings for maximum benefit. Colleagues have relished this challenge and opportunity, bringing professional input and enthusiasm to working through such a complex jigsaw puzzle. The output will be used in Q4 to help narrow down the longlist of proposals to a shortlist.

3.6 **Longlist of proposals –** following approval of the longlist of proposals in Q3, the programme has held several workshops with our clinical, operational, estates/site, finance and infrastructure colleagues. These have focused on developing the required detail of the estates options, socio-economic value, aligning the NHP and the ICS

Clinical Strategy and benefits identification. This has provided real and tangible information regarding each proposal, which will now be used to appraise the longlist.

As part of the programme's continued commitment to communicating and listening to our staff, public, patients and wider stakeholders, a series of engagement events regarding the longlist of proposals have taken place. Section 4 provides more detail on these activities. The insight gained from such activities is invaluable and will be used as a key input to the workshop to appraise the longlist.

3.7 **Identification and quantification of benefits –** work has commenced with clinical and estates colleagues, supported by external advisors, to create a log of benefits and associated risks. Whilst this is a formal and somewhat technical element of the business cases, this important step allows the programme to capture and quantify the true impact of our ageing estate and the benefit new hospital facilities will bring.

3.8 **Assessing the options workshop –** this is a significant milestone for the programme as the longlist of proposals is narrowed to a shortlist. The first of two workshops was held in October 2021, where patient representatives and wider stakeholders positively worked alongside clinical, operational, estates and finance colleagues to discuss the longlist of proposals and Critical Success Factors (CSFs). Such workshops allow for a really important wide range of perspective. The programme is pleased to report workshop attendees formally approved the longlist and CSFs, subject to some recommended amendments to the CSFs.

The second workshop will take place in February 2022, when the programme is looking forward to another session of positive and lively input from attendees. This workshop will use the CSFs to appraise the longlist. The output of this will be a shortlist of options, which the programme looks forward to announcing in Q4.

4 Public, patient and workforce communications and engagement

4.1 A number of key communications, involvement and engagement activities have taken place during this period namely:

4.2 Ongoing proactive communications to encourage local people, staff and stakeholders to get involved and have their say, well supported by all Lancashire and South

Cumbria NHS partners through internal and external communications channels.

4.3 A range of new blogs and updates have been published on the NHP website and shared through NHP and partner social media channels, to raise awareness about the programme, explain the process that is being followed and encourage people to share feedback. The programme launched a NHP Programme Director blog to describe how the longlist was developed.

4.4 Through October and November 2021, an advertising campaign was delivered to promote the New Hospitals Programme and encourage local residents to get involved – including local print and online media, radio adverts and social media advertising.

4.5 A wide range of proactive engagement on the longlist of proposals has been conducted, including market research; public roadshow events; workshops and focus groups with under-represented communities; online surveys; stakeholder meetings; online discussion on the NHP Big Chat; staff meetings and briefings; and social media. Reporting on the longlist engagement to date has concluded and an insight synthesis report has been shared with the Communications and Engagement Oversight Group.

4.6 Engagement highlights to date are summarised below at an engagement mechanism level:

- 3,824 responses to NHP online surveys;
- 22,374 visits to the Big Chat website (12,586 unique visitors), with 3,000 people joining the online discussion;
- Two waves of market research completed, with 1,000 people interviewed in each (telephone, in-person and online);
- 879 staff attended two dedicated colleague summits;
- Social media reach of 720K; 1,258 followers across Facebook and Twitter;
- 11,713 people have visited the NHP website to date; with 4,503 page views for the longlist blog update;
- 234 participants from 29 different groups have participated in Healthwatch Together focus groups;
- Face-to-face conversations held with 796 local people through Healthwatch-led roadshow events, which visited 16 local community sites;
- Across all engagement channels, 4,689 seldom heard group representatives have become involved; and

- In total, 12,281 unique individuals have been engaged with online and face-to-face, including 6,470 members of the public and patients.

4.7 This important stream of work continues throughout Q4, including sharing and discussing the shortlist of options and a follow up colleague summit providing an opportunity for NHS colleagues across L&SC to receive an update on the programme and take part in another engaging question and answer session.

5 Stakeholder management

5.1 Board members will recognise there is a breadth of stakeholders in such a programme. During Q3, there has been a continuation of stakeholder updates, meetings and correspondence with MPs, local authorities and community groups. Work on the socio-economic benefits of new hospital facilities continues, working closely with the Lancashire Local Enterprise Partnership (LEP). The programme looks forward to continuing this important strand of the programme in Q4, in particular sharing the shortlist of options.

6 Programme governance and risk

6.1 During Q3, MIAA (Mersey Internal Audit Agency) Advisory Services have undertaken an independent review of the programme governance and assurance arrangements across the NHP. A draft report has been issued for comment with the programme and Governance Advisory Group providing initial comments. An updated version will be presented to the group in January 2022. The final report will include an action plan and decision making matrix in line with programme and statutory body governance frameworks, as well as that of the business case processes.

6.2 Throughout Q3, the programme has strengthened the risk register and progressed interdependency mapping. The full risk register is reviewed and reported to the various groups within the programme governance framework. Risks scoring 15 and above are then reported and discussed at the Strategic Oversight Group (SOG) each month.

An interdependency workshop has taken place with ICS colleagues, producing a draft map of all interrelated projects and programmes. This then allows active management of dependent relationships.

7 Next period – Q4 2021/22

7.1 The key focus of Q4 will be preparing and delivering the formal appraisal of the longlist of proposals, which will establish a shortlist (as per section 3.8) of options which will progress towards the SOC or PCBC stage. This is a significant milestone for the programme and will involve a formal workshop (February 2022) with wide ranging attendees, including patient representatives and stakeholders. The short listing process will use information comprising, but not limited to, the Framework Model of Care, estates/buildings solutions, benefits assessment, reports into net zero carbon, a digital blueprint and the output of the public and staff engagement undertaken to date, with each proposal being appraised against the Critical Success Factors evidence.

Following the workshop, the programme will publish the shortlist of options and welcomes discussions with wider stakeholders, including Health Overview and Scrutiny Committees, community groups, MPs etc.

It is worth noting formal approval from statutory bodies is required ahead of submitting business cases and the programme will continue to keep Boards sighted on progress and provide assurance on the process being followed.

8 Conclusion

8.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 3 2021/22.

9 Recommendations

9.1 The Committee is requested to:

- Note the progress undertaken in Q3.
- Note the progress in developing key products to support business case (section 3).
- Note the activities planned for the next period namely appraising the longlist to a shortlist of options.

Rebecca Malin
Programme Director
January 2022

Jerry Hawker
Programme SRO

Strategic Commissioning Committee

Date of meeting	10 March 2022
Title of paper	CCG Closedown/Transition to ICB
Presented by	Helen Curtis, Deputy Accountable Officer & Director of Quality and Performance Chorley South Ribble &Greater Preston CCGs Carl Ashworth, Strategy and Policy Director, LSC ICS
Author	Helen Curtis, Deputy Accountable Officer & Director of Quality and Performance Chorley South Ribble &Greater Preston CCGs Carl Ashworth, Strategy and Policy Director, LSC ICS
Agenda item	7
Confidential	Yes

Purpose of the paper

To update the Committee on progress with delivery of the closedown and transition programme.

Executive summary

This paper provides the Strategic Commissioning Committee (SCC) with key updates on the progress of closedown and transition to the Integrated Care Board (ICB) in shadow form from 1 April 2022.

Since the previous update, progress has been made in the following areas:

- **Programme Plan** – As it had previously been agreed at both the Transition Board and the Strategic Commissioning Committee that CCGs would continue with the end of March date wherever practicable and as the overall programme plan has now changed to having the 31 March 2022 date as the end date for all required tasks and actions, exception reporting would be null until the end of March as no tasks are due until this time. The Executive Working Group agreed that this would not give the required assurance and so a new approach to reporting needed to be adopted. This is outlined in appendix 1.

- **MIAA Audit Committee Event** – An event was held on 31 January 2022 in conjunction with MIAA, focusing on safe transition to the Lancashire and South Cumbria (LSC) ICB. The event was primarily aimed at the audit committee chairs and members who play a key role in their statutory body to ensure requirements are delivered appropriately. The slides from the event are attached in appendices 4 and 5.

- **Receiver –** An update is provided on actions to support shadow operation of the ICB to commence from 1 April 2022.

- **Critical Path** - The Critical path has now been reviewed based on the revised timeline and is attached at Appendix 4.

- **Risk Register** - The staffing capacity risk (R0055) was discussed at the Executive Working Group on 21 February 2022 where further concerns were raised particularly regarding the gaps and pressures on the corporate function. The risk Register is attached at Appendix 5.

Recommendations

The Committee is asked to note the update outlined in this paper

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

Meeting	Date	Outcome
LSC Transition Board	1 March 2022	Further discussion at SCC.

Conflicts of interest identified

None 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	X			Overseen via LSC closedown risk register
Are associated risks detailed on the ICS Risk Register?	X			

Report authorised by:	Helen Curtis, Deputy Accountable Officer & Director of Quality and Performance Chorley South Ribble &Greater Preston CCGs

CCG Closedown/Transition

1. CCG Closedown Programme Plan

1.1 As it had previously been agreed at both the Transition Board and the Strategic Commissioning Committee that CCGs would continue with the end of March date wherever practicable and as the overall programme plan has now changed to having the 31 March 2022 date as the end date for all required tasks and actions, exception reporting would be null until the end of March as no tasks are due until this time. The Executive Working Group agreed that this would not give the required assurance and so a new approach to reporting needed to be adopted. This is attached in Appendix 1.

1.2 CCG closedown meetings continue across LSC, and the new reporting process requires that after each meeting a proforma is completed where any issues or risks have been identified against the full list of tasks/milestones. As CCGs have different dates for closedown meetings, and at this stage it is not possible to align these for the remainder of the closedown programme, a 'deadline date' for the return of proformas and any further assurance updates to be sent to MIAA will be confirmed to ensure that the Executive Working Group, Transition Board, and the Strategic Commissioning Committee, can be appropriately updated.

1.3 Meetings of the Executive Working Group have now been scheduled to take place on a weekly basis in order that any issues can be addressed in a timely manner.

1.4 All CCG's have confirmed they have now updated their local programme plans following the updates to the due diligence received at the end of January 2022.

1.5 The overall programme plan and assurance submissions from CCGs can be found in Appendices 2 and 3.

2. MIAA Audit Committee Event

2.1 An event was held on 31 January 2022 in conjunction with MIAA and focusing on safe transition to the LSC ICB. The event was primarily aimed at the Audit Committee chairs and members who play a key role in their statutory body to ensure requirements are delivered appropriately.

2.2 The event focused on three specific areas in the breakout sessions – quality, finance, and people. In addition, there were presentations by, internal, and external audit partners, and NHSE. The slides from the event are attached in Appendices 4 and 5.

Lancashire and South Cumbria
Health and Care Partnership

3. Facilitating shadow ICB operation in Q1 2022/23

3.1 It has been agreed that, in the light of the three-month delay in the formal establishment of ICBs, wherever possible, we should retain the plan to shift to full shadow system operations as of 1 April 2022. Clearly, this shift will take place in advance of the formal establishment of the ICB on 1 July 2022, meaning that interim arrangements in Q1 will need to operate within the current legislative responsibilities.

3.2 To support the safe transition, a number of requirements of arrangements in Q1 have been identified, most of which are common to all functions:

- Agree LSC governance mechanisms for functions that enable CCGs to exercise statutory requirements during Q1.
- Agree governance for any associated reporting and monitoring during Q1.
- LSC lead for each function – and clarity on the portfolio within which each element of CCG business will come under – should be provided.
- Establish central storage location for handover information with protected access for relevant team members.

3.3 The timeline for the agreement of system operating models for key ICB functions has been revised to focus on two key time periods:

(a) Q1, where we will need to ensure that proposals ensure that the statutory responsibilities of CCGs within that function can be shown to be met.

(b) the remainder of 2022/23, recognising the need to undertake a management of change process to develop the structures required to deliver this model.

3.4 The development of the ICB constitution, governance, and committee structure includes an assessment of the reporting arrangements for each committee, as well as external reporting and monitoring requirements. Interim arrangements for Q1 are under discussion and will cover the interim reporting arrangements to ensure that any statutory expectations of CCGs are met. These requirements will inform the design work for interim operating models for each function.

3.5 The designate management structure of the ICB is being populated - this structure will identify the portfolio roles of each Executive as they are appointed. In the meantime, interim Executive leads will be confirmed.

3.6 Work is underway within the ICS corporate governance function to set up shared filing arrangements for the ICB, aligned to the committee and functional structures – these will ensure protected access to relevant team members to shared files. As part of these arrangements, we will ensure that the structures established for operation in Q1 are ready to receive the handover of information from CCGs – indeed, we would anticipate that these will be ready (as required) to accept handover information in advance of the 1 April 2022.

3.7 To facilitate the development of a system operating model from 1 April 2022, a Data Sharing Agreement (DSA), wider than the specific scope of the HR DSA is under development to enable sharing of information across CCGs, CSU, and potentially providers. This document will sign partners up at the highest level to sharing such information that should, once signed, provide overall air cover for further work with IG leads on the detail within each function.

4. Policy alignment

4.1 CCGs are pulling together current policies across a number of functions - corporate, HR, finance, data, IT, clinical, medicines management etc, together with an assessment of whether polices are aligned or divergent.

4.2 For ICB establishment, we are working on a basic principle that - certainly for clinical policies - unless the work required to do so is too great, criteria for access to clinical treatment/services such be equal and consistent from 1 July 2022.

4.3 It is suggested that, where any of the above policies are already aligned/consistent across LSC we should "lift and shift" into the ICB and re-badge, with a workplan being built for each segment for a review to take place during the remainder of 2022/2023 to ensure they are fit for purpose and to undertake any updates required.

4.4 For the areas where there is no alignment a Task and Finish group will be convened drawing in the relevant Subject Matter Experts, each tasked with undertaking a review of the "scale of the problem" (e.g. how many policies in their area of expertise are not aligned, how long potentially that may take and the level of risk if they were to remain misaligned) to inform a prioritisation of action on alignment.

4.5 Slides providing an update on progress with this work can be found in Appendix 6.

5. Critical Path and ICB timeline

5.1 The critical path has been updated to reflect the delay to implementation and the issue of the revised Readiness to Operate Statement and is attached in Appendix 7.

6. Risk Register

6.1 All six risks on the closedown risk register are scheduled for review at the Executive Group meeting on 8 March 2022. This risk register is attached in Appendix 8.

6.2 There was an ask at the last Transition Board that the staffing capacity risk (R0055) be reviewed in relation to the risk score and this has been done. In addition this particular risk was considered at the Executive Working Group on 21 February 2022 in relation to specific concerns regarding gaps in staffing in the corporate function combined with business as usual activities at the year end. The Programme Director for Closedown has escalated this to the ICS Interim Chief Officer, elaborated on this at the Transition Board on 1 March 2022 and will be further discussed at the Strategic Commissioning Committee.

6.3 There have been no other changes in content or score to the other risks on the risk register to escalate to the Strategic Commissioning Committee.

7. Recommendations

The Committee is asked to note this update.

Helen Curtis/Carl Ashworth

1 March 2022

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	**10 March 2022**
Title of paper	**Delegation of NHS England's Commissioning Functions**
Presented by	**Peter Tinson, Director of Collaborative Commissioning**
Author	**Peter Tinson**
Agenda item	**8**
Confidential	**No**

Purpose of the paper				
To provide an update to members.				
Executive summary				
This presentation provides an up-to-date position on the discussions with NHS England regarding the delegations of functions. (Presentation to follow).				
Recommendations				
Members are asked to note the current position.				
Governance and reporting (list other forums that have discussed this paper)				
Meeting	**Date**		**Outcomes**	
ICB Design Group	28.02.22		Endorsed and recommended to go to SCC	
Conflicts of interest identified				
None.				
Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed				
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

Commissioning Delegation - update

Strategic Commissioning Committee – 10 March 2022

Context – a reminder

- Previous Committee paper in October 2021
- Confirmed that NHSEI intended to delegate some of its direct commissioning functions to ICBs as soon as operationally feasible and subject to the will of Parliament. Specifically:

Now by July 2022

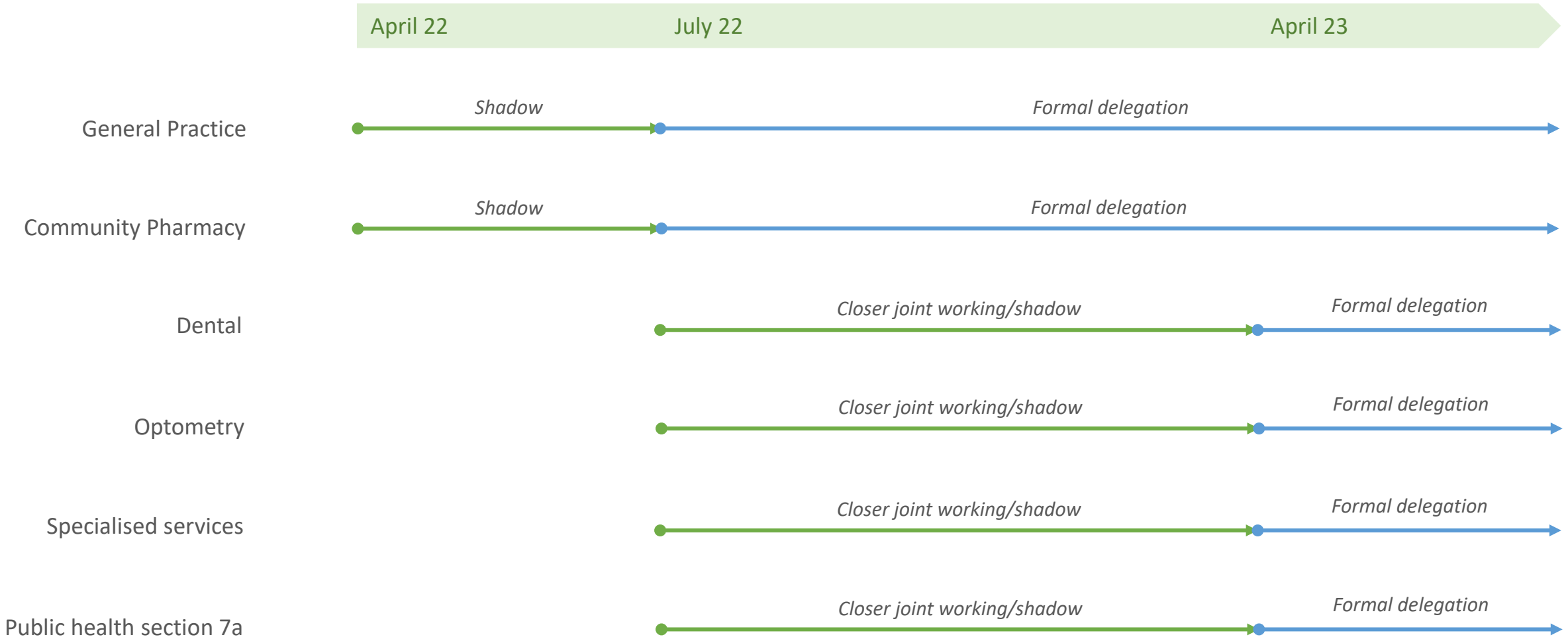
- **assume** delegated responsibility for **primary medical services** (currently delegated to all clinical commissioning groups [CCGs], and continuing to exclude Section 7A Public Health functions)
- **be able to** take on delegated responsibility for **dental** (**primary, secondary and community**), **general ophthalmic services** and **pharmaceutical services** (including dispensing doctors and dispensing appliance contractors)
- establish mechanisms to strengthen joint working between NHS England and NHS Improvement and ICSs, including through joint committees, across all areas of **direct commissioning** (in systems where they are not already delegated).

By April 2023

- taken on delegated responsibility for **dental** (**primary, secondary and community**), **general ophthalmic services** and **pharmaceutical services**
- taken on delegated commissioning responsibility for a **proportion of specialised services** (subject to system and service readiness) with national standards and access policies remaining at a national level
- worked collaboratively with NHS England and NHS Improvement to determine whether some Section 7A **Public Health services** will be delegated, with decisions on the appropriate model and timescale
- worked collaboratively with NHS England and NHS Improvement to determine whether **some health and justice**, **sexual assault and abuse service** commissioning functions will be delegated, with decisions on the appropriate model and timescale.

NHS commissioning » Intention to delegate commissioning functions to integrated care systems, July 2021 (england.nhs.uk)

Delegation phasing



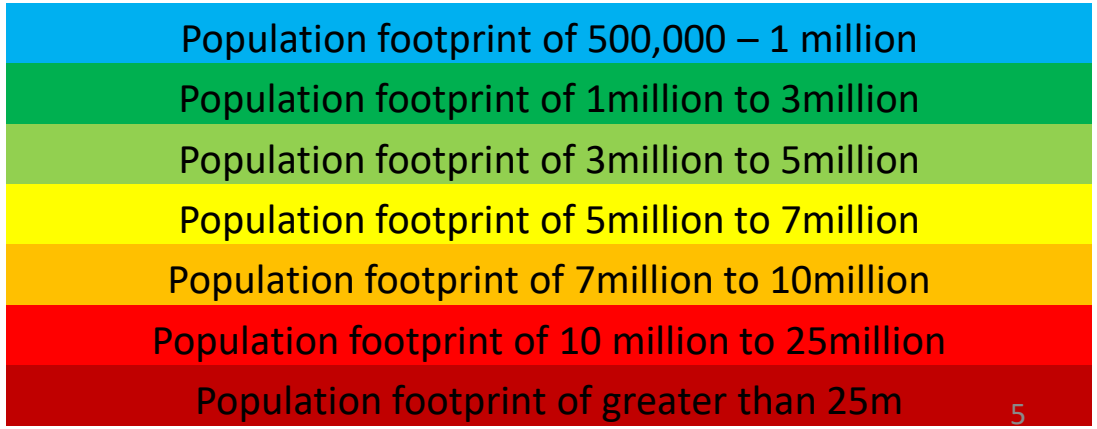
Primary care

- Table below identifies current number of primary care contracts and financial value:

Provider	Number of providers or providers	Value of contracts
General Practice	201 contracts	£273,498,000
Pharmacy	424 providers (includes Dispensing Doctors and Dispensing Appliance contractors)	Circa £44,000,000 (paid by the BSA plus an additional £1,000,000 for non BSA items)
Dental	219 dental practices (some providers have multiple contracts)	£96,549,000 (dental and orthodontic contracts only)
Optometry	269 contracts	£18,100,000

Specialised services

- Continue to await NHSEI guidance regarding specialised service planning populations
- Last week received a NW draft list of specialised services which are anticipated to be delegated to ICBs from April 2023
- Discussions to take place with NW Health & Justice and Specialised Commissioning Team and other NW ICBs to explore the application of the list considering NW ICB geographies, provider landscape and capabilities. Specifically which services does it make sense to:
  - Plan on an ICB footprint
  - Plan on a NW footprint (three ICBs collaborate)
- The planning populations may be based on the below:



Public health section 7a

- NHSEI works closely with Public Health England and the Department of Health and Social Care to provide and commission a range of public health services

- The services currently commissioned in this way are:
  - National immunisation programmes
  - National cancer and non-cancer screening programmes
  - Child Health Information Services (CHIS)
  - Public health services for adults and children in secure and detained settings in England
  - Sexual assault services (Sexual Assault Referral Centres)

- Initial discussions have taken place with NHSEI colleagues regarding the above, who are providing a briefing for the ICB Commissioning Delegation Group in April 2022 followed by the presentation of a proposed future arrangements strawman for consideration in June 2022

Commissioning support and corporate support

Primary Care Commissioning

- NHSEI L&SC General Practice and Community Pharmacy commissioning staff will align to the ICB on 1 July 2022
- All L&SC NHSE primary care commissioning staff will formally transfer to the ICB on 1 April 2023 (see overleaf)
- In practice all primary care commissioning staff have increasingly worked collaboratively throughout the pandemic and will continue to do so – a one team approach enabled by a clear operating model (see overleaf)

Specialised Commissioning

- Discussions regarding commissioning support will follow agreement of the list of specialised services to be delegated to the ICB from 1 April 2023. The ICB remains open minded to considering all support options, including shared support with other NW ICBs

Public Health Section 7a

- Similarly discussions regarding commissioning support will follow agreement of the public health section 7a services to be delegated to the ICB from 1 April 2023. Again the ICB remains open minded to considering all support options

Corporate Support

- NHSEI will continue to provide corporate support (e.g. finance, business intelligence, complaints, etc.) for delegated services during 2022/23. The ICB will work with NHSEI to review these arrangements during 2022/23 and identify and progress any opportunities to integrate with ICB corporate functions by 1 April 2023

Commissioning support and corporate support

Primary care commissioning staff

Team	WTE
Transformation	7
General Practice and Optometry	7.5
Dental and Pharmacy	5.6
Local Professional Network	1
	21.1

Operating model – functional map

Integrated Primary & Community Care

Place

- Develop integrated neighbourhood self-care, care and wellbeing
  - All age (children and adults)
  - All need (physical and mental health)
- Develop integrated place wide care and wellbeing
- Deliver PCN transformation support
- Provide primary care delivery improvement support for:
  - PCN
  - General Practice
  - Community Pharmacy
  - Community Dental
  - Community Optometry

Together

- Develop and deliver transformation programme, including:
  - Workforce
  - Digital
  - Estates
- Design PCN development support
- Develop long term condition care models and pathways
- Develop enhanced services

System

- Develop integrated primary and community care strategy and delivery framework
- Define consistent standards, measures and outcomes
- Assure delivery of above
- Deliver contracting, performance and finance for all primary care services

Staffing options

- NHSEI L&SC General Practice and Community Pharmacy commissioning staff will align to the ICB on 1 July 2022. All L&SC NHSE primary care commissioning staff will formally transfer to the ICB on 1 April 2023
- Arrangements from 1 April 2023 for specialised commissioning, public health section 7a and corporate support are to be determined

Appendix 3: NHS England and NHS Improvement operating models

Model	Type of integration	New employer?	Change of line manager to host or new employer?	Significant change in other terms of employment, eg salary, benefits, etc?	Placed in another organisation?	New job description?	Permanent change?
Aligned	Virtual	×	×	×	×	×	✓×
Assigned	Virtual	×	×	×	✓×	✓×	✓×
Embedded	Virtual	×	✓ with link to manager within NHS England	×	✓	✓×	✓×
Transferred	Actual	✓	✓	×	✓	✓×	✓
Seconded	Actual	×	✓	✓×	✓	✓	×
Recruited	Actual	✓×	✓	✓	✓×	✓	✓

Key: ×= no ✓= yes ✓×= depends on the situation

Comments: Many of the models have some flexibility in how they are applied in practice. For example, an employee could be assigned to work in a system on a permanent or temporary basis. It is unlikely that such an employee will require a new job description. However, if the assignment requires a significant change to the employee's duties, it may require a new job description, which would be agreed in advance with the employee.
In addition, the individual circumstances of the situation will dictate the legal consequences of using a particular model. For example, embedding functions or posts in another organisation could unintentionally trigger a transfer of employment under the TUPE legislation. This could result in a change in the employer for the affected employees.

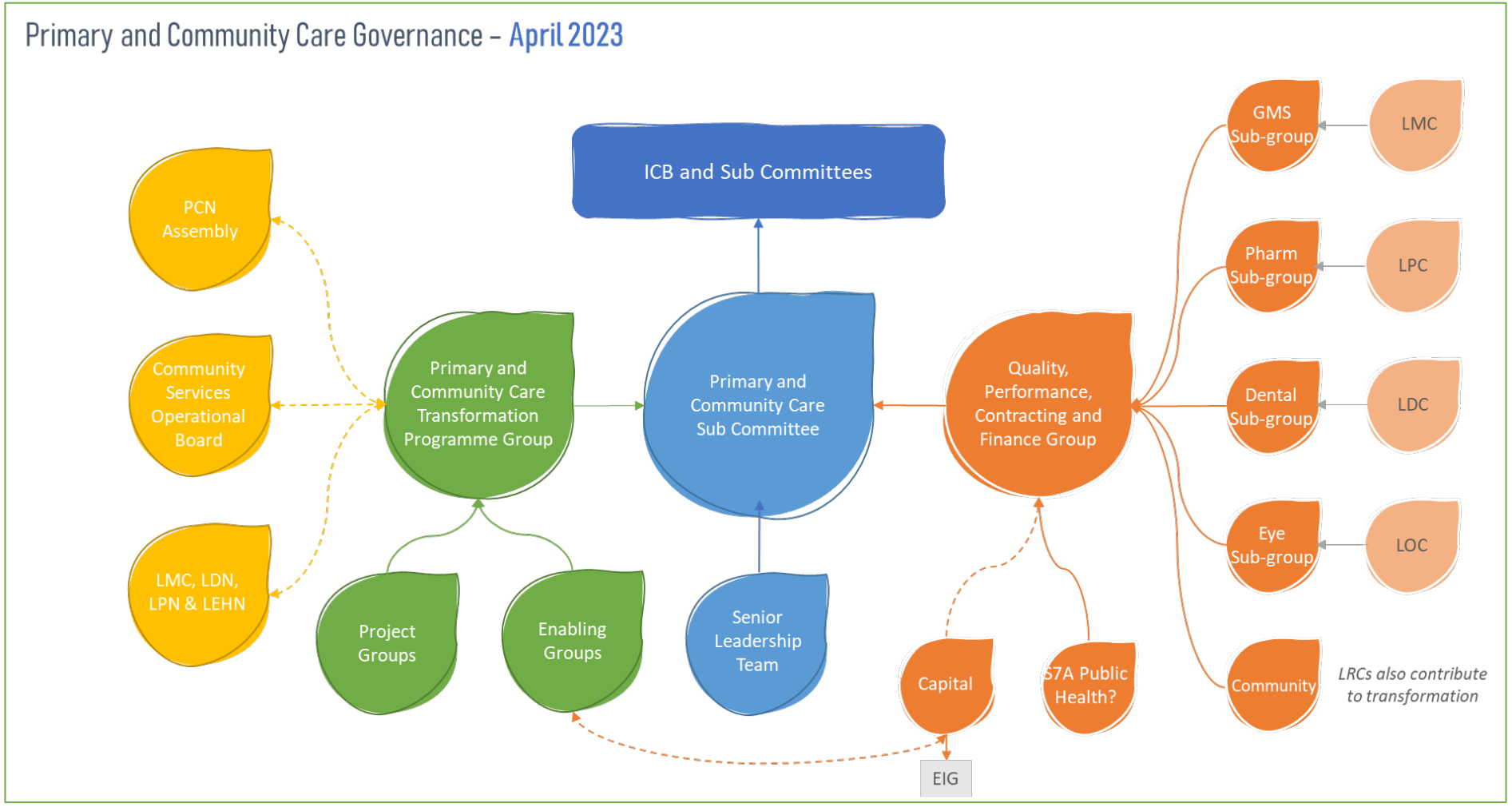
B0790_ICS_HR-Framework-Technical-Guidance_FINAL18Aug.pdf (england.nhs.uk)

Governance

- Initial focus on governance arrangements for General Practice and Community Pharmacy
- CCG Primary Care Commissioning Committees continue until end of June 2022
- In December 2021 ICS Development Oversight Group received and supported proposed primary and community care governance arrangements (illustration overleaf). Recognised that these were very likely to change in response to emerging ICB and PBP governance arrangements and especially any NHSEI delegation requirements
- ICB has recently received the draft NHSEI delegation agreement and been asked to provide any comments by the end of the week (11 March 2022). The agreement is being reviewed by ICB Commissioning Delegation Group members. It is in excess of 70 pages and consequently does not accompany this slide deck
- Later slides summarise key elements of the NHSEI explanatory note which accompanied the agreement

Governance

- Primary and community care governance arrangements (subject to change)



Draft NHSEI delegation agreement – NHSEI explanatory note

- Underpin delegation of Primary Medical Services, Primary Dental Services, Prescribed Dental Services, Primary Ophthalmic Services, Pharmaceutical Services and Local Pharmaceutical Services
- Reflects the principles which have informed ICS establishment: system by default, consistency between functions, building on precedent and adaptive to development
- Includes a number of critical changes from the PMC delegation agreement which will apply across all delegated functions:
  - Liability moves to the ICB:
    The Bill locates liability with the body exercising delegated functions
  - Onward Delegation:
    Delegation from an ICB to another (relevant) body is permitted within the agreement, subject to some parameters
    Onward delegation to providers (NHS Trusts or Foundation Trusts) or joint committees including providers is not permitted
    Onward delegation to joint committees of ICBs is permitted and does not require NHSE approval
    Other delegations or joint committees are permitted subject to approval by NHSE
    'Triple delegation' – the further delegation of a function from a body which has delegated functions from the ICB – is prohibited
  - Financial Flexibility:
    ICBs will have the ability to shift monies from the Delegated Budget to their wider budgets (and vice versa), while meeting their contractual obligations, including those through nationally agreed contracts, such as the Community Pharmacy Contractual Framework
  - Duty to comply with Guidance:
    ICBs now need to comply with a list of specified guidance when exercising the functions. This will include guidance such as the Primary Care policy manuals

- Planning and Reporting:
  The ICB is now required to include their plans for exercise of the delegated functions and a report on their performance against these plans in their ICS plan and annual report
- PCCC Requirements:
  The agreement does not mandate the establishment of a PCCC. ICBs which wish to maintain their PCCC are able to do so, while considering how to integrate Primary Care with their wider responsibilities
- Assurance:
  The current approach (which relies almost exclusively on the SOF) is being replaced by a broader and more flexible assurance arrangement. Where appropriate, the agreement has been adapted to refer to any "any applicable assurance frameworks". This is to appropriately tailor assurance to support the discharge of newly delegated functions, and to reassure NHSE that national standards are being maintained
- Strengthened duties to collaborate, comply with the Triple Aim, address health inequalities, and include under-represented groups in decision making

- NHSE Retentions

Following delegation, NHSE will retain responsibility for those functions which are core to its national accountability and regulatory roles. Some duties will also be retained for efficiency-based reasons – for example, where splitting a function 42 ways would be a less effective use of resources. NHSE will continue to carry out the following activities:

- Managing national contract development and negotiations
- Maintaining national stakeholder relationships, including with professional bodies and other representative organisations
- Designing and deploying national and regional transformation programmes
- Carrying out national and regional enabling functions, where highly specialist expertise and/or scale will continue to be required (e.g. clinical validation for GPs).
- Maintaining specific national support systems – i.e. commissioning and contracting support, payment and administrative systems (i.e. the BSA). All support systems and processes will be mandatory for ICBs to use unless otherwise specified

Pre-delegation assessment

- An updated Pre Delegation Assessment Proforma (PDAP) and supporting information is required by the NHSEI regional team on 18 March 2022. Followed by national moderation panel review on 4 April 2022

- The PDAP includes an:
  - Overarching assessment of ICS progress towards delegation
  - Key Milestones towards delegation

- For these domains:

Domain	Principle
Transformation	There is a clear understanding of how receiving each new responsibility will benefit population health outcomes.
	There is a shared understanding across all ICS partners on the benefits of delegation.
Governance and Leadership	Governance enables safe, high quality delivery.
	Clinical leadership combines the specialist expertise to lead and scrutinise individual functions, and the collaborative working necessary to identify, enable, and oversee clinical improvements.
Finance	Major financial risk factors are clearly understood and mitigated.
Workforce and Capability	There is an understanding of the workforce and capability and capacity requirements, with any major risks understood and processed for mitigation.

- The ICB response largely consists of the action plan plus supporting evidence of delivery

Project planning

- Project will continue though 2022/23 into early 2023/24
- Expecting further NHSEI planning guidance/requirements and due diligence materials imminently
- Consequently likely to quickly become more resource intensive
- Updated project plan accompanies this slide deck (continually being reviewed and updated)
- Transition risks minimised due to phasing and alignment and transfer of existing commissioning staff and corporate support
- Immediate focus on ensuring governance arrangements in place

Recommendation

- The Strategic Commissioning Committee is recommended to:

    1. Receive this update for information
    2. Provide feedback
    3. Support the approach outlined
    4. Request that members communicate the update to relevant committees/groups/colleagues

Peter Tinson
ICS Director of Collaborative Commissioning
06/03/22

Strategic Commissioning Committee

Date of meeting	**10th March 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.
Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

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

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

Report authorised by:	Roger Parr

ICS Quality and Performance Report

March 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

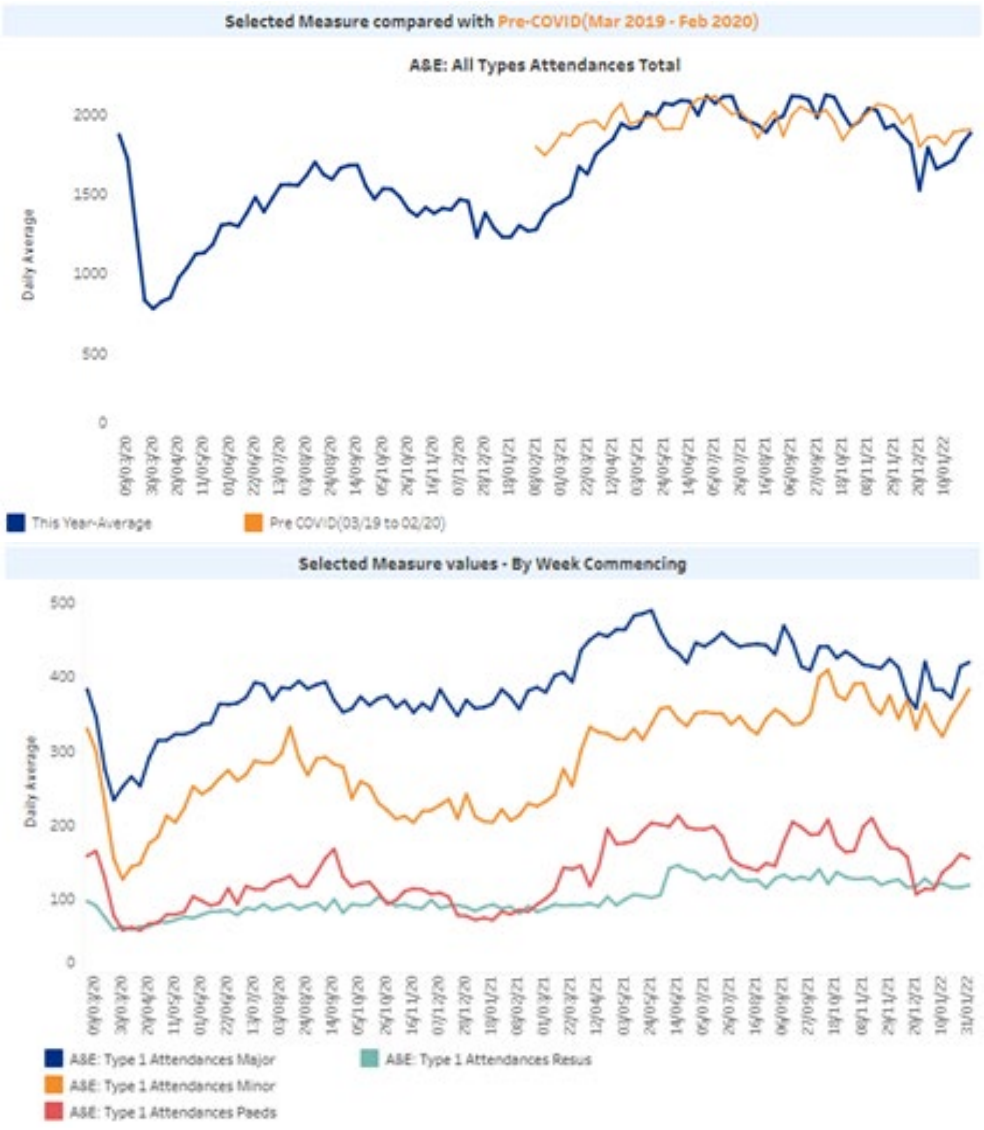
This month the report focuses on the following elements of Quality and Performance:

- Urgent Care
- Cancer Services
- Diagnostics
- Elective Care
- Nosocomial Infections
- Individual Patient Activity and Continuing Healthcare
- Safeguarding
- Mental Health
- Learning Disabilities and Autism
- ICS/ICB Complaints, MP Letters, and PALS
- 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: Incomplete Pathway Waiters – Top 20 providers with Independent Sector identified (Apr21 to Nov21)
    - Appendix 4: Proportion of Patients aged 14+ on the Learning Disability register who have had an annual health check (Dec-21) – PCN Level
    - Appendix 5: Patients aged 14+ on the Learning Disability register who have had an annual health check (Dec-21) – Practice Level
    - Appendix 6: ICS Performance Metrics (separate attachment)

3. Urgent Care

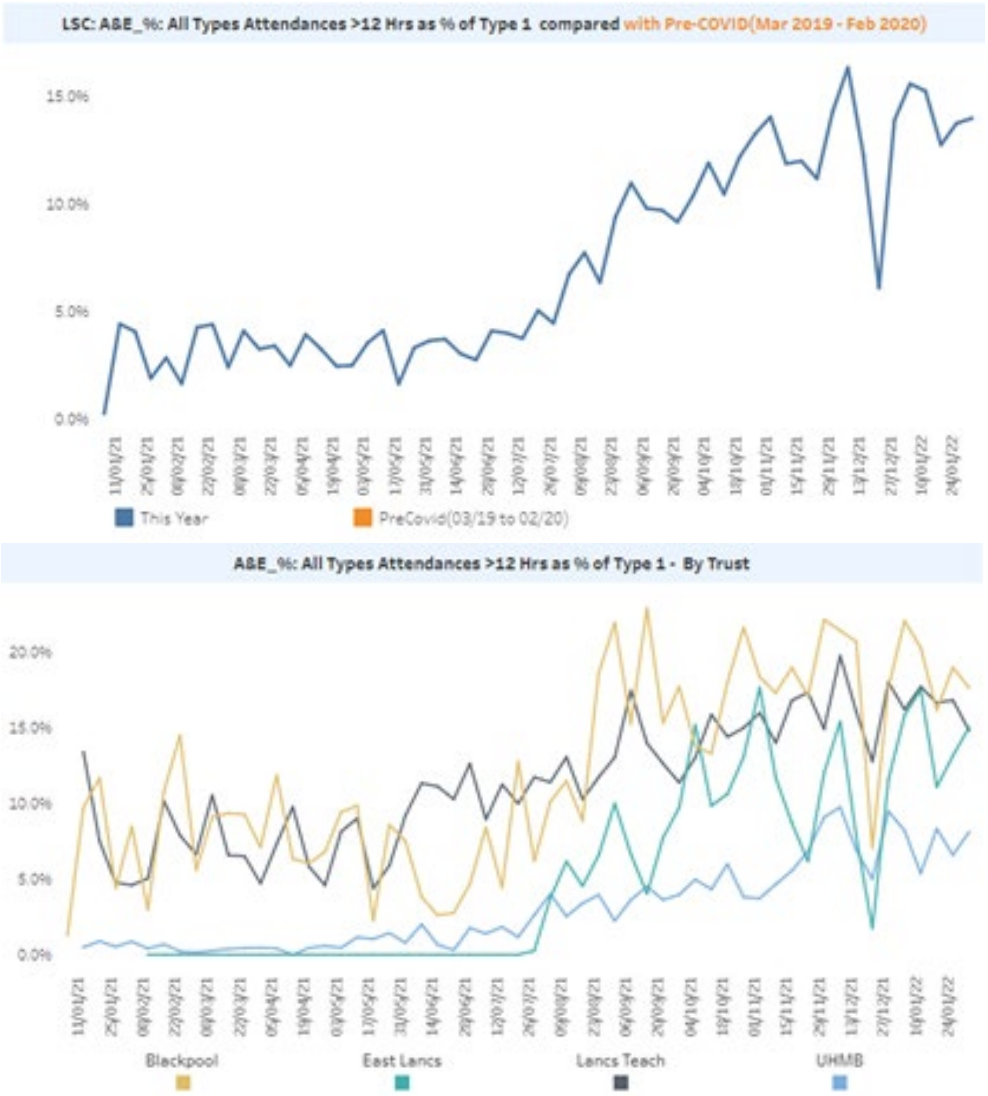
3.1. In January 2022 L&SC all type A&E performance was 73.48% compared to 72.6% in CM and 64.02% in GM against the national 95% standard. Cumulatively April 2021 to January 2022, L&SC performance is 77.83% compared to 74.6% for C&M and 68.9% in GM.

3.2. During the month of January 2022, the 'all type' attendance numbers have been below pre-COVID levels climbing back to similar levels by the end of the month. The trends in attendances were similar across paediatrics, and adults presenting with minor and major conditions.



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

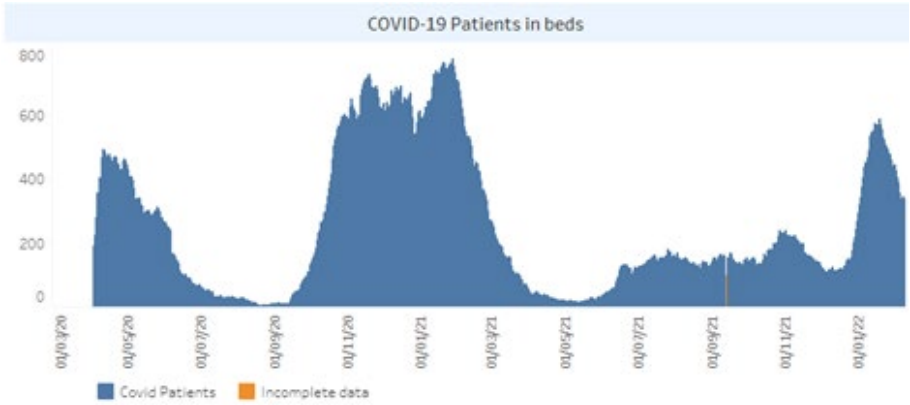
3.3.1. The number pf patients waiting over 12 hours from type 1 attendance to ED for admission has continued to be high throughout January 2022. 12 waits were experienced across all sites with the lowest percentage at UHMB.

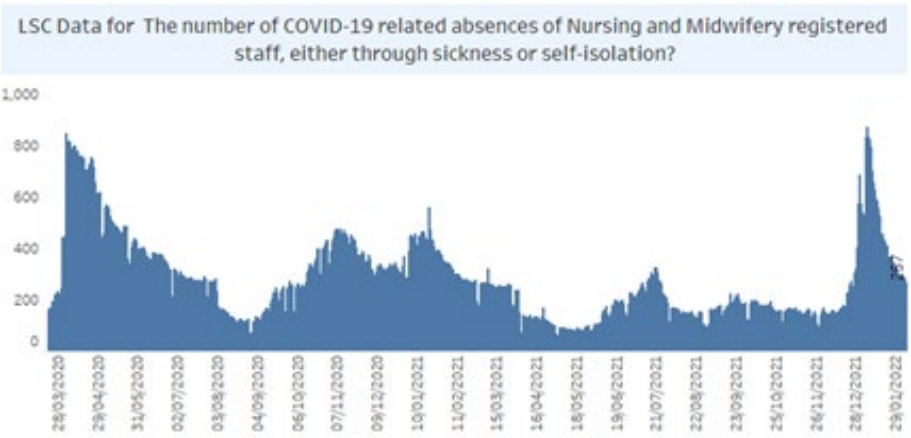


3.3.2. The main reason for long waits is availability of acute medical beds in hospitals. The timeliness of bed allocation has in recent months been impacted by the staffing available to operate these beds safely and the need to cohort patients in covid and non-covid beds. Trust have opened escalation beds to support improved flow. A high number of patients are also in hospital beds that are medically fit for discharge but required further care support.

3.3.3. 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.

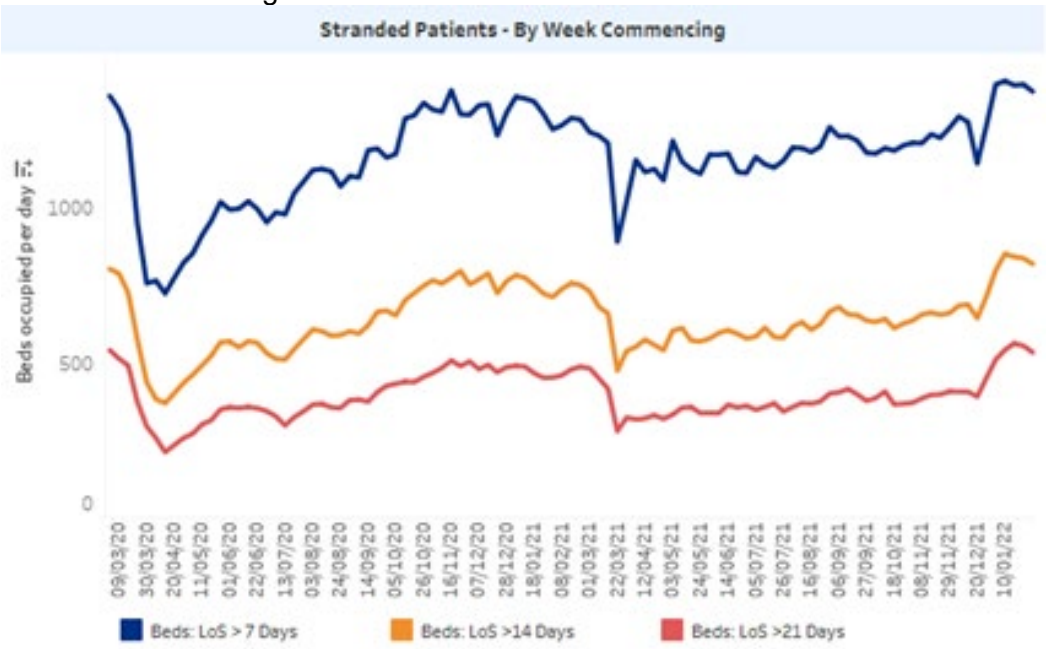
3.3.4. The number of COVID patients in hospital beds decreased throughout January 2022 although 446 COVID positive patients still occupied acute beds on 31st January 2022. Similarly, COVID related staff absence decreased in January 2022 but still high with 285 Nursing and Midwifery registers staff with COVID related absence on 31st January 2022.

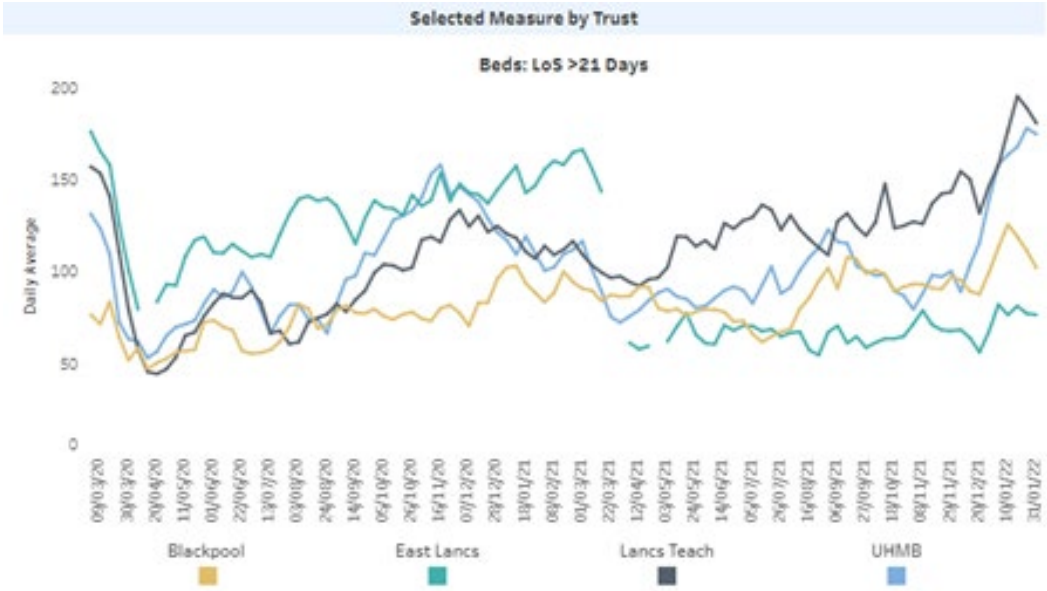




3.4. Length of Stay

3.4.1. 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. All 3 of these metrics have continued to peak throughout January 2022 on an L&SC level however the most significant increase has been at UHMB and LTHT.



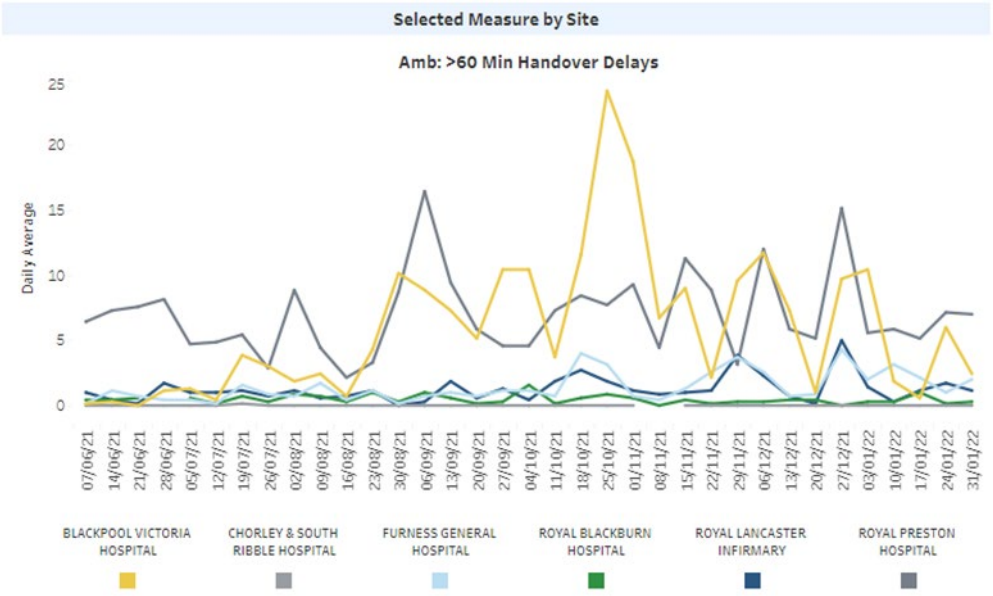


3.4.2. Many of the patients in acute hospital bed that are medically fit are waiting to return home with formal support (pathway 1) or waiting for discharge to assess bed in a 24 hour designated setting environment (pathway 2). Regulated Care continue to work under extreme pressure however beds are slowly reopening following closure due to COVID outbreaks.

3.4.3. A focus on supporting discharge at system and place level continues to be a priority and actions to support are monitored through the Joint Cell and L&SC Gold Command.

3.5. <u>Ambulance Delays</u>

3.5.1. During December 2021 60+ minute ambulance delays have continued although have improved from the peaks previously experienced. RPH and BVH are the most challenged sites. The system average ambulance turnaround time for the week commencing 31st January 2022 was 34 minutes compared to 39 minutes in C&M and 38 minutes in GM.



3.6. Patient Experience

A report on patient experience of using the urgent care system is being developed from Healthwatch Lancashire, Healthwatch Blackburn, Healthwatch Cumbria and Healthwatch Blackpool along with the HW Lancashire case studies. Local communication teams will be working with local A&E Delivery Boards on the findings and recommendations.

3.7. Local Plans for managing patient flow

3.7.1. Acute trusts have continued to enact local plans for improving patient flow with system partners to support safe discharge of patients. Some examples below demonstrate the range of actions being taken:

- Discharge care bundle to standardise care and support the safe discharge of patients.
- Roll out of NHS 111 First, increased local Clinical Assessment Service capacity, the expansion of COVID Virtual Ward to include self-monitoring, the development and expansion of 2hr Urgent Community Response, and Winter Access Fund (Primary Care).
- A programme of work to support ambulances to improve turnaround times is in place, including the development of community-based responses, 2-hour UCR and alternative pathways to conveyance (including Same Day Emergency Care, Falls Lifting Service, local CAS and Intensive Home Support Service pathways).
- Tactical Command calls, which include partners across health providers and Local Authorities.
- Allocation of funds to enable Blackpool Social Care to assist in patient flow out of the hospital, allowing the Council to go into conversation with two care homes to help support the step-down process.
- Mobilisation of interim and intermediate care beds
- Commissioning of additional crisis support hours
- Prioritising therapy staff to provide more Home First slots
- Additional Age UK hospital aftercare capacity
- LCC discharge grants.

3.7.2. The A&E Delivery Boards closely monitor performance and oversee progress of all transformational schemes to support the position.

4. Cancer

4.1. Headlines for SCC

- L&SC is the second most restored system for referrals seen at 126% compared to England at 117% referrals seen
- There have been 1,413 additional referrals – 611 in lower GI alone (43%)
- Treatments overall at 107% above NW and England
- Significant issues at LTH for skin first appointments – current wait 7 weeks
- Process of moving long waits to other trusts developing to reduce waits across the system
  - The Cancer Alliance welcome CCG support in ensuring this happens in a timely fashion
- Backlog of patients waiting over 62-days has levelled at just over 1,000
- Half of the backlog is in Colorectal
- 46% of the backlog is at ELHT
- Pressures across a range of key diagnostics including CT, endoscopy
- Cancer screening programmes are not fully recovered, with issues within Bowel Screening
- Surgical pressure in kidney with mutual aid between ELHT and LTHT

4.2. Constitutional Wait Times

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

Standard	Cancer Alliance Ranking
2WW	20/21
Breast Symptomatic	13/21
FDS	13/21
1st Treatment	15/21
62-Day referral to treatment	18/21

- Pressures across the system are having a negative impact on performance against operational standards
- 14 Day performance has deteriorated recently due to pressures in breast, skin, and breast at LTHT
- Only 3% of breast symptomatic patients seen within 14 days at UHMB
- Lower GI, Gynaecology (LTHT) and head and neck (BTHT) are the main drivers for our 31-day first treatment performance with a mixture of volume and theatre constraints driving longer waits for treatments
- Pressures across surgery and radiotherapy
- Performance across the board is driving poor 62-day figures. Only skin is compliant. The pathways contributing the most breaches are urology and lower GI

4.3. Performance December 2021

The table below compares L&SCs performance against North West Alliances and the England average for December 2021. This includes monitoring against the faster diagnosis standard.

	2ww 1st seen standards		FDS	31-day treatment standards				62-day referral to treatment standards		
	Urgent suspected cancer	Breast symptomatic	Faster Diagnosis Standard	1s treatment	Subsequent surgery	Subsequent radiotherapy	Subsequent drugs	Urgent GP suspected cancer	Urgent Screening	Consultant upgrade
BTH	71.0%	77.3%	65.5%	97.1%	100.0%	N/A	100.0%	65.3%	26.7%	78.4%
ELHT	80.9%	57.1%	72.3%	94.0%	94.4%	N/A	98.1%	61.1%	80.0%	80.7%
LTH	55.4%	10.7%	65.7%	87.1%	75.3%	95.5%	98.9%	51.4%	0.0%	84.9%
UHMB	71.0%	3.3%	74.3%	95.5%	87.5%	N/A	97.5%	68.1%	59.6%	89.5%
CA	70.6%	43.4%	69.8%	92.6%	84.4%	98.4%	99.0%	60.2%	56.2%	84.2%
NW	75.6%	38.2%	67.0%	94.1%	86.5%	99.0%	99.8%	65.6%	69.2%	78.7%
England	78.6%	50.9%	70.5%	93.4%	83.0%	98.9%	94.1%	67.0%	75.9%	78.9%
Standard	93%	93%	75%	96%	98%	94%	94%	85%	90%	N/A

4.3.1. The table above shows that in December 2021 L&SC ICS performance against the cancer waiting times targets has been challenging.

4.3.2. There are several challenges that are impacting upon performance across all trusts. The volume of referrals for key specialties is having a negative impact on ability to see patients in a timely fashion, as evidenced in the deteriorating 14-day position and our FDS performance.

Pressures in breast, lower GI, and skin. Evidence demonstrates that delays at the front of the pathway increase a patient's likelihood of breaching 62-days.

4.3.3. Diagnostic pressures within urology and surgery delays are contributing the most breaches against our 62-day standard. Endoscopy capacity and the high demand in the lower GI pathway accounts for 19% of all breaches of the 62-day standard. Urology breaches account for 26% of all breaches. Referrals for lower GI have been double those seen in 2019. Surgical pressures at LTH, 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, we continue to monitor the situation via weekly escalation meetings. Mutual aid across the region is significantly challenging as all systems are under pressure.

4.3.4. L&SC Cumbria Cancer Alliance are ranked 2nd out of the 21 Cancer Alliances in England in terms of restoration of urgent cancer referral numbers seeing an additional 1,413 referrals in December 2021 vs December 2019. 611 (43%) of those additional referrals seen are in suspected Lower GI alone.

4.3.5. Restoration of treatments is 107%. Above NW and England

4.3.6. The table below shows the level of restoration in December 21 compared to December 2019 for referrals and 1st treatments at providers in L&SC.

Trust	Referrals Seen	1st Treatments
BTH	144%	136%
ELHT	129%	83%
LTH	112%	108%
UHMB	123%	114%
CA	126%	107%
England	117%	103%

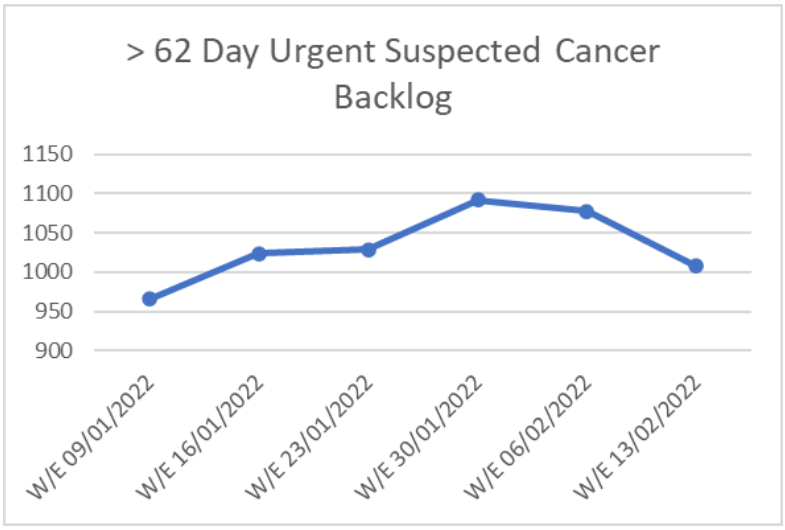
4.4. Skin

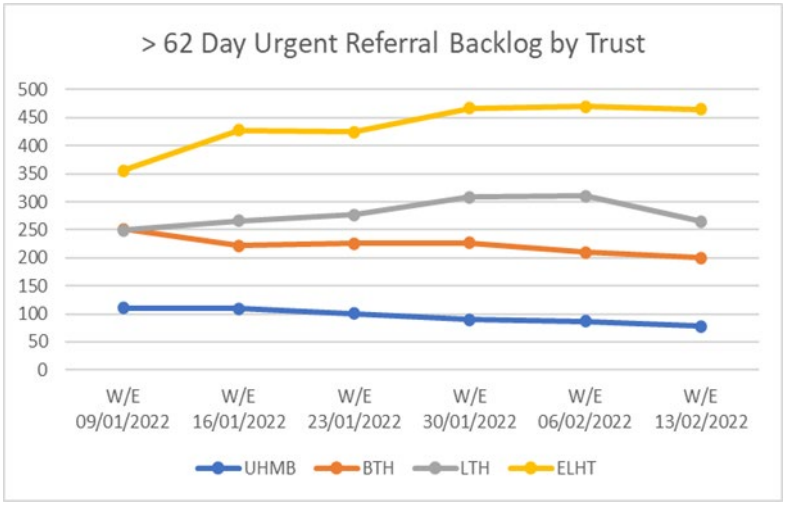
4.4.1. There is a particular issue to raise at LTHT in respect of skin capacity for the front end. Waits for FA are currently in the region of 40 days. Performance for December was 11% against the 93% standard. BTHT are offering mutual aid and ELHT and UHMB have agreed to take patients to reduce waits and balance inequity across the system. The process is being developed and the Cancer Alliance would welcome CCG support in this.

4.5. Backlog

4.5.1. The backlog of patients waiting over 62-days has been stable over the last 6 weeks. Our current backlog of urgent suspected cancer referrals (excluding upgrades and screening patients, which is the national metric) is 1,008. Of this 48% (488) of patients are within lower GI pathway alone. 46% of our backlog is at East Lancashire hospital with most of those in lower GI. As per the national reducing the backlog plan, we have until March 23 to achieve our backlog target of 407. This will be exceptionally challenging given pressures within lower GI and prostate.

4.5.2. The backlog graphs below highlight the overall position, split by trust and pathway.





4.6. Cancer Wait Time Improvement Plan

- Pathway improvement work within most challenged pathways in gynaecology, prostate, upper and lower GI, sarcoma, non-specific symptoms, lung, and breast. These will continue into 22-23 year
- Completion of the pathway analyser tool to identify main areas of concern
- Endoscopy improvement programme underway
- Close working with CDCs to support faster diagnostic capacity
- Focus on LGI for backlog reduction
- Innovation funding to reduce pressures on endoscopy
- Working to develop alternative pathways for patients based on FIT result
- Workforce investment
- Workforce review for additional professionals at front end of breast pathways
- External review of endoscopy booking and listing processes completed and action plans being developed at each trust and at system level
- Image-based skin pathway being implemented at LTHT to move to a triage model increasing front-end capacity

4.7. Cancer Serious Incidents

4.7.1. The Table below shows total number of StEIS incidents in relation to patients with a cancer diagnosis reported per year and year to date 21/22.

Year	01/04/2019-31/03/2020	01/04/2020-31/03/2021	01/04/2021-31/12/2021 Q1/Q2/Q3	Total
Number of StEIS Incidents	30	31	21	82

4.7.2. The Table below shows total number of StEIS incident reported by Trust/CCG broken down by year. The data shows that 40% of the StEIS incidents reported in relation to patients with a cancer diagnosis were reported by UHMB. In 2021 to-date, UHMB has had the same number of StEIS incidents reported in relation to cancer patients as LTHT. This shows a reduction in StEIS incident reported by UHMB from the previous 2 years.

Trust	01/04/2019-31/03/2020	01/04/2020-31/03/2021	01/04/2021-31/12/2021 Q1/Q2/Q3	Total
BTH	6	0	1	**7**
ELHT	5	5	3	**13**
LTH	2	6	8	**13**
UHMB	12	17	8	**33**
S & O	4	1	0	**5**
GPCCG	1	1	0	**2**
MBCCG	0	1	0	**1**
ELCCG	0	0	1	**1**
Total	**30**	**31**	**21**	**82**

4.8. Actions / learning implemented

4.8.1. Below is a summary of actions taken by Trusts/CCGs following review of StEIS incidents and learning being implemented.

- Review of internal referral processes and management of urgent patients.
- Ensuring all cancer patients are placed on the Somerset Cancer Register for monitoring and tracking.
- If a clinic, list, or scan appointment is cancelled all urgent patients to be reviewed by lead nurse or consultant.
- Ensuring administrative/electronic systems safety netting procedures are robust including training and guidance for staff.
- Sharing and circulating lessons learnt to governance meetings and to staff for learning and reflection.
- Staff to ensure any patient documentation received is clearly recorded and tracked.

- Details of diagnostic imaging to be included in all clinical correspondence.
- Consultant to consultant referrals need to be made for urgent suspected cancer patients.

4.9. Complaints / MP letters received by L&SC CCGs specific to Cancer Services

4.9.1. From the information provided for 2020/21 and 2021/22 (Q1, Q2, Q3) there was a total of eight complaints, eleven MP letters and two enquiries split by general enquiry and GP enquiry. Most of the incidents were categorised by the service providers as delays to treatment, cancelled operations, clinical care concerns, urgent scans downgraded and out of area treatment request.

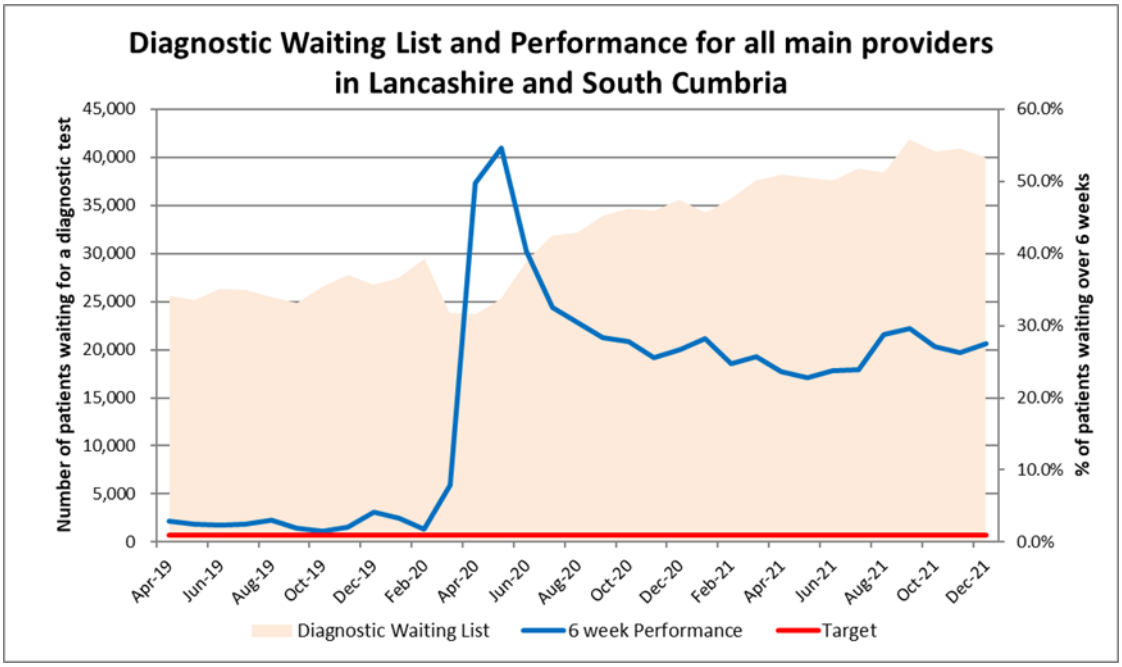
4.9.2. Other themes noted were in relation to SMS text reminders for Cancer Screening appointments and a query regarding the Breast Screening mobile unit in ELHT.

4.9.3. Trusts and CCGs will now report this information on a quarterly basis to identify any recurrent themes, learning and actions taken in relation to STEIS incidents and Complaints/ MP enquiries.

5. Diagnostics

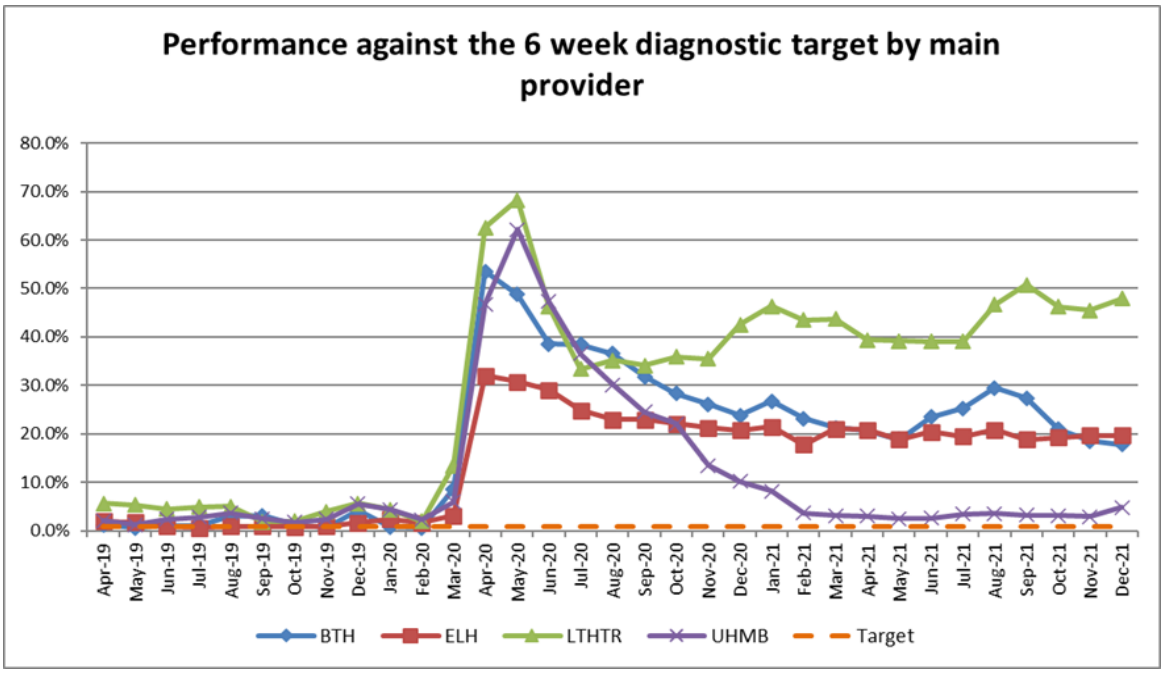
5.1. Overview of Diagnostic Performance

The percentage of patients waiting over 6 weeks for a diagnostic test across L&SC deteriorated in December 2021 to 27.6%, driven by a reduction in performance at LTHT and UHMB albeit from a much lower level of breaches (4.8%). ELHT, showed no significant change in their performance position, however BTHT showed an improved position in December 2021.



5.2. Overview of Performance at Provider Level

Comparison between lead providers shows that LTHT remain the outliers for performance in L&SC, with deteriorating performance in the last month widening the gap. The performance at ELHT remains static, whilst BTHT has shown significant improvements in performance over the last 4 reporting periods. The performance at UHMB is still significantly above the other 3 providers despite a deterioration to 4.8%.



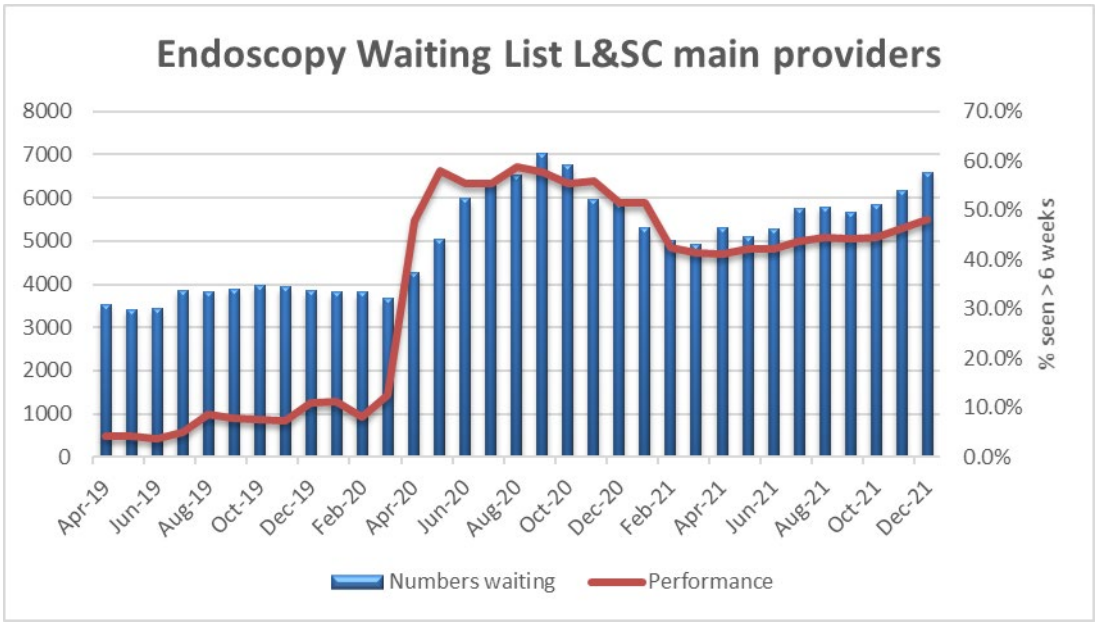
5.3. Performance at Procedure Level

The month on month in the table below shows the differing pressures in performance for Endoscopy and Non Endoscopy in diagnostics. For Endoscopy, only BTHT showed an improved position in December and only ELHT showed an improved position in their Non Endoscopy performance. In terms of performance Endoscopy remains the most challenged area.

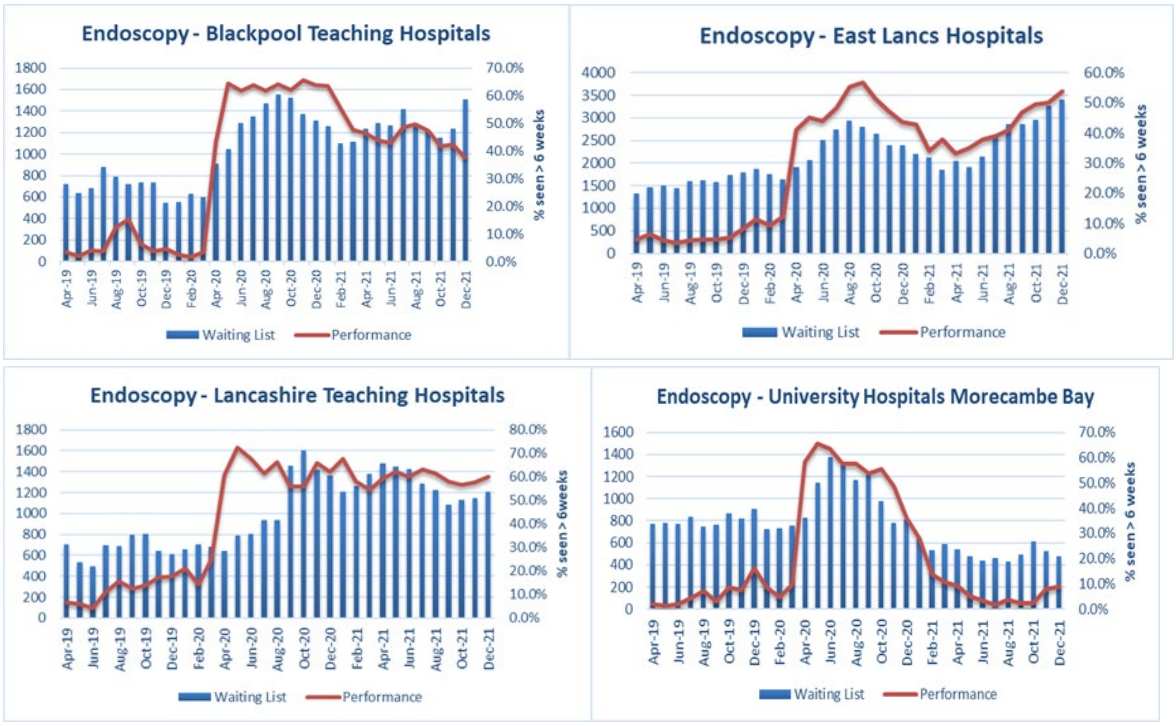
	% of patients waiting over 6 weeks (Dec 21)		
Provider	Endoscopy	Non Endoscopy	All Diagnostic Tests
Blackpool Teaching Hospitals	38% ↓	9% ↑	18% ↓
East Lancashire Hospitals	54% ↑	9% ↓	20% ↔
Lancashire Teaching Hospitals	60% ↑	47% ↑	48% ↑
Morecambe Bay Hospitals	8% ↑	5% ↑	5% ↑

5.4. Endoscopy

5.4.1. There are significant pressures on Endoscopy across L&SC. The waiting list has increased to just over 6,500 patients from a starting position in the financial year of just over 5,000. The general trend over the calendar year has been deteriorating performance and increasing waiting lists.



5.4.2. The information for ELHT shows both a continued deteriorating performance and an increasing waiting list, LTHT has seen an increase in the number waiting over the past 3 reporting periods and consequently a deteriorating performance position, with 6 in 10 patients waiting longer than 6 weeks. BTHT have seen a significant spike in the waiting list, however their performance continues an improving trajectory since August 2021. UHMB have seen a worsening in performance though they continue to remain the best performing in L&SC.



5.4.3. The position at LTHT should be further improved by an agreement with Ramsay Healthcare for them to undertake endoscopic procedures at their sites at Buckshaw and Fulwood Hall. Volumes are increasing and are currently up to 50 procedures per week.

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:

- Community Diagnostic Centres - All parts of the ICS have included endoscopy provision in their Year 2+ plans. Analysis of the operation plan guidance of 3.5 rooms per 100k population of people aged 50 years plus suggests LTHT requires 2 extra rooms required UHMB 1 extra room and BTHT 1 extra room. At this point the NHSE national team funding allocation unconfirmed. A bid has been awarded of £500k for roll-out of Cytosponge into CDCs and nominated primary care.

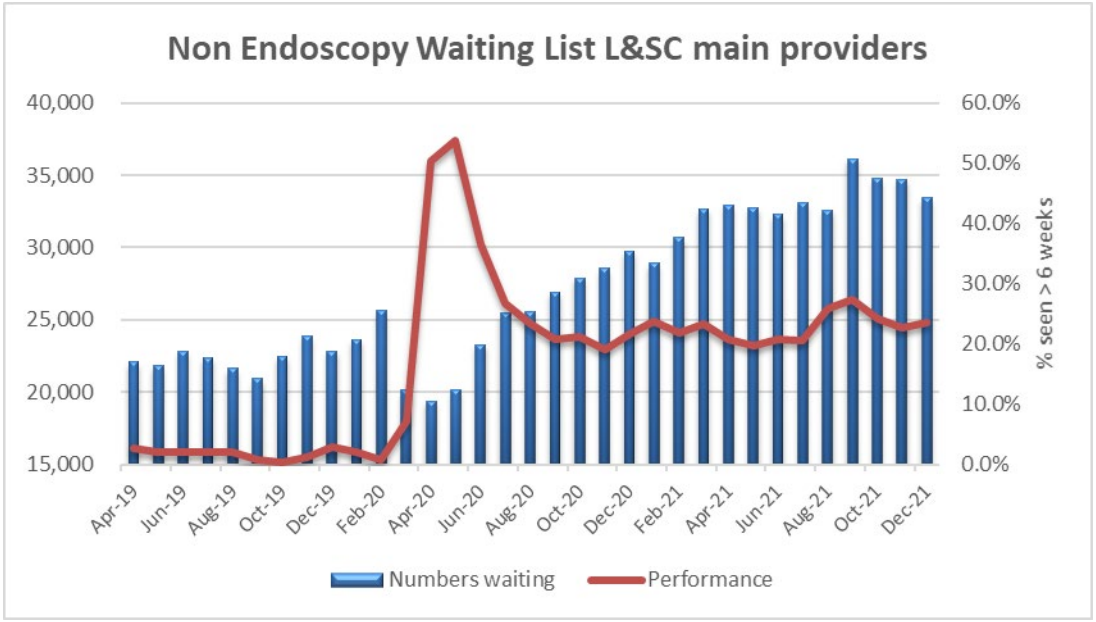
- North West Endoscopy Academy – The hub and spoke modelling is developing with monies awarded allowing for mobilising at pace to recruitment into new posts and capital requirement.

- Productivity – UHMB are piloting THRIVE (in room productivity tool) after funding secured by the Cancer Alliance.

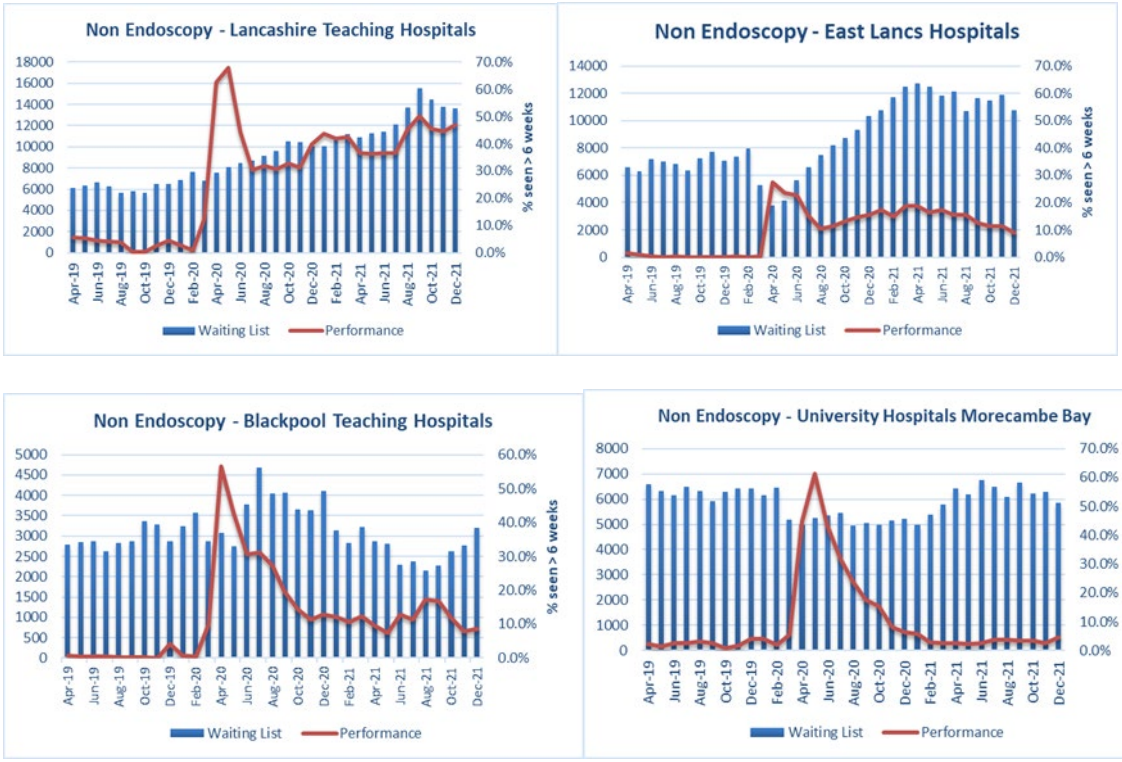
- Demand Management – L&SC FIT steering group working with NHSE to agree new pathway for low risk patients. Meridian are working with LTHT and ELHT for a diagnostic analysis of their booking and referral validation pathways, with Changeology working with BTHT and UHMB.

5.5. Non Endoscopy

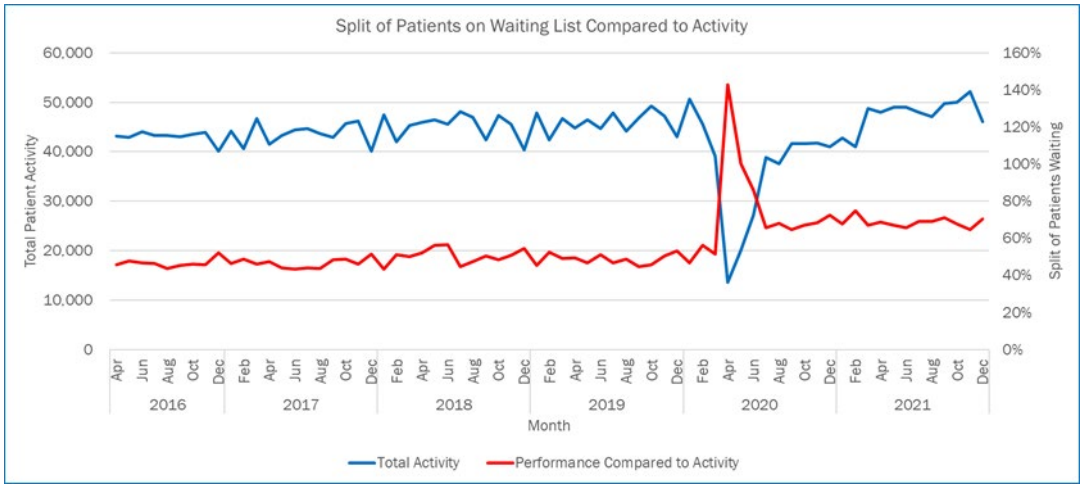
5.5.1. The Non Endoscopy waiting list fell again in December 2021 by circa 1,300 patients, mainly due to a significant fall in the waiting list at ELHT. The waiting list reduced at both LTHT and UHMB, however BTHT showed an increase in the waiting list in December 2021. Performance worsened in December 2021 with only ELHT showing an improvement in performance in the month.



5.5.2. The graphs below show falling waiting lists at ELHT, UHMB and LTHT with the increase in waiting list at BTHT. The performance at ELHT continues the improving trajectory, where LTHT has since a worsening in performance in the last month, UHMB continues to perform significantly better than the other 3 trusts, despite a slight worsening in performance in the month.

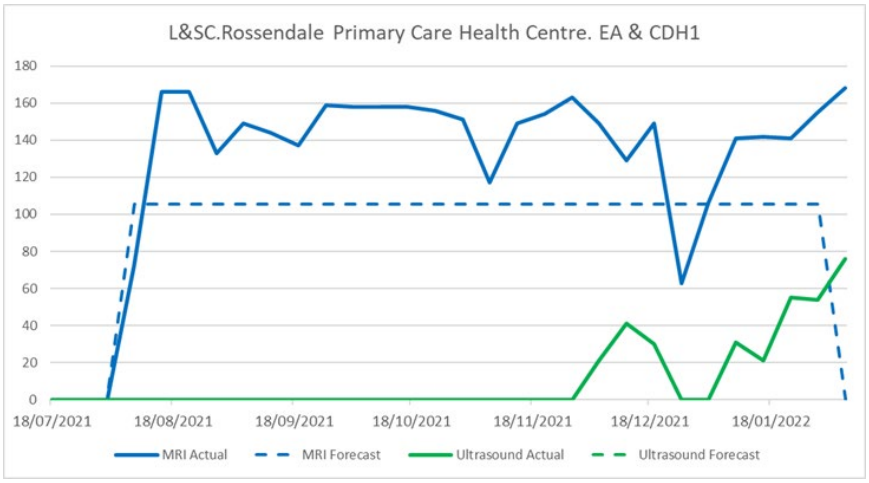


5.5.3. The activity for November 2021 suggested that waiting list would deteriorate. The graph shows activity for Non Endoscopic procedures across all four providers. There is a dip in the December 2021 in activity consistent with historic trends, although activity continues to be higher than pre pandemic levels. 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.

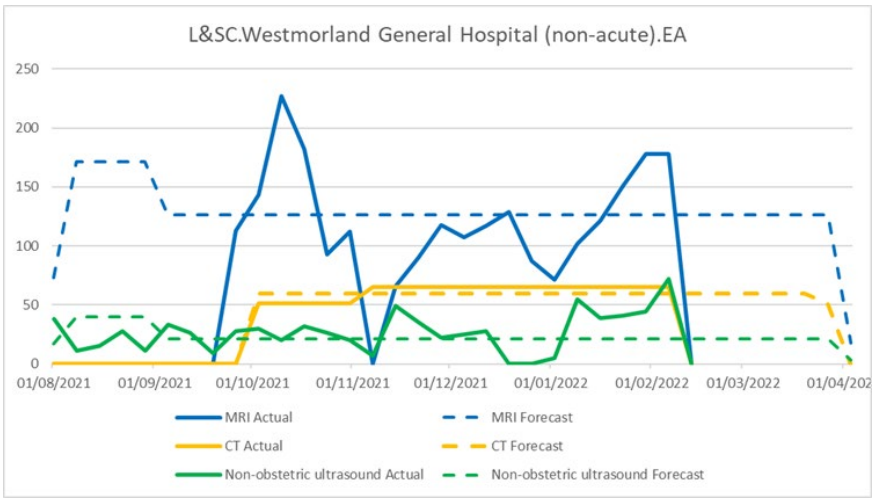


5.6. Community Diagnostic Centres (CDC)

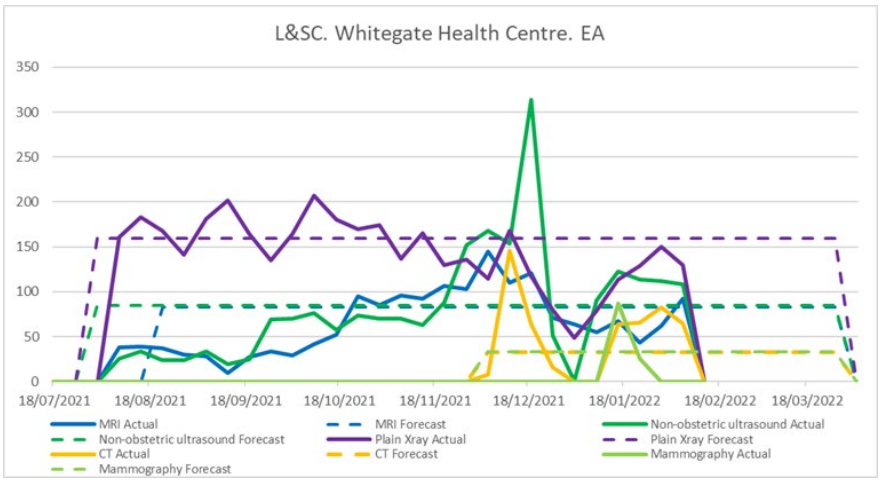
5.6.1. The activity reported at the CDCs is dependent on the model rolled out to this stage. The CDCs continue to be developed with planning for more diagnostic procedures to be delivered over the next 2 years. The latest information available shows that for the CDC in Pennine Lancashire the actual level of activity for MRI has been above the planned level since it came on stream at the end of July 2021 and significant increased into February 2022 and has recently opened to Non Obstetric Ultrasound which also has increased significantly in the same period.



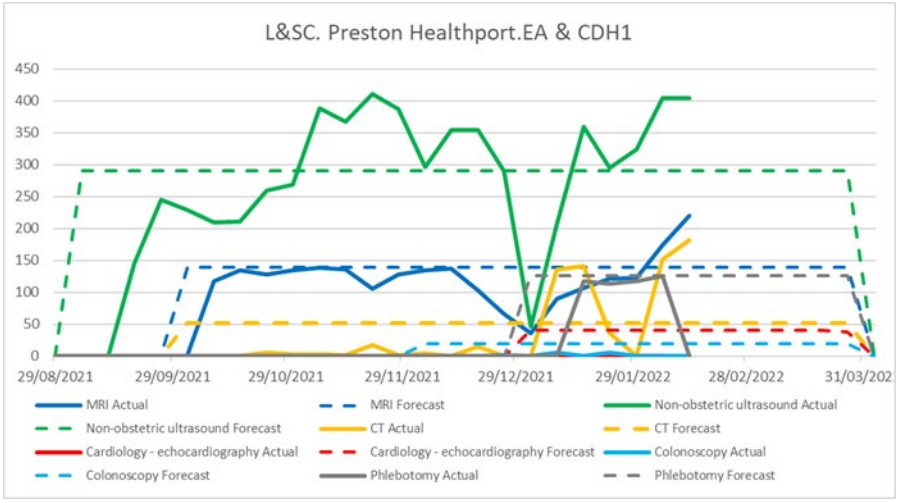
5.6.2. For Morecambe Bay the information shows that over the period MRI has seen a significant increase in activity into February 2022 as has non obstetric ultrasound, CT scans activity continues above planned activity.



5.6.3. For the Fylde Coast CDC, the delivery of plain X ray has been above target until mid November 2021 when it fell away and now is under plan, the activity for Non Obstetric Ultrasound and CT scan has grown over the reporting period and was significantly above plan from mid November 2021 to December 2021. Since December 2021 activity across all the procedures has increased.

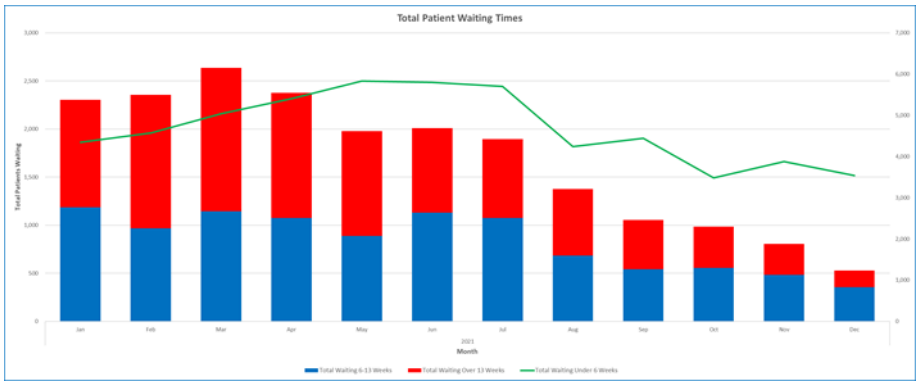


5.6.4. For the Central Lancashire CDC the Non Obstetric Ultrasound and CT scan activity started later than planned but has been above plan since late October 2021 and the beginning of 2022 respectively. The activity for Non Obstetric Ultrasound, MRI and CT has increase significantly since December 2021.

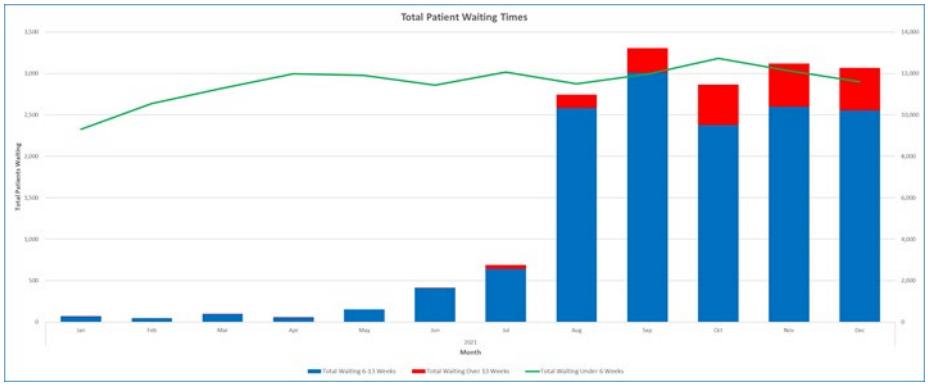


5.7. Breakdown of waiting lists for Non Endoscopy Procedures

5.7.1. The graph below is the waiting list for MRI scans across L&SC main providers. There has been a significant fall in the numbers waiting over 6 weeks and under 6 weeks. The present rate of activity both within Acute Trusts and at CDCs will hopefully minimise the number of over 6 week waiters by the end of this financial year. Consideration should then be given as to whether the capacity being used for MR scans could be better utilised driving the waiting list down for other procedures.



5.7.2. The graph below shows the waiting list for Non Obstetric Ultrasound, which increased significantly in August 2021 and has now steadied. Continuing activity in CDC is essential to keeping the waiting list steady and an extra activity will have a positive effect on the number of patients waiting.

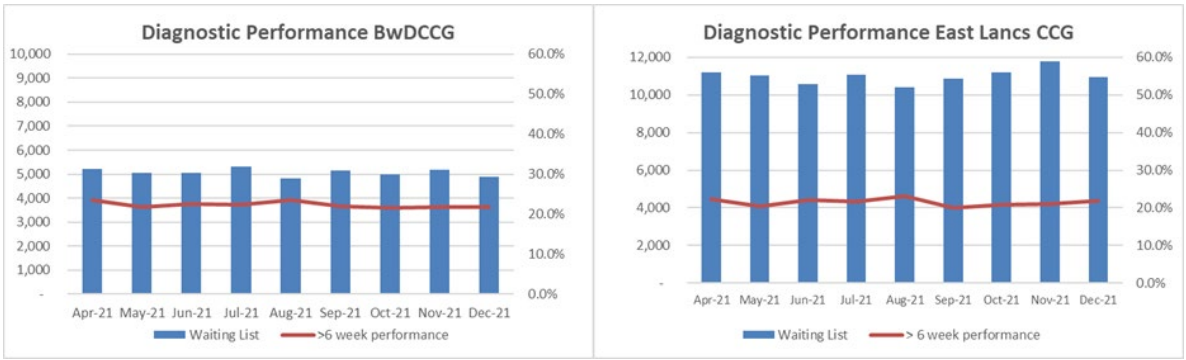


5.7.3. The graph below shows the waiting list for CT scans which continues to increase. Extra capacity in CT scanning within the CDCs will help to reduce or at least arrest the growth in the waiting list.

5.8. <u>Performance at CCG level</u>

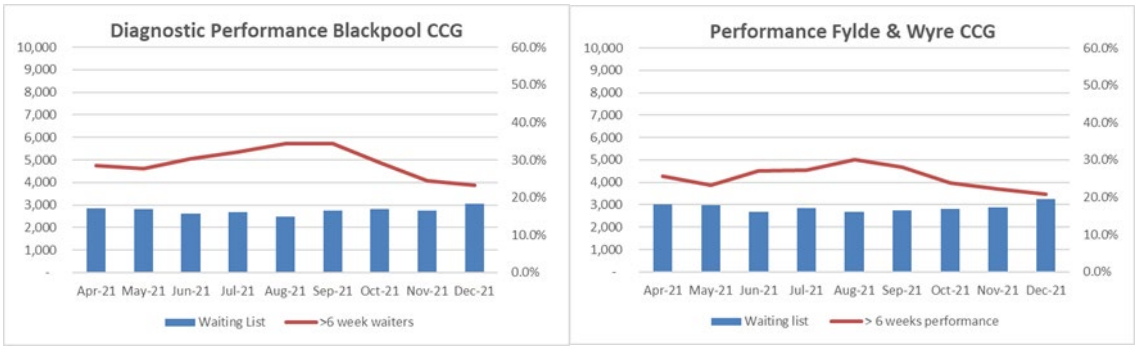
5.8.1. The report has monitored performance at CCG level to understand the waiting times for the populations of the CCG rather than for the main providers within those CCG footprints. The data is for all diagnostic procedures further developments of this report will aim to split it by Endoscopy and Non Endoscopy as with the providers.

5.8.2. For the CCGs within the Pennine Lancashire Place Based Partnership, the performance from the start of this financial year aligns consistently with the performance at ELHT. The fall in the waiting list across both CCGs reflects the fall in the waiting list for Non Endoscopy procedures in ELHT.

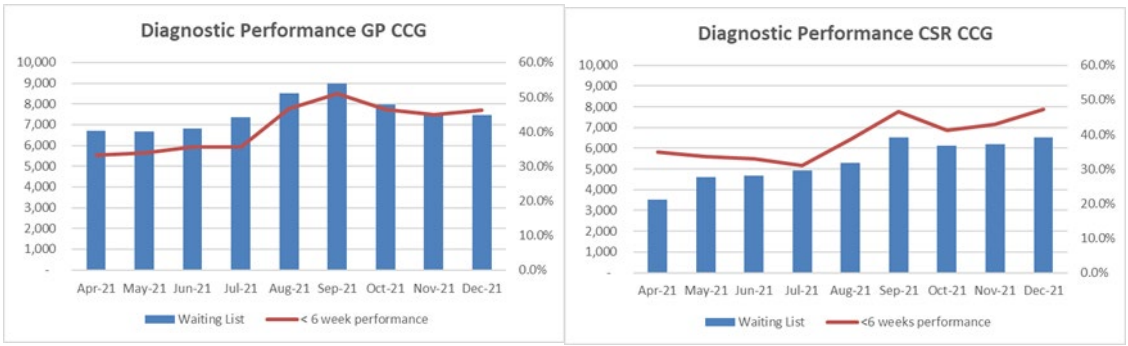


5.8.3. For the CCGs within the Fylde Coast Placed Based Partnership the performance has again aligned consistently with the main provider BTHT. The improvement in performance from BTHT over the previous 5 months is more marked at Blackpool CCG, than at Fylde and Wyre

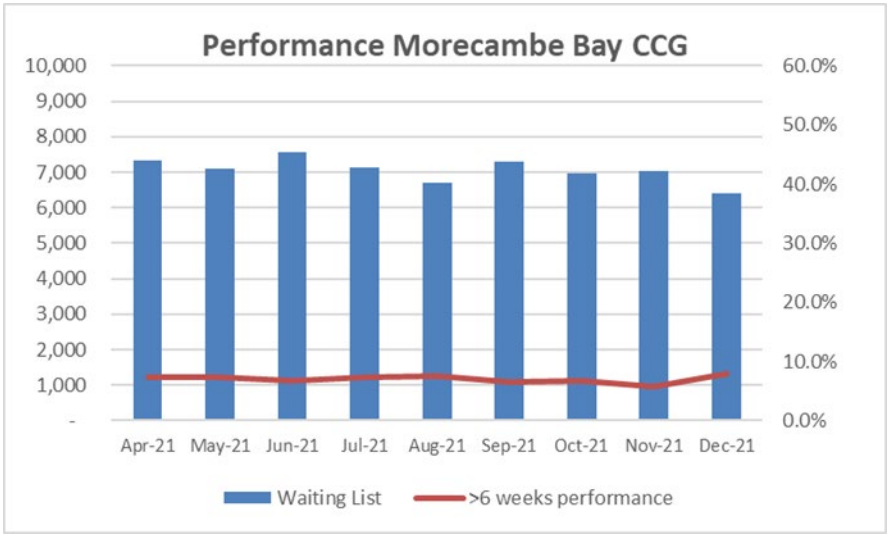
CCG. The increase in the waiting list at BTHT in December 2021 has been reflected by a rise in the waiting list for both CCGs.



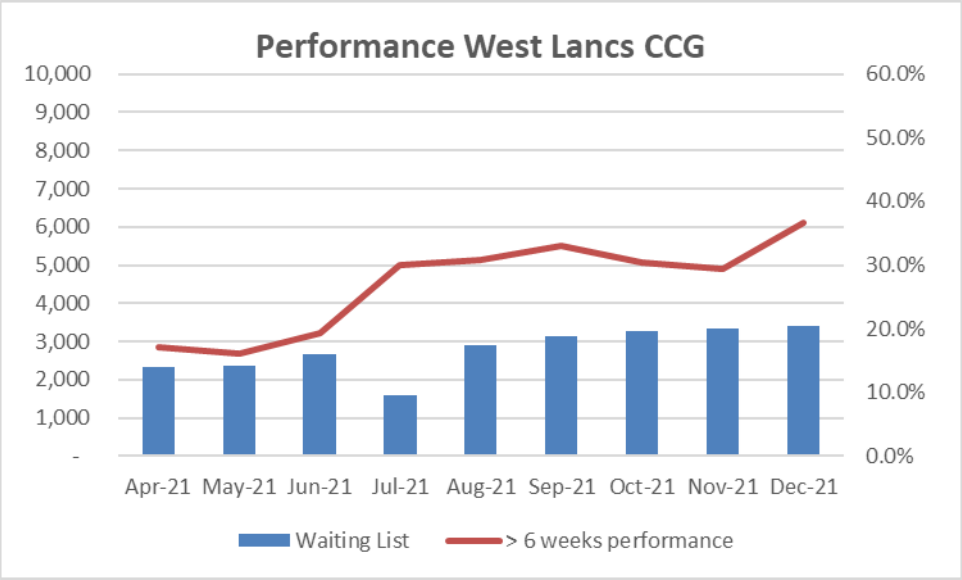
5.8.4. For the CCG within Central Lancashire Place Based Partnership, the performance is again consistent with that of the main provider LTHT. There are, however, differences in the trend of both performance and weighting lists between the CCGs. Greater Preston continues to see a fall in patients waiting, whereas C&SR CCGs performance deteriorated in the previous month and the waiting list is on an upward trend. Both CCGs have seen a worsening in performance in the last month with CSRs being more marked.



5.8.5. The performance for Morecambe Bay CCG shows a significant fall in their waiting list in December 2021, however the performance for the CCG is above that for their main provider UHMB and has deteriorated in the month. A further analysis of the information shows the performance is affected by patients seen at LTHT and North Cumbria Integrated Care NHS FT.



5.8.6. The performance for West Lancashire Placed Based Partnership is mainly driven through providers outside the boundaries of L&SC ICB. The performance has significantly deteriorated in the latest month mainly due to an increase in the number of patients waiting over 6 weeks at Southport and Ormskirk NHS Trust and Wigan Wrightington and Leigh NHS Trust.



6. Elective Care

6.1. Demand

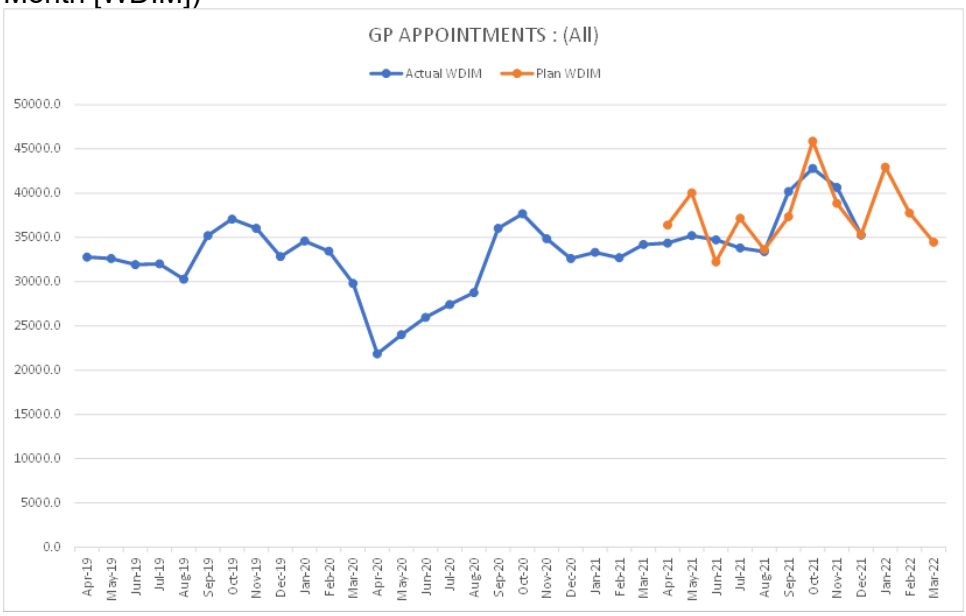
6.1.1. Appointment activity per working day in the month within GP practices have increased above levels seen in the September 2019 – February 2020 (pre-COVID) period (Chart 1) during the past 4 months (September 2021 – December 2021). However, there are variations underneath this at CCG level with both BwD CCG and GP CCG seeing clear increases reported in general practice appointments per working day in the month compared to pre-pandemic levels (in excess of 25% higher). When the number of general practice appointments per 1000 population is reviewed then practices within the Fylde Coast ICP offer the greatest number of appointments per 1000 population.

6.1.2. There are always challenges in collating and comparing appointments without understanding the appointment type; i.e. the data does not distinguish between a routine nurse appointment taking 10mins and a GP long term condition health check which would take 20 minutes.

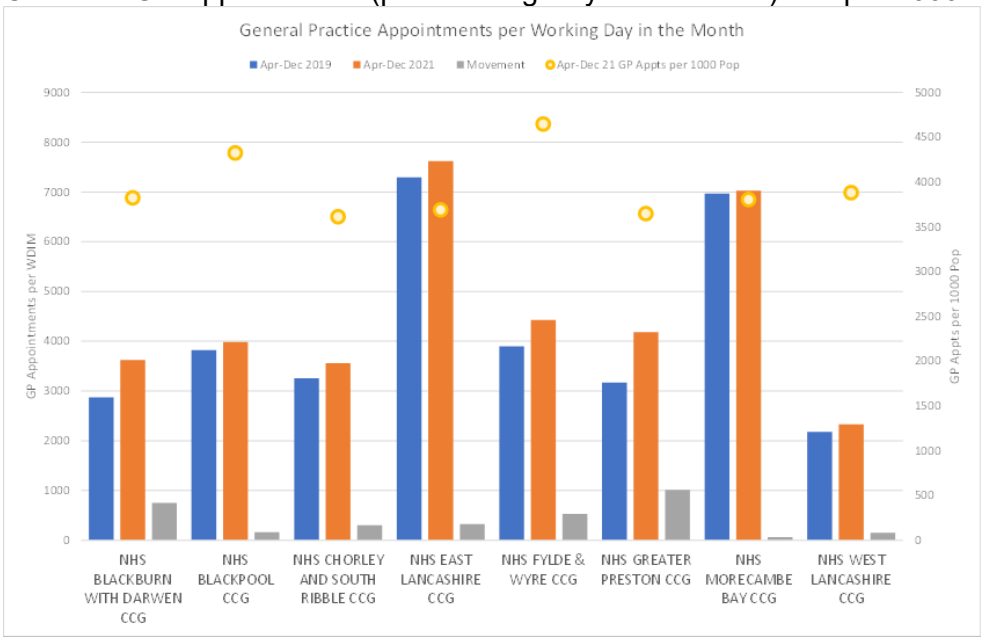
6.1.3. The Primary Care Transformation programme has a number of projects currently running to understand in more detail general practice demand, capacity and activity and the pressures currently facing them. This output of these pieces of work will be used to support contractors and inform future system transformation work, involving other provider partners.

6.1.4. [Note : The GP appointment systems from which this data is taken are not primarily designed for data analysis purposes.]

6.1.5. Chart 1 – GP Appointment trends and 2021 H1 / H2 plan (adjusted for Working Days in the Month [WDIM])



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

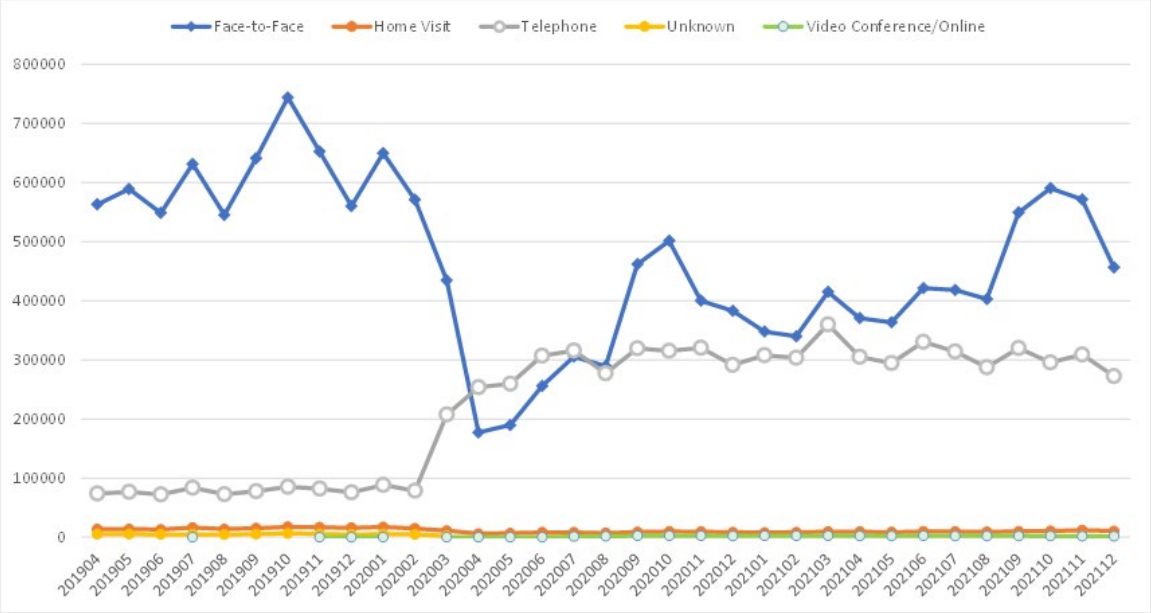


6.1.7. The proportions of appointment 'type' changed during the pandemic with reductions in face-to-face appointments and increases in telephone and video appointments. However, face to face appointment numbers have steadily increased since April 2020 - May 2020, with the most significant increases seen from September 2021, while telephone appointments have been maintained therefore contributing to the overall increase in appointment numbers.

6.1.8. The number and proportion of video appointment numbers undertaken are low. However, there is a known coding issue with this appointment type and therefore the data for video appointments does not fully reflect the true numbers undertaken.

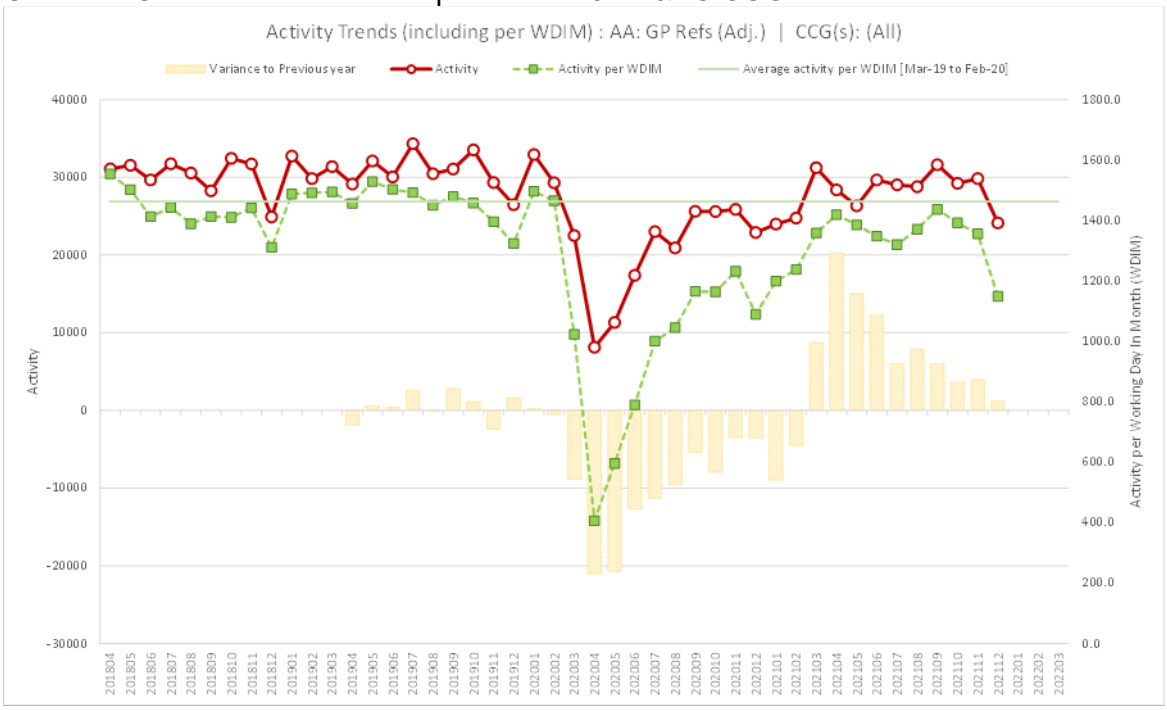
Period	Face-to-Face	Home Visit	Telephone	Unknown	Video Online	TOTAL
Apr-Dec 2019	5,472,961	136,624	700,942	46,397	5	**6,356,929**
Apr-Dec 2021	4,143,427	89,134	2,728,262	0	18,641	**6,979,464**
Variance	-1,329,534	-47,490	2,027,320	-46,397	18,636	**622,535**
% Total Activity	**Face-to-Face**	**Home Visit**	**Telephone**	**Unknown**	**Video Online**	**TOTAL**
Apr-Dec 2019	86.1%	2.1%	11.0%	0.7%	0.0%	**100.0%**
Apr-Dec 2021	59.4%	1.3%	39.1%	0.0%	0.3%	**100.0%**

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



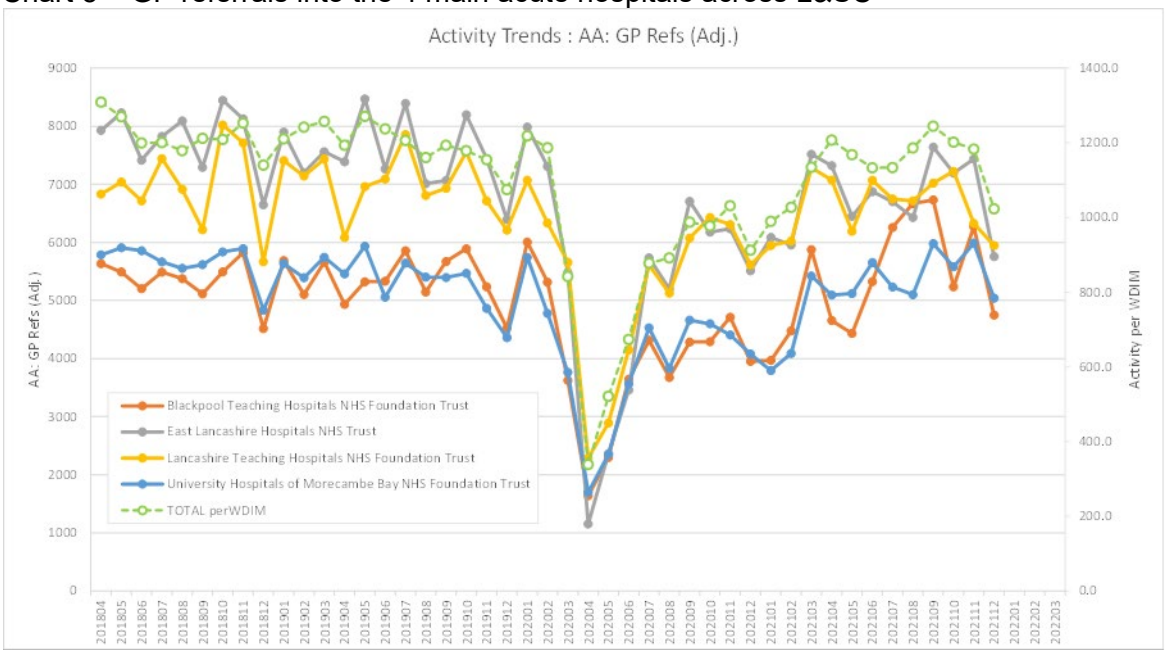
6.1.10. Chart 4 below shows the trend over time of the totality of GP referrals received by all providers across all 8 x L&SC CCGs. This shows that although GP referrals per working day in the month have been recovering, they are not yet back to historic levels. This would suggest that the 'catch up' of expected referrals has not yet been realised and there is potentially a backlog. Further work will be required to explore this to try to understand whether some of the changes seen are due to patient choice, patient demand, GP referral patterns or other reasons.

6.1.11. Chart 4 – GP referral trends – all providers – 8 x L&SC CCGs



6.1.12. Chart 5 below shows GP referrals to the four main ICS acute hospitals. GP referrals have continued to recover back towards historic levels with the April 2021 - December 2021 activity across the 4 x L&SC providers (adjusted for working days in the month [WDIM]) was 98.2% of the GP referral activity in April 2019 - December 2019.

6.1.13. Chart 5 – GP referrals into the 4 main acute hospitals across L&SC

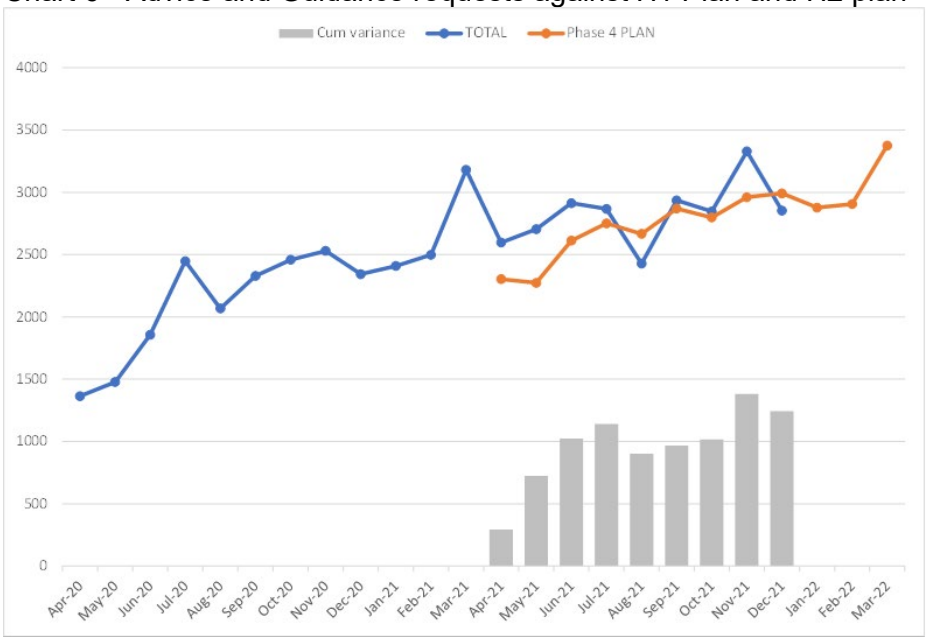


6.1.14. One approach being utilised across L&SC to support management of demand into the acute system has been the implementation of Advice and Guidance (based on the Morecambe Bay system [Except West Lancs which uses Consultant Connect]). The use of this system has been steadily increasing, and it is expected that this will continue [Chart 5]. The H2 planning submission target required that "A minimum of 12 A&G requests should be delivered per 100 outpatient first attendances or equivalent via other triage approaches by March 2022".

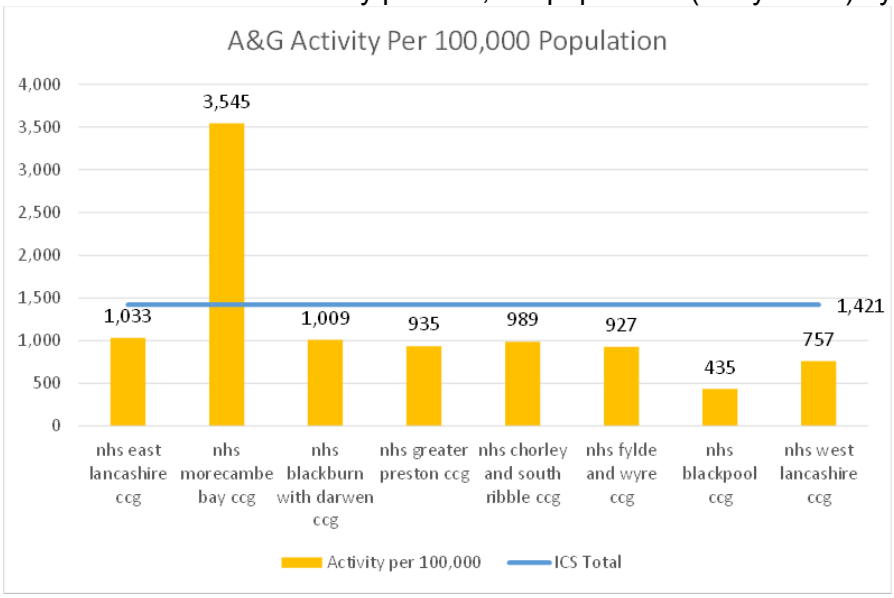
Current performance for 'specialist advice' reported via the ECRG is currently at 18.2% for the system in December 2021. However, in addition to the advice and guidance data this total now also includes the Morecambe Bay Clinical Referral Assessment Service as part of reporting the overall 'specialist advice' element. Further work is underway via the ECRG to refine the RAS reporting from all providers and to separate administrative vs clinical assessment and the associated outcomes.

6.1.15. Figures presented to the L&SC Advice and Guidance working group indicate that across the 8 x L&SC CCGs in December 2021, around 91.3% of all A&G activity is through the UHMB system, with around 6.8% via the ERS system and the small remainder via 'Consultant Connect' in WL CCG. The volume of advice and guidance requests (across all 3 of these systems) has been above the H1 and H2 plans across the year to date. MB 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.

6.1.16. Chart 6 - Advice and Guidance requests against H1 Plan and H2 plan



6.1.17. Chart 7 - Actual A&G activity per 100,000 population (all systems) by CCG [Apr – Dec 2021]



6.1.18. 87.9% of all Advice and Guidance requests in April 2021 - December 21 through the UHMB system were responded to within 2 days while initial referrals to outpatients were effectively halved (Table 1)

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

Treatment Plan (Apr-Dec)	BEFORE	AFTER A&G	MOVEMENT	% SHIFT
Admit	2713	2524	-189	-7.0%
Carry out further investigations	1180	2229	1049	88.9%
Forced Closure		875	875	
Manage patient's care myself	1372	6722	5350	389.9%
Other	1502	2144	642	42.7%
Radiology test sanctioned by radiologist		855	855	
Refer to outpatients	9932	5025	-4907	-49.4%
Seek advice from another source	3538	738	-2800	-79.1%
(blank)	2786	1911	-875	-31.4%
TOTAL	**23023**	**23023**	**0**	**0.0%**

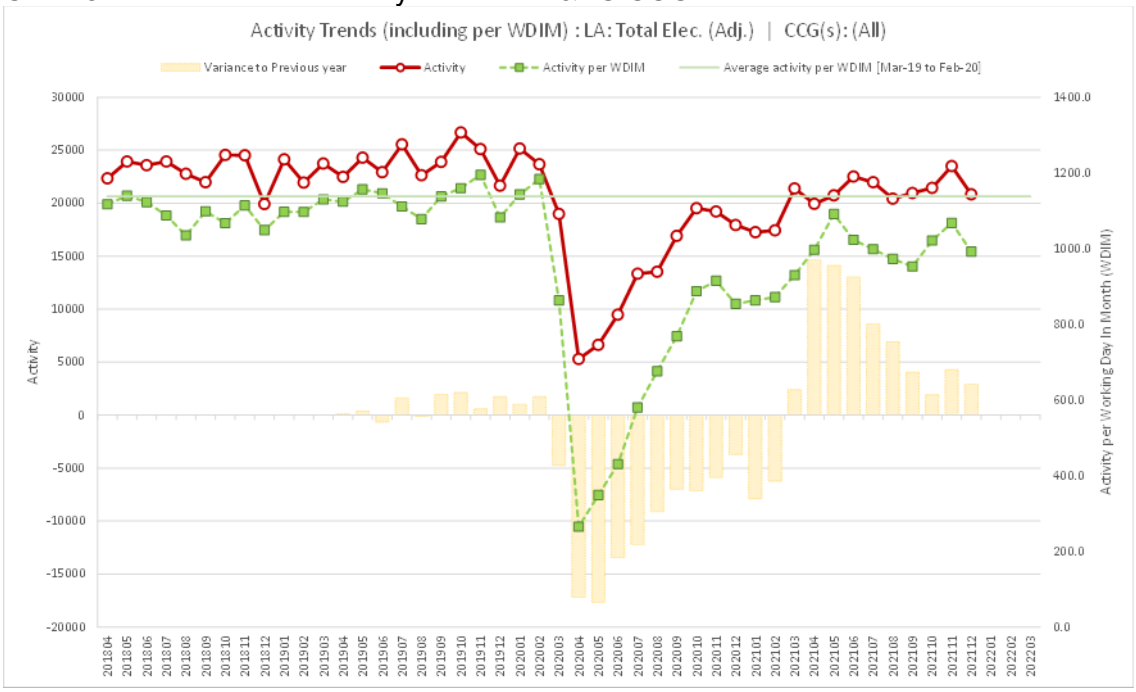
6.1.20. Radiology, Dermatology, Cardiology and Clinical Haematology are the 4 specialties that receive the greatest number of Advice and Guidance requests (34.2% of all A&G requests in April – December 2021). Work is ongoing to track the changes in demand by speciality and population group to ensure 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

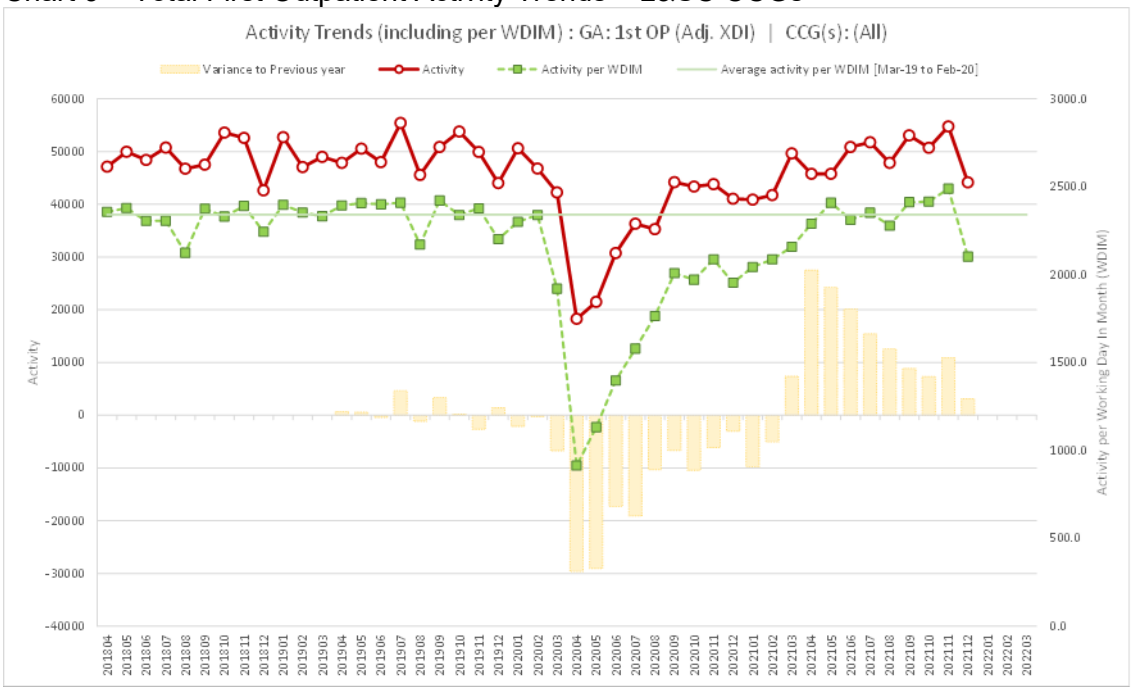
6.2.1. Activity trends based on the national dataset for CCGs (across all providers) indicates that recovery is not yet back to 2019-20 levels for the totality of electives activity while Outpatient activity recovery (first and follow-up) declined this month. It is of note that December 2021 saw the rapid rise in Omicron cases with an associated increase in staff absence and increases in non-elective admissions or COVID +ve patients.

Activity Type	Dec 2019 (Activity per WDIM)	Dec 2021 (Activity per WDIM)	Dec 21 Indicative Recovery %
Total Elective (EL+DC)	1082.3	992.1	91.67%
First Outpatients	2201.4	2102.7	95.51%
Follow-Up Outpatients	4382.6	4213.0	96.13%

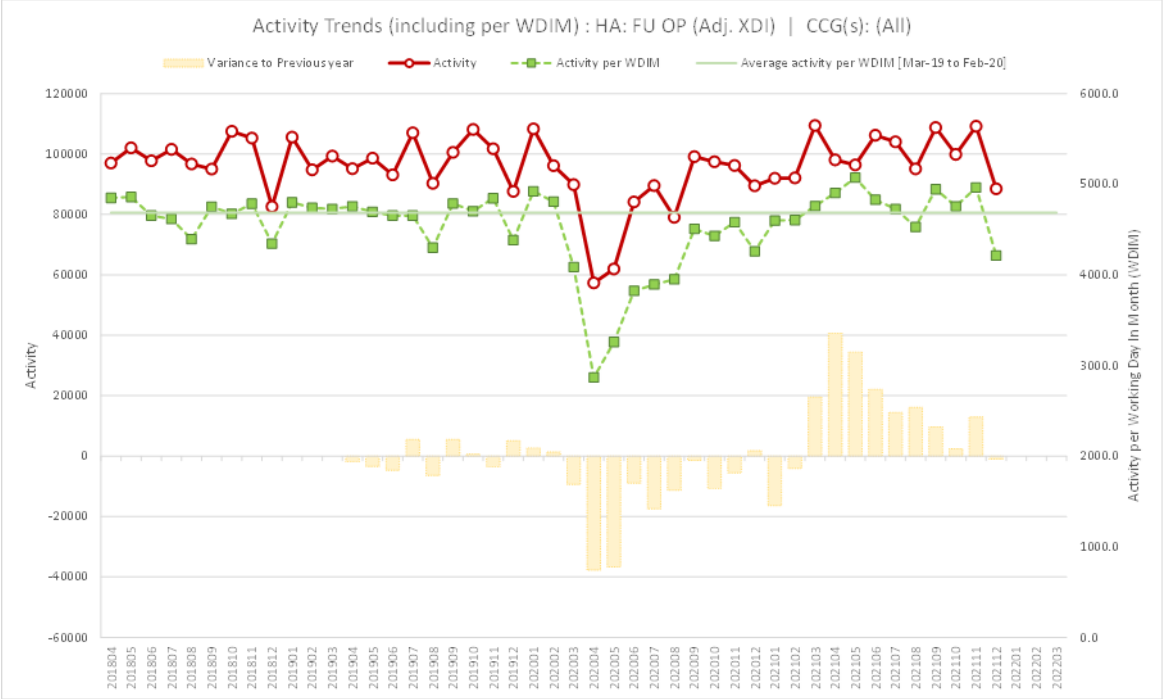
6.2.2. Chart 8 – Total Elective Activity Trends – L&SC CCGs



6.2.3. Chart 9 – Total First Outpatient Activity Trends – L&SC CCGs



6.2.4. Chart 10 – Total Follow-Up Outpatient Activity Trends – L&SC CCGs



6.2.5. Weekly Activity Return information has been reviewed across the North West, and for the week to 30th January 2022, the total elective recovery position (elective ordinary and daycases) was strongest in L&SC for this week. There is variation at provider level underneath this L&SC position. It is worth noting that this single week will reflect a position in acute providers where staffing will have been particularly pressured.

6.2.6. Recovery – Elective activity and daycases (w/e 30th January 2022) – ICS Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
North West	22,753	18,941	3,812	83.2 %
C&M	8,365	7,114	1,251	85 %
GM	9,380	7,401	1,979	78.9 %
L&SC	5,008	4,426	582	88.4 %

6.2.7. Recovery – Elective activity and day cases (w/e 30th January 2022) – Provider Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
L&SC	5,008	4,426	582	88.4 %
Blackpool Teaching	1,191	1,036	155	87 %
East Lancashire	1,386	1,269	117	91.6 %
Lancashire Teaching	1,374	1,255	119	91.3 %
Morecambe Bay	1,057	866	191	81.9 %

6.2.8. In terms of outpatient first activity L&SC is continuing to report the greatest level of recovery for first attendances in the North West.

6.2.9. Recovery – Outpatient (First) (w/e 30th January 2022) – ICS Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
North West	56,309	51,441	4,868	91.4 %
C&M	22,464	19,679	2,785	87.6 %
GM	23,504	21,833	1,671	92.9 %
L&SC	10,341	9,929	412	96 %

6.2.10. Recovery – Outpatient (Follow-up) (w/e 30th January 2022) – ICS Level

Name	Historic Weekly Activity	Current Weekly Activity (raw values)	Variance	% activity restored (raw values)
North West	134,178	133,937	241	99.8 %
C&M	54,843	54,467	376	99.3 %
GM	56,321	57,861	-1,540	102.7 %
L&SC	23,014	21,609	1,405	93.9 %

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

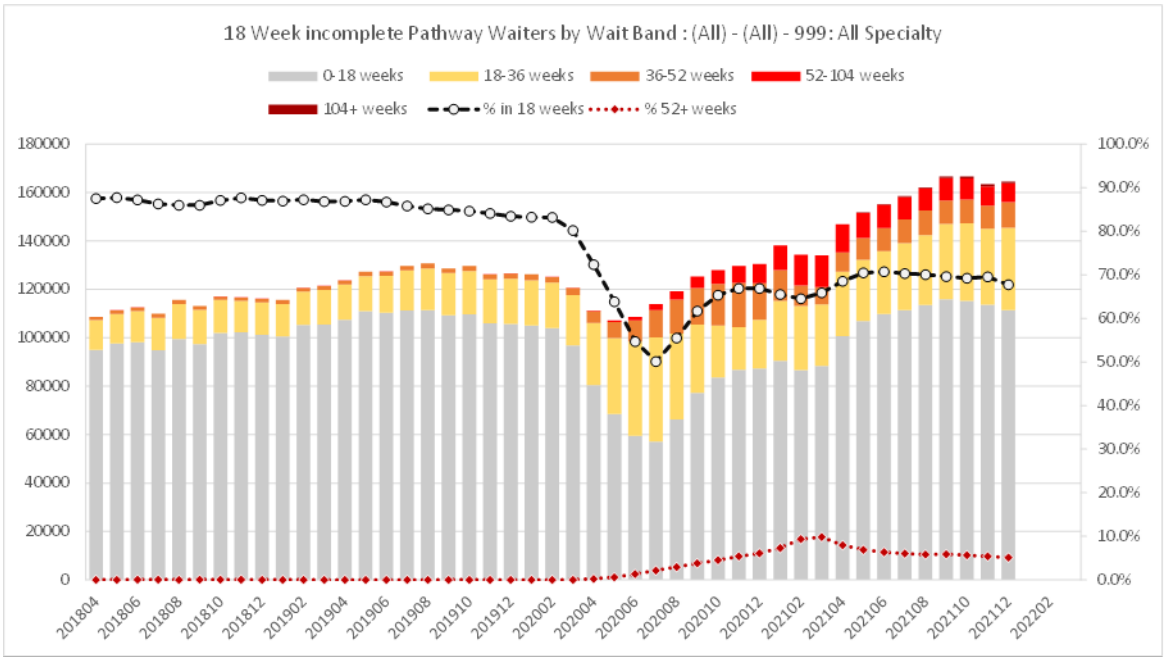
6.3.1. There are 3 key measures associated with referral to treatment times:

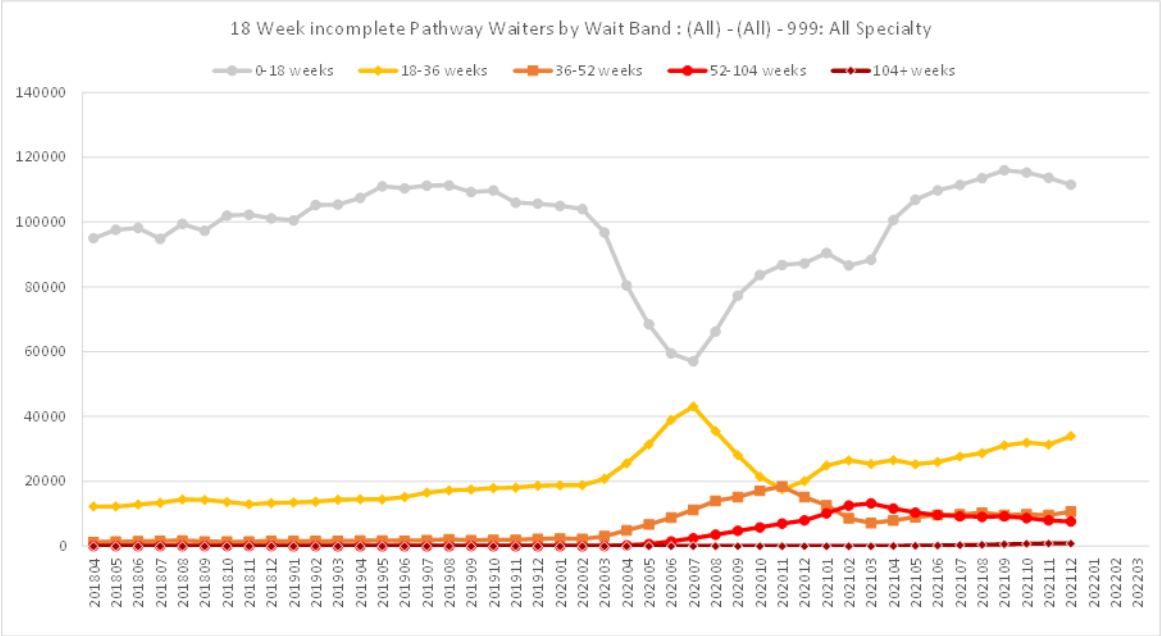
- The number of patients waiting to start treatment (incomplete pathways)
- The % of patients currently waiting up to 18 weeks to start treatment (Target 92%)
- The number and % of patients currently waiting 52+ weeks to start treatment (Target 0%)

6.3.2. The chart below shows the ICS performance (aggregated for the 8 x CCGs) against these 3 measures. Prior to the COVID pandemic, the total number of patients waiting to start treatment had stabilised and was showing signs that it was starting to reduce. In February 2020 the total number of patients waiting to start treatment was 125,065 and although the 18-week standard was not being met (83.2%), there were only 5 patients waiting over 52-week (<0.01%). As of December 2021:

- The total number of patients waiting to start treatment is now 164,614 [an increase of 1,184 from last month]
- Performance against the 18-week standard was 67.7%
- There were 8,466 over 52-week waiters (5.1%) [a reduction of 372 patients from last month]
- 854 patients had been waiting in excess of 104 weeks [a reduction of 9 from last month]

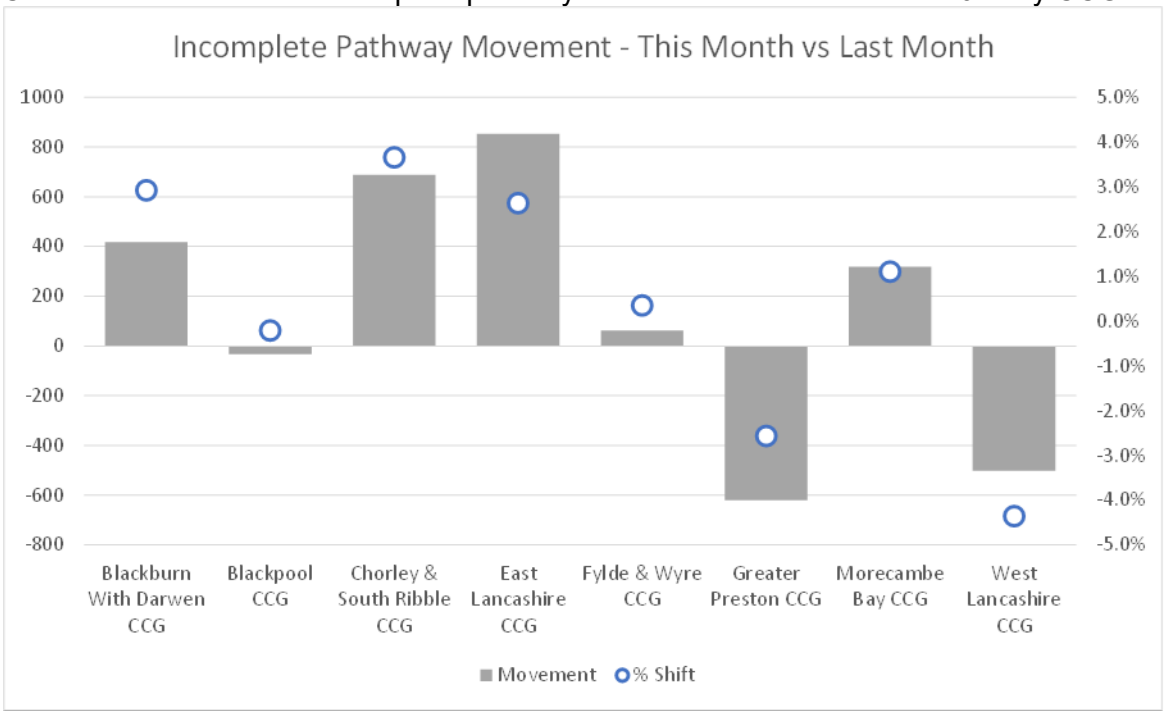
6.3.3. Chart 11 - 18 week Incomplete Pathway Waiters – L&SC





6.3.4. There is variation in the waiting list movements between CCGs which will link directly to the providers and specialties within which their patients are waiting. GP CCG has seen the greatest reported reduction in waiters this month, followed by WL CCG. 4 x CCGs have seen increases in waiting lists of over 300 patients.

6.3.5. Chart 12 - Movement in incomplete pathway waiters between Nov - Dec 2021 by CCG



6.3.6. Appendix 3 highlights the incomplete pathway movement since April 2021 for the top 20 providers (based on waiting list sizes). Independent Sector providers are reporting decreases in their waiting lists while many NHS provider lists appear to be increasing.

6.3.7. Specific providers to note:

- Euxton Hall has seen significant month on month reductions in patients waiting from June 2021 onwards. Some of these reductions will be due to the opening of the Buckshaw Hospital site which has picked up some of the Euxton Hall waiting list activity. There has also been a review and cleansing of waiting lists during this period. No data is currently being reported for Buckshaw Hospital within the 18 week dataset.
- The step change reduction in waiters reported by Spire Fylde Coast between July 2021 and August 2021 related to both a validation of their waiting list which identified a number of patients who had already had their treatment, together with long waiter Ophthalmology Cataract patients being transferred to alternative providers, specifically Community Health Eye Care. No data is currently being reported for CHEC within the 18 week dataset.
- North Cumbria Integrated Care NHS Foundation Trust reported a significant drop in waiters in November 2021 which continued through into December 2021. This has been confirmed as a data submission issue by the provider which should be resolved for the January 2022 data. For reference, in the national data only 79 waiters were reported for L&SC CCGs when there were actually 892 patients waiting. Hence there are an additional 813 waiters currently unreported in the December 2021 statistics.

6.3.8. The slow decrease in the number of over 52 week waiters has continued in December 2021 although the 104+ week waiter numbers have seen little movement. The number of 0-18 week waiters has reduced for the third consecutive month.

6.3.9. Within the December 2021 return, 854 patients across L&SC had been waiting in excess of 104 weeks. Over half of these 104+ week waiters are reported to be waiting at LTHT, with a further 23.8% at UHMB. 5 x specialties account for over two-thirds of these long waiters:

6.3.10. Trauma and Orthopaedics, ENT, Plastic Surgery, General Surgery and 'all other treatment functions in the surgical group'.

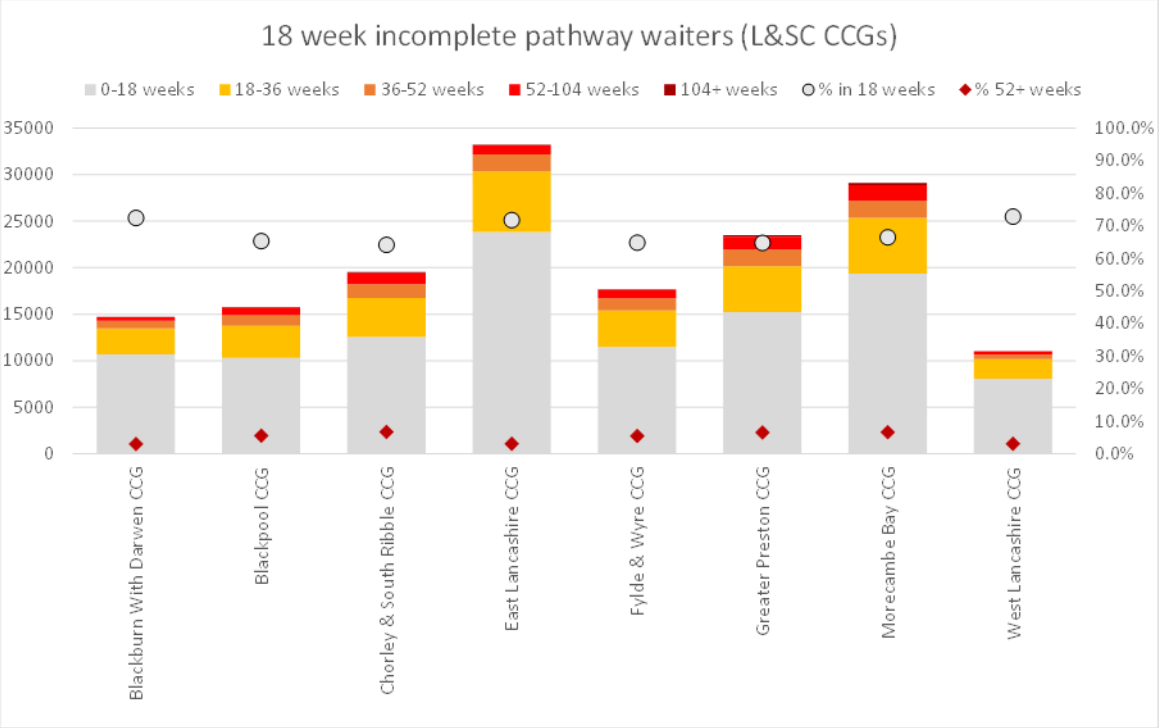
6.3.11. Table – 104+ week waiters by provider and specialty (December 2021)

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	2	59	11	2	5	0	3	82	9.6%
101: UROLOGY	31	10	2	1	2	1	2	49	5.7%
110: TRAUMA & ORTHOPAEDICS	27	87	4	14	0	9	18	159	18.6%
120: ENT	84	12	13	2	1	4	2	118	13.8%
130: OPHTHALMOLOGY	35	12	3	0	1	0	2	53	6.2%
160: PLASTIC SURGERY	84	0	0	0	0	0	1	85	10.0%
300: GENERAL MEDICINE	39	0	0	0	0	0	0	39	4.6%
301: GASTROENTEROLOGY	1	0	1	0	0	0	0	2	0.2%
400: NEUROLOGY	49	0	0	0	0	0	0	49	5.7%
502: GYNAECOLOGY	10	2	19	1	0	0	3	35	4.1%
X05: All other TREATMENT FUNCTIONS in the Surgical group no	114	8	5	0	7	1	7	142	16.6%
X04: All other TREATMENT FUNCTIONS in the Paediatric group	0	3	15	0	0	0	0	18	2.1%
X02: All other TREATMENT FUNCTIONS in the Medical Services	11	9	0	0	0	0	1	21	2.5%
Grand Total	**487**	**203**	**73**	**20**	**17**	**15**	**39**	**854**	**100.0%**
% TOTAL	57.0%	23.8%	8.5%	2.3%	2.0%	1.8%	4.6%	**100.0%**	

6.3.12. 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 December 2021 by CCG. Central Lancashire ICP CCGs and MB CCG all have over 6.5% of their waiters who have been waiting in excess of 52 weeks for treatment.

6.3.13. Table - Waiting list variation between CCGs (December 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	10671	2817	795	411	36	14730	72.4%	3.0%
Blackpool CCG	10318	3422	1165	811	65	15781	65.4%	5.6%
Chorley & South Ribble CCG	12550	4212	1458	1186	130	19536	64.2%	6.7%
East Lancashire CCG	23842	6521	1826	957	69	33215	71.8%	3.1%
Fylde & Wyre CCG	11476	3938	1300	888	82	17684	64.9%	5.5%
Greater Preston CCG	15228	4929	1804	1384	171	23516	64.8%	6.6%
Morecambe Bay CCG	19366	6005	1820	1652	282	29125	66.5%	6.6%
West Lancashire CCG	8039	2122	524	323	19	11027	72.9%	3.1%
Grand Total	**111490**	**33966**	**10692**	**7612**	**854**	**164614**	**67.7%**	**5.1%**



6.3.14. 81.6% of all over 52-week waiters for the CCGs are at the four main providers in the ICS, with 51.2% at LTHT (See Appendix 1).

6.3.15. 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 (1,886) with 91.4% 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 ICBs to "be able to take on delegated responsibility for dental (primary, secondary and community)" from April 2022 and have "taken on delegated responsibility for dental (primary, secondary and community) " by April 2023. [PAR817-NHS-England-and-NHS-Improvements-direct-commissioning-functions.pdf]

6.4. All CCGs continue to work with their provider colleagues in seeking assurance that national guidance is being followed in respect of Clinical Harm Reviews for patients waiting in excess of 52 and 104 weeks. Specific focus is being paid to a system wide position across L&SC.

6.5. Improvement work is commencing at BTHT to improve timely communications to patients and primary care in respect of long waits.

6.6. The Dermatology service at LTHT continues to be formally reported as a vulnerable service due to workforce capacity and the impact this will have on the pathway including 2 week waits. Mitigating actions are underway including the development of a teledermatology service for a 12 month period. In addition, Greater Preston CCG have been notified of a

reduced outpatient capacity in Gastroenterology in LTHT which is resulting in long waits for patients (routine and urgent appointments); action has been taken to support the service.

6.7. In December 2021 ELHT reported 3 patients waiting >104week (1 x Oral Surgery, 1 x Urology and 1 x T&O) which is an improved position from November 2021. No harm has been reported as a result of the delays.

6.8. Recommendation:

6.8.1. Elective Care Recovery Group to work with NHSE regarding actions to be taken to support providers in reducing the long waiters in advance of the delegation of responsibility to the ICB.

6.9. Learning Disability – Annual Health Check (14+)

6.9.1. Many people with a Learning Disability experience poorer health and die at a younger age. The Annual Health Check scheme is designed to encourage practices to identify all patients aged 14 and over with learning disabilities and offer them an annual health check. This is a priority measure within the System Oversight Framework (SOF), CORE20PLUS5 approach, and is within the PCN Network Plan for 2021/22 and 2022/23.

6.9.2. The NHSE&I letter to general practice dated 27th January 2022, Next steps for general practice following the accelerated COVID-19 vaccination booster campaign, detailed the current priorities for general practice now that there is lower demand for boosters. It details three key priority areas; ongoing delivery of the COVID-19 vaccination programme, management of symptomatic COVID-19 patients in the community and continued delivery of general practice services. The latter of which includes annual health checks for vulnerable patients, tackling the backlog of deferred care events and asks practices to take a clinical prioritisation approach for all of their workload, looking to minimise any health inequalities.

6.9.3. The latest Learning Disability AHC figures (December 2021) for each of the CCGs in L&SC together with the North West and National position are shown below. This reports that in the 9 month period from April to December 2021, 37.46% of patients (14+) recorded on GP practice registers with a Learning Disability have had an AHC. This is lower than both the North West (39.7%) and England (41%) position at this point in time.

6.9.4. Learning Disability Annual Health Checks (14+) [December 21]

Code	CCG	Patients Aged 14+ on LD register	Patients 14+ with AHC and HAP	Patients 14+ with AHC and declined HAP	Patients 14+ with AHC and NO HAP	% 14+ with AHC	% 14+ with AHC and HAP
00Q	NHS BLACKBURN WITH DARWEN CCG	858	304	0	26	38.46%	35.43%
00R	NHS BLACKPOOL CCG	874	311	4	32	39.70%	35.58%
00X	NHS CHORLEY AND SOUTH RIBBLE CCG	1126	414	4	56	42.10%	36.77%
01A	NHS EAST LANCASHIRE CCG	1963	431	1	131	28.68%	21.96%
02M	NHS FYLDE AND WYRE CCG	711	211	0	38	35.02%	29.68%
01E	NHS GREATER PRESTON CCG	1122	456	3	44	44.83%	40.64%
01K	NHS MORECAMBE BAY CCG	1770	641	1	99	41.86%	36.21%
02G	NHS WEST LANCASHIRE CCG	556	100	11	46	28.24%	17.99%
	Lancashire & South Cumbria ICB	**8980**	**2868**	**24**	**472**	**37.46%**	**31.94%**
	NORTH WEST	40014	12124	165	3598	39.70%	30.30%
	ENGLAND	297493	96780	1728	23476	41.00%	32.53%

6.9.5. However, the proportion of patients with an AHC who also have a Health Action Plan recorded is more in line with the North West and England average positions. 31.94% of LD patients have a HAP across L&SC (range 17.99% - 40.64%) compared with 30.3% across the North West and 32.53% nationally.

6.9.6. There is even greater variation across L&SC PCNs [Appendix 4] and Practices [Appendix 5] in the proportion of LD patients that receive an AHC and associated Health Action Plan. It should be noted that the data does not take into account the varying levels of deprivation

between the PCNs and other known factors which impact on the ability to engage and undertake health checks.

6.9.7. It should be noted that the data does not take into account the varying levels of deprivation between the PCNs and other known factors which impact on the ability to engage and undertake health checks.

6.10. Recommendation:

6.10.1. Primary Care Team in conjunction with Mental Health colleagues to explore ways to support the increased delivery of annual health checks to patients with Learning Disability and to advise as to actions and timescales for delivery.

6.10.2. As a result of the NHSE&I prioritisation letter, long term condition, mental health and learning disability health check data has been reviewed at a Primary Care Sub-Cell Meeting and cascaded to PBPs for further local discussion and review. It was agreed at the Winter Access Fund Oversight Group that unallocated funding slippage will be used by PBPs to support general practice to undertake additional health checks, including home visits, to target the backlog taking a prioritisation approach. In addition, the Primary Care Sub Cell with working with mental health, learning disability and autism colleagues to consider the best approach to health checks for this cohorts of patients going forward.

7. COVID-19 Nosocomial Infections

7.1. Introduction

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

7.2. Overview

7.2.1. The community prevalence of COVID-19 has shown a continued decline over the last few weeks.

7.2.2. On 9th February 2022, the overarching community prevalence for the North West was 464.2 per 100,000 population and represented a fall in the number of positive cases by nearly a third (32%) on the previous week (which was also down 22% on the week before). The current downward trend in community prevalence means that the figure for the North West is significantly below that of the average for England of 665.3 per 100,000 population.

7.2.3. The weekly case rate for 60+ years for the North West was 276.2 per 100,000 population, which was a decrease of 22% on the previous week (which was also down a more modest 7% on the week before). This is below the average for England of 355.2.2 per 100,000 population.

7.2.4. The number of COVID-19 positive inpatients across L&SC has fallen consistently since the last report. This stood at 236 patients, compared to 556 patients for week ending 16th January 2022, representing an on-month fall of 57.6%. The highest reductions in positive patients since 23rd January 2022 were seen at BTHT (82, -56.9%) and UHMB (55, -45.1%).

7.2.5. The number of COVID-19 nosocomial cases also fell significantly during this period, with cases falling by 84.2%, from 101 on 23rd January 2022 to 20 by 13th February 2022.

7.3. Outbreaks

7.3.1. On 15th February 2022, LTHT had 17 active outbreaks across the trust.

7.3.2. Post infection reviews highlighted delays in notification of first positive cases, concerns around staff not correctly adhering to PPE requirements and not washing their hands in between patients, areas cluttered, equipment not decontaminated properly and poor ventilation in smaller staff rooms. Actions included deep cleans undertaken, full patient and staff screening, a review of staff rooms and ventilation, additional air purifiers, focussed IPC training and ongoing IPC audits until practice improves and targeted communications to reinforce the importance of good IPC practice.

7.3.3. UHMB had 19 wards in outbreak. The majority of the patients affected have tended to be hospital-onset indeterminate associated (onset within day 3-7 of admission). Similarly, to the care settings, the majority of the positive cases, both staff and patients, have been picked up on routine testing. They continue to be predominately asymptomatic, or with mild, cold-like symptoms; and a high percentage are fully vaccinated, including the booster.

7.3.4. The Trust continue to complete risk assessments on all 'service critical' staff to ensure that they return to work in a safe and timely manner, which has had a positive impact on staff levels. All visiting at the Trust was stopped in the week before Christmas, face to face appointments have been reduced and staff have been encouraged to work from home if able to reduce transmission.

7.3.5. ELHT had 13 active outbreaks across the Trust, all of which involved staff and patients. The Infection Prevention Control Team conduct audits and post infection reviews to identify any learning and the need for remedial action. Learning continues to highlight the need for prompt screening and where possible, prompt isolation of identified cases. Audit findings are fed back to ward managers and matrons and Divisional Directors of Nursing are informed to oversee the completion of necessary actions.

7.3.6. As at 15th February 2002 there were 3 outbreaks across BTHT; this is an improvement from 10 outbreaks in the previous month. Investigations continue however the most common cause remains exposure to other positive patients or staff. Opportunities to screen patients have been missed and this has been raised with the relevant Divisions and compliance is being monitored through the Silver Command meeting.

7.4. Regulated Care

7.4.1. At 18th January 2022, the number of care homes in outbreak and in incidents were:

ICP	Care homes in outbreak	Care homes in incident
Morecambe Bay	8	5
Fylde Coast	13	3
Pennine	22	5
Central Lancashire	31	9
West Lancashire	6	2

Source: LCC

7.5. General Trends & Themes

7.5.1. Although the number of outbreaks across the care home settings remains high, this has decreased substantially since last month's report. There are currently a total of 80 care homes (19%) in outbreak and a further 24 (6%) in incident.

7.5.2. There is currently a mixture of both staff and residents affected, with a small number of larger homes experiencing significant outbreaks for staff and / or patients, following a cumulation of cases over a number of weeks, which incrementally extended their outbreak period. However, the majority of cases have remained either asymptomatic or have experienced mild cold-like symptoms. In addition, most cases were reported as having been fully vaccinated (including the booster) and were identified through routine testing. A small number of patients have required admission to hospital, but this has tended to be for other reasons than Covid.

7.5.3. Recent changes in government guidance reducing the isolation period for staff has improved staff availability for work and the additional reduction in the outbreak period from 28 days to 14 days has also had a positive effect on system flow.

7.5.4. Care homes with mental health or learning disability residents tend to have higher proportion of unvaccinated patients and are being supported by Safeguarding teams.

7.5.5. The recent Omicron surge has led to high staff sickness and absences due to staff isolating and although homes have generally managed well, partly due to previous experience of COVID-19 outbreaks, but also due to the fact that affected patients were on the whole only mildly ill, some have struggled and required additional CCG and strategic commissioner support.

7.5.6. Recently, Local Authority IPC teams have been challenged in being able to visit all homes of concern due to the number of ongoing outbreaks and incidents and team capacity.

7.5.7. The data around the COVID-19 booster uptake for care homes staff remains a concern. Work is continuing locally and nationally to address this including access to reliable information and data on vaccine through messaging and education. This has been escalated via the Testing Cell.

7.5.8. The availability of testing kits has improved and has been assisted by mutual aid.

7.6. Updated guidance

- An update on conditions surrounding self-isolation was issued on 3 February, providing certain conditions are met people testing positive may only need to isolate for 5 days and people in close contact with positive individuals may not need to isolate at all: https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-and-treatment/how-long-to-self-isolate/
- VCOD: On 31 January 2022 Secretary of State announced that the Government intends to revoke the regulations requiring vaccination as a condition of deployment for healthcare workers from 1 April 2022:
  https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1584-update-letter-vcod-for-all-healthcare-workers.pdf.
  As a result, the 'VCOD for healthcare workers: Phase 1 – Planning and preparation' and Phase 2: VCOD Implementation guidance has been paused, pending outcome of the Parliamentary consultation process. FAQs were subsequently issued to support this:
  https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/02/C1584-vcod-for-healthcare-workers-faqs.pdf

8. Individual Patient Activity and Continuing Healthcare

8.1. Introduction

8.1.1. The ICS IPA Activity section is a month end activity snapshot on 31st January 2022 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 through 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 is only partly included in the majority of this report, it is being received (8 months data currently received) but cannot currently be compared against 2019/20 data. Trends/themes highlighted in this report 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 100%. The number received month on month is remaining consistent which indicates that the increase against 2020 figures is now normally and should be used when calculating staff resource.

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 32%. As per D2As the number received month on month from July 2021 is fairly consistent and should now be seen as the demand on the system.

8.2.3. Incomplete Referrals (ICRs) – there are 86 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. 225 cases have decrease from the end of June 2021. An additional 5 staff were retained from the 'recovery project' to support the service whilst recruitment was undertaken for the new ICS funded posts (the majority of these staff have now left the service and the newly recruited staff are nearly fully trained). This reduction highlights the improvement in performance due to the increase in staff.

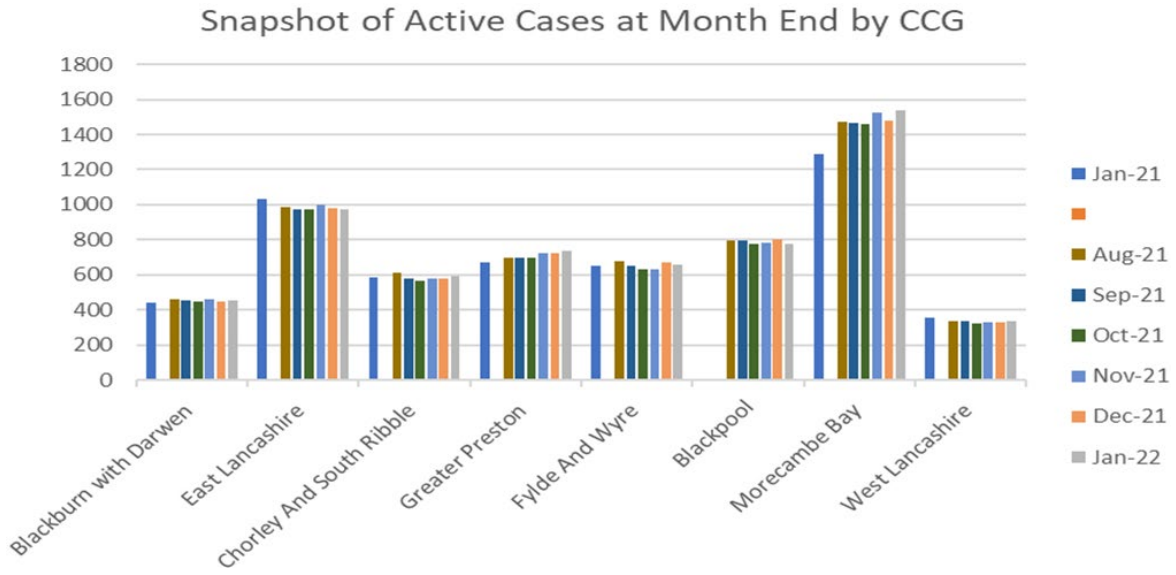
8.2.4. Quality Premium (QP) - Four of the eight CCGs met the QP target of completing over 80% of eligibility decisions within 28 days of the referral being made, in December 2021. A trajectory has been submitted to NHSE/I in line with the ICR trajectory with a target of all CCGs meeting the QP by the end of Q4 2021/22. Even though the ICS average of 78% nearly meets the 80%, the high number of ICRs means there is a high risk that the trajectory to meet the 28 day QP by the end of Q4 will not be met.

8.2.5. All CCGs are meeting the QP 'Less than 15% of all NHS CHC assessments take place in Acute Hospital Setting', with the ICS as a whole reporting between 0-2% month on month.

8.2.6. Overdue Reviews (ODRs)- 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 and this project started in December 2021 with 230 reviews completed; detailed updates are given in the weekly activity report.

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

CCG	Jan-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	1 Month Movement		12 Month Movement	
Blackburn with Darwen	441	459	454	445	457	449	451	0.4%	2	2.3%	10
East Lancashire	1031	989	972	974	1002	978	975	-0.3%	-3	-5.4%	-56
Chorley And South Ribble	583	610	579	565	578	577	593	2.8%	16	1.7%	10
Greater Preston	668	697	695	700	726	720	739	2.6%	19	10.6%	71
Fylde And Wyre	654	679	650	631	634	668	660	-1.2%	-8	0.9%	6
Blackpool	n/a	798	796	778	779	803	774	-3.6%	-29	n/a	n/a
Morecambe Bay	1287	1471	1468	1457	1524	1482	1536	3.6%	54	19.3%	249
West Lancashire	355	338	333	319	326	330	335	1.5%	5	-5.6%	-20
ICS Total	5019	6041	5947	5869	6026	6007	6063	0.9%	56	20.8%	1044



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. Note: table differs from previous months as it now includes Blackpool data from June 2021 to December 2021, contributing significantly to the 12 month increase.

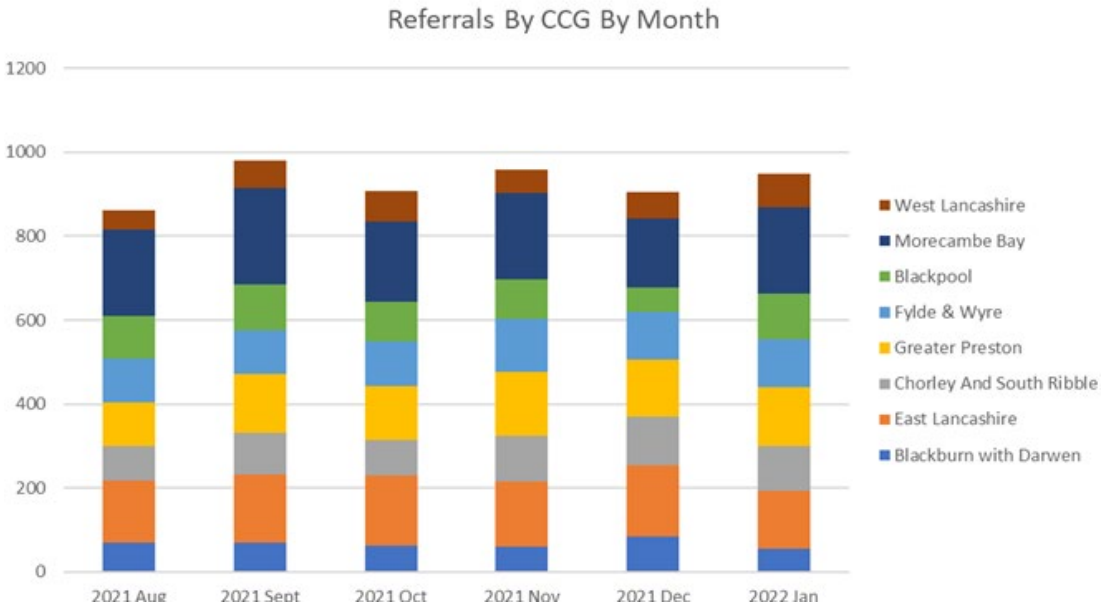
8.3.2. The number of packages has risen by 22 across the period reported. There is no consistent trend month on month either as an ICS or by individual CCGs. The 4.4% increase from October 2021 to November 2021 was the highest monthly increase of this financial year with the 2nd (0.9%) highest increase being between December 2021 and January 2022.

8.3.3. 5 CCGs reported an increase in January 2022 with Morecambe Bay (3.6%) and Greater Preston (2.8%) reporting the greatest increase. Greater Preston at 10.6% and Morecambe Bay at 19.3% are outliers in the 12 month totals increase.

8.4. Referrals Received

CCG	2021 Aug	2021 Sept	2021 Oct	2021 Nov	2021 Dec	2022 Jan		6 Month Average	2019-20 Monthly Average	Monthly Movement	
Blackburn with Darwen	70	71	62	61	84	56		67	54	-28	-33%
East Lancashire	147	162	168	155	169	138		157	146	-31	-18%
Chorley And South Ribble	82	99	84	108	117	105		99	89	-12	-10%
Greater Preston	104	141	130	153	136	142		134	111	6	4%
Fylde & Wyre	105	104	106	126	114	113		111	111	-1	-1%
Blackpool	101	107	94	93	57	108		93	n/a	51	89%
Morecambe Bay	206	232	190	207	165	207		201	171	42	25%
West Lancashire	46	65	73	56	64	79		64	54	15	23%
ICS Total	**861**	**981**	**907**	**959**	**906**	**948**		**927**	**734**	**42**	**5%**

Referral Type	2021 Aug	2021 Sept	2021 Oct	2021 Nov	2021 Dec	2022 Jan		6 Month Average	2019-20 Monthly Average	Monthly Movement	
Checklist	130	123	116	144	95	109		120	167	14	15%
Initial DST	74	97	111	129	97	113		104	36	16	16%
Fast Track	365	429	380	368	385	377		384	292	-8	-2%
D2A	96	105	108	88	78	90		94	47	12	15%
FNC Referral	3	8	7	9	16	9		9	28	-7	-44%
Non CHC	181	192	179	211	222	240		204	158	18	8%
CYP Checklist	12	27	6	6	12	6		12	0	-6	-50%
PUPOC				4	1	4		3	0	3	300 %
Total	**861**	**981**	**907**	**959**	**906**	**948**		**927**	**734**	**42**	**5%**



8.4.1. The average number of referrals over the last 6 months is currently around 26% higher than the 2019-20 average (increased from a 17% decrease in December 2021), with significant increases in Fast Track (32%), Discharge to Assess (100%), 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); the increase is evenly split across the 8 CCGs.

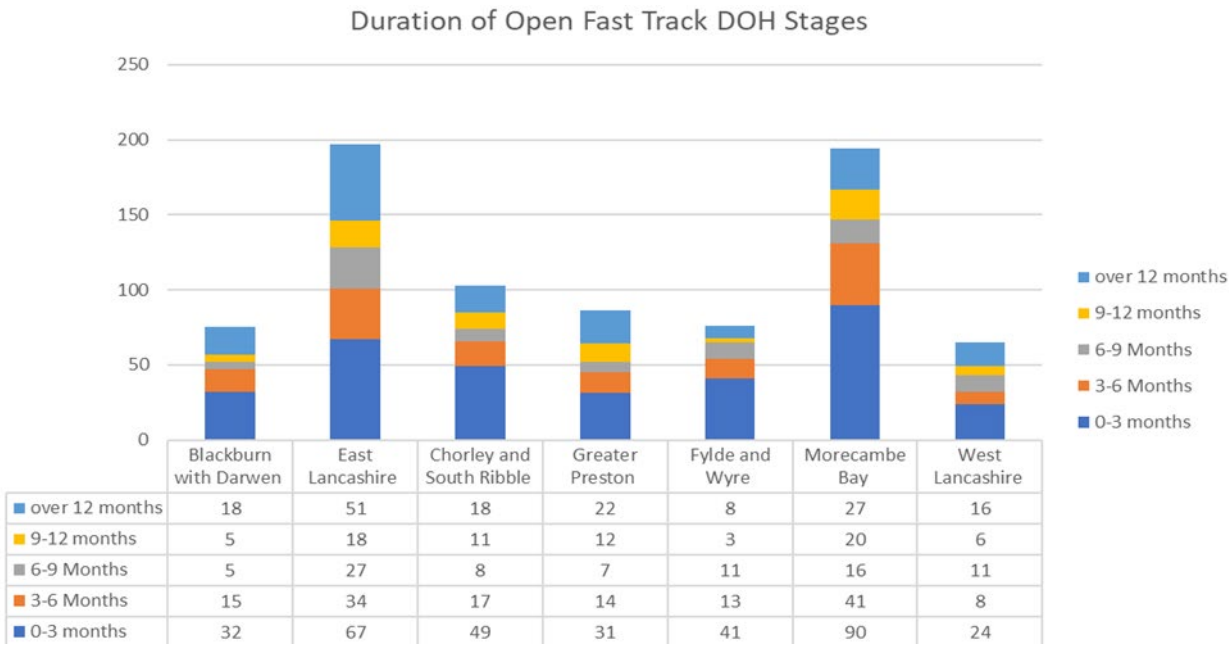
8.4.3. Month on month activity is up 4.6% with the main reason being the number of Checklist referrals which are up 14.7%. Overall, the January 2022 total is 2% higher than the 6 month average.

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

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

Month	Number of Referrals	Snapshot of Patients	% Fast Tracks Stage > 3 months
Aug-21	360	822	55%
Sep-21	429	735	52%
Oct-21	380	713	54%
Nov-21	368	802	55%
Dec-21	407	758	53%
Jan-22	327	730	58%

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	32	15	5	5	18	75	57%
East Lancashire	67	34	27	18	51	197	66%
Chorley and South Ribble	49	17	8	11	18	103	52%
Greater Preston	31	14	7	12	22	86	64%
Fylde and Wyre	41	13	11	3	8	76	46%
Morecambe Bay	90	41	16	20	27	194	54%
West Lancashire	24	8	11	6	16	65	63%
Grand Total	**334**	**142**	**85**	**75**	**160**	**796**	**58%**



8.5.1. Section 8.4.1 shows a 32% increase in the 6 month average of Fast Track referrals (384) compared to 2019-20 (292).

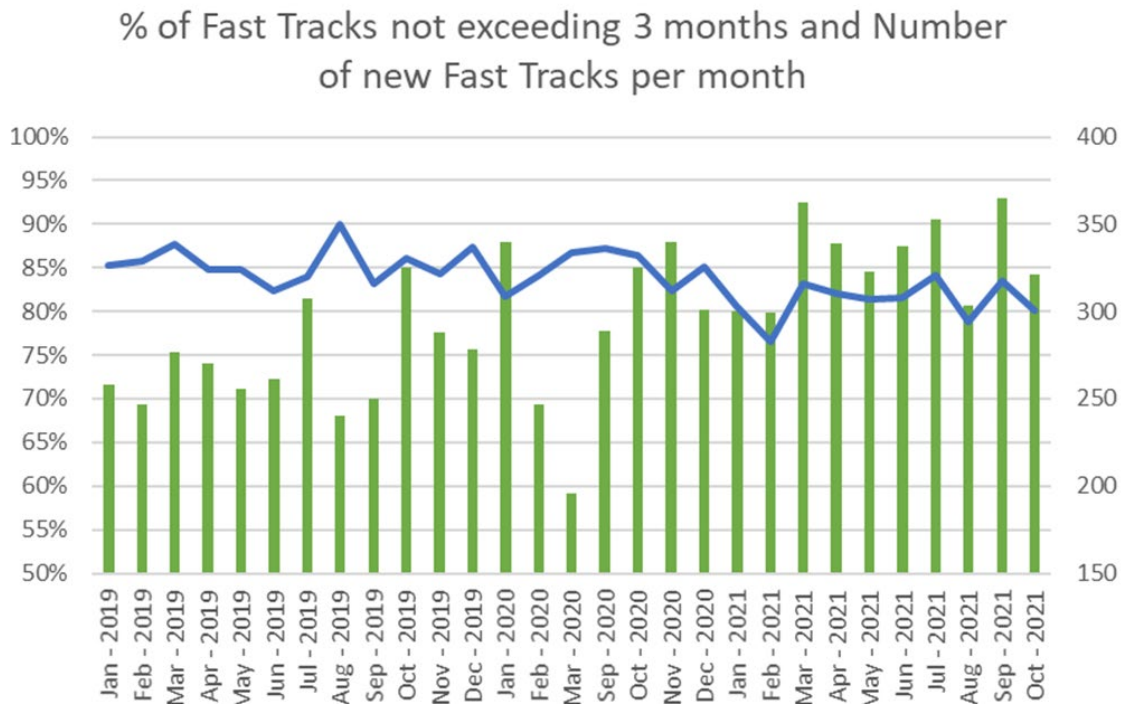
8.5.2. The percentage of Fast Track patients with a package > 3 months continues to remain high (58%); until the 3 month reviews are completed it is hard to determine if this is because the referrals should not have been Fast Track referrals. From a quality review of a sample of Fast Track referrals this does not appear to be the case as the Fast track referrals were appropriate at the time of submission.

8.5.3. EL CCG has the largest number of patients with a stage > 12 months (51 patients which is 26% of East Lancashire Fast Track packages).

8.5.4. A number of the Fast track Reviews are being undertaken by Community providers. These reviews ensure the patient has the correct care, they do not follow the MLCSU process where a 3 month review for Fast Tracks are followed by a DST with the patient then either dropping out of funding or having their package changed to a CHC or FNC package.

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	85%	6%	3%	2%	3%	258
Feb - 2019	86%	8%	2%	1%	4%	247
Mar - 2019	88%	6%	1%	1%	4%	277
Apr - 2019	85%	7%	4%	1%	3%	270
May - 2019	85%	3%	5%	3%	4%	256
Jun - 2019	82%	9%	2%	2%	5%	261
Jul - 2019	84%	7%	3%	2%	5%	307
Aug - 2019	90%	4%	1%	1%	4%	240
Sep - 2019	83%	8%	2%	0%	6%	250
Oct - 2019	86%	6%	2%	1%	4%	325
Nov - 2019	84%	7%	2%	3%	3%	288
Dec - 2019	87%	6%	1%	0%	5%	278
Jan - 2020	82%	7%	4%	2%	5%	340
Feb - 2020	84%	5%	2%	4%	4%	247
Mar - 2020	87%	6%	4%	1%	3%	196
Sep - 2020	87%	4%	3%	1%	4%	289
Oct - 2020	86%	6%	2%	2%	4%	325
Nov - 2020	82%	7%	3%	3%	5%	340
Dec - 2020	85%	5%	3%	2%	5%	301
Jan - 2021	81%	7%	4%	1%	8%	300
Feb - 2021	77%	11%	3%	9%	0%	299
Mar - 2021	83%	6%	2%	8%	0%	362
Apr - 2021	82%	8%	2%	8%	0%	339
May - 2021	81%	7%	10%	1%	0%	323
Jun - 2021	82%	9%	9%	0%	0%	337
Jul - 2021	84%	7%	9%	0%	0%	353
Aug - 2021	79%	19%	2%	0%	0%	303
Sep - 2021	84%	16%	0%	0%	0%	365
Oct - 2021	80%	20%	0%	0%	0%	321



8.6.1. The table and graph above, detail the number of Fast Tracks received each month from January 2019 – September 2021, breaking down how long the Fast Track package was/is open as a percentage of the total received each month.

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 (December 2021) includes a balance for late entered data for the previous 2 months, to allow consistency in line with Quarterly NHS submissions.

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Initial DST Assessments	161	152	132	134	119	102
Initial DST Assessments carried out in Acute Settings	1	1	0	3	4	2
Quality Premium %	1%	1%	0%	2%	3%	2%

8.7.2. In January 2022, a total of 102 DSTs were completed (Inc. Blackpool CCG). 2 of these were completed in 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 above shows this QP has now been met for each CCG for the last 6 months.

8.7.3. This QP has significantly increased from 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	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Blackburn with Darwen	23%	33%	0%	73%	80%	80%
East Lancashire	29%	25%	53%	65%	70%	82%
Chorley And South Ribble	36%	27%	62%	45%	89%	67%
Greater Preston	27%	53%	81%	79%	67%	93%
Fylde & Wyre	52%	50%	57%	62%	59%	71%
Blackpool	77%	83%	75%	68%	74%	75%
Morecambe Bay	65%	79%	61%	77%	65%	81%
West Lancashire	30%	75%	75%	67%	67%	60%
ICS Total	**40%**	**61%**	**65%**	**70%**	**70%**	**78%**

8.7.5. 4 of the 8 CCGs met the QP target of completing over 80% of eligibility decisions within 28 days of the referral being made, in January 2022.

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.

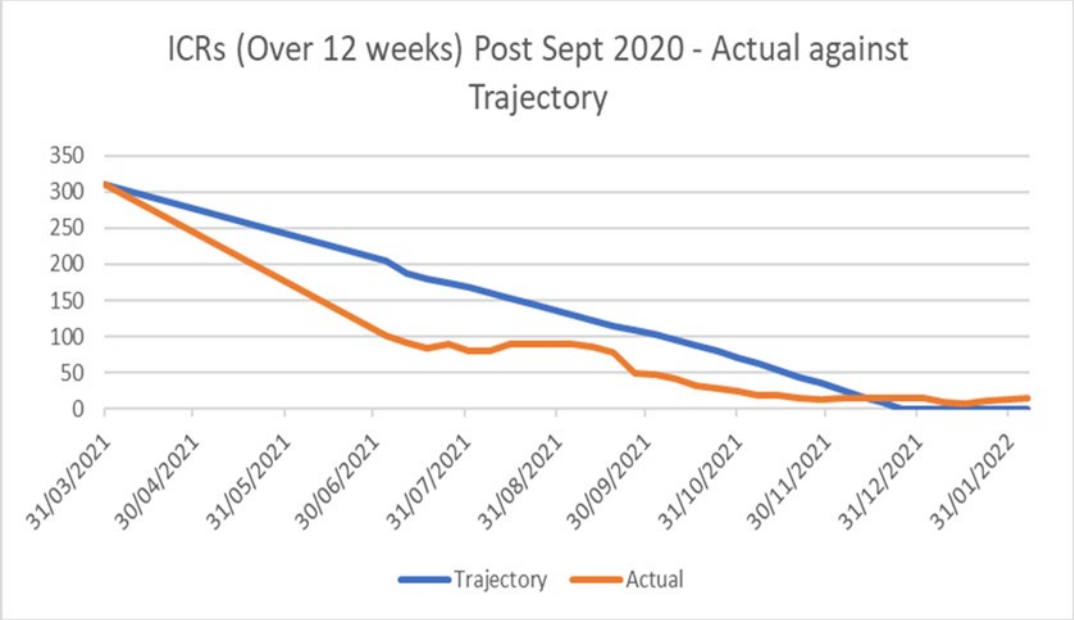
8.7.7. The numbers are however consistent with those reported in 2019/20.

	CCG	NHS Blackburn with Darwen CCG	NHS East Lancashire CCG	NHS Blackpool CCG	NHS Fylde & Wyre CCG	NHS Chorley and South Ribble CCG	NHS Greater Preston CCG	NHS Morecambe Bay CCG	NHS West Lancashire CCG
Q4 20/21	Actual	49	27	88	60	49	50	65	40
Q1 21/22	Trajectory	≥30% to 39.9%	≥20% to 29.9%	>80%	≥50% to 59.9%	≥30% to 39.9%	≥30% to 39.9%	≥50% to 59.9%	≥30% to 39.9%
	Actual	39	24	85	54	23	21	59	20
	Comparison								
Q2 21/22	Trajectory	≥40% to 49.9%	≥30% to 39.9%	>80%	≥60% to 64.9%	≥40% to 49.9%	≥40% to 49.9%	≥65% to 69.9%	≥40% to 49.9%
	Actual	30	20	82	49	24	39	69	44
	Comparison								
Q3 21/22	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	71	63	72	61	64	75	70	67
	Comparison								

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Total Outcomes	208	168	142	196	139	142
Total within 28 Days	83	102	92	138	97	111
Quality Premium %	**40%**	**61%**	**65%**	**70%**	**70%**	**78%**
Cases eligible	41	36	36	38	37	26
% Eligible	25%	27%	31%	25%	32%	24%

8.8. Incomplete Referrals over 28 days (data from w/e 06/02/22))

Incomplete Referrals over 28 days	Up to 2 weeks	2 - 4 weeks	4 - 12 weeks	12 - 26 weeks	Over 26 weeks	Sub-total
Blackburn with Darwen	0	3	0	1	0	4
East Lancashire	0	4	10	4	1	19
Chorley and South Ribble	1	0	7	1	0	9
Greater Preston	0	4	6	1	0	11
Blackpool	2	0	1	0	0	3
Fylde and Wyre	3	2	12	2	1	20
Morecambe Bay	2	3	9	4	0	18
West Lancashire	1	1	0	0	0	2
Total	**9**	**17**	**45**	**13**	**2**	**86**



8.8.1. In June 2021 a trajectory for 2021/22 was submitted to NHSE/I of the predicted number of referrals breaching 28 days (per quarter) and the predicted Quality Premium – DSTs completed within 28 days. 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.

8.8.2. There is currently a backlog of 86 ICRs in the system that have breached 28 days, this is broken down by CCG in the table above. This is higher than the number reported in December 2021 and is split slightly differently. The number has increased, fallen behind the trajectory, which highlights that the BAU capacity is not sufficient to meet demand. This has partly been due to staff sickness within Health and Local Authority teams, delays in the induction of new staff and MDT cancellations. These issues and the impact they have had on the number of ICRs have been escalated with the likely impact of not meeting the 28 day Quality Premium by the end of Q4 2021/22 as per the trajectory to NHSE/I.

8.8.3. The following points should give some assurance that although the current position is not where we want to be there are positives that the position should improve:

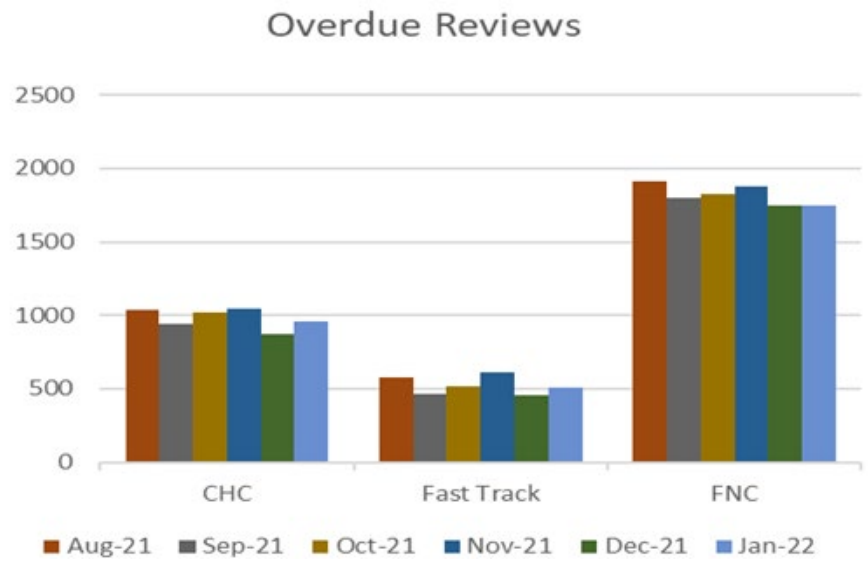
- Blackpool CCG recruitment completed.
- MLCSU recruitment for additional posts has been completed and training for staff to be completed before the end of February 2022
- MLCSU are reviewing alternative methods to clearing the ICRs (updates in future reports)
- MLCSU – project team standardising procedures and data quality across MLCSU; this is currently being rolled out across L&SC.

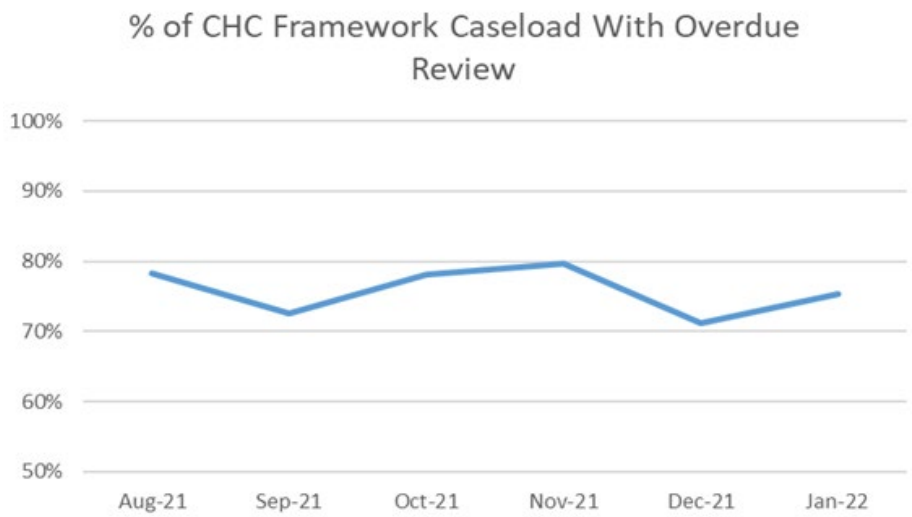
8.8.4. Staffing, processes and processing are being reviewed to ensure going into Q1 2022/23 that all new referrals have an assessment and decision within 28 days.

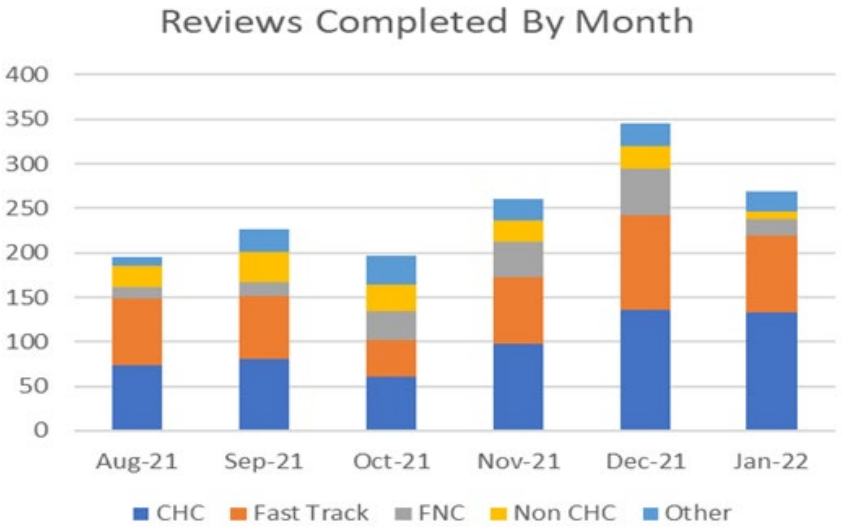
8.8.5. The trajectory to NHSE/I was based on ICRs that have already breached the 28 day period by 12 weeks. The graph highlights that we have missed out the deadline we set to clear these ICRs by 31st December 2021. We currently have 15 ICRs over 12 weeks.

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

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Monthly Movement	% Change
CHC	1040	941	1016	1049	875	955	80	9.1%
Fast Track	579	461	520	614	460	511	51	11.1%
FNC	1908	1799	1828	1877	1751	1751	0	0.0%
Total	**3527**	**3201**	**3364**	**3540**	**3086**	**3217**	**131**	**4.2%**
% of CHC Framework Review Caseload	**78%**	**73%**	**78%**	**80%**	**71%**	**75%**		



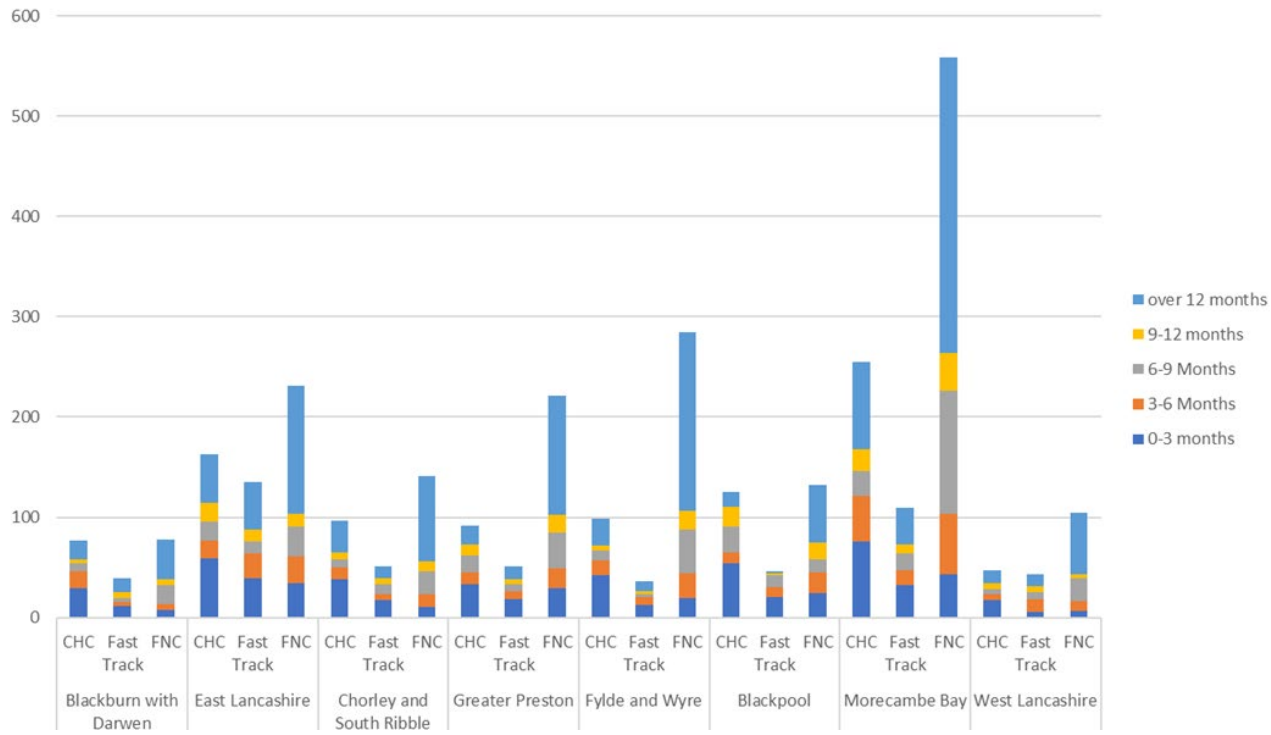




8.9.1. There has been a monthly increase in the number of CHC Framework reviews that are overdue. This percentage will continue to rise in the coming months as clearing the backlog of ICRs has led to an increase in the number of CHC and FNC packages that will require their 3 month reviews becoming due as the resource is not currently in place to handle the workload, with on average around 100 reviews per month currently being recorded. A recent change in process has resulted in a larger number of Fast Track reviews being reported from August 2021 to January 2022. 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 (Children and Young People) 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 started in December 2021 with 230 reviews completed, detailed updates are given in the weekly activity report.

	0-3 months	3-6 Months	6-9 Months	9-12 months	over 12 months	Grand Total
CHC	349	135	118	93	260	955
Fast Track	160	86	70	48	147	511
FNC	176	181	308	125	961	1751
Grand Total	**685**	**402**	**496**	**266**	**1368**	**3217**

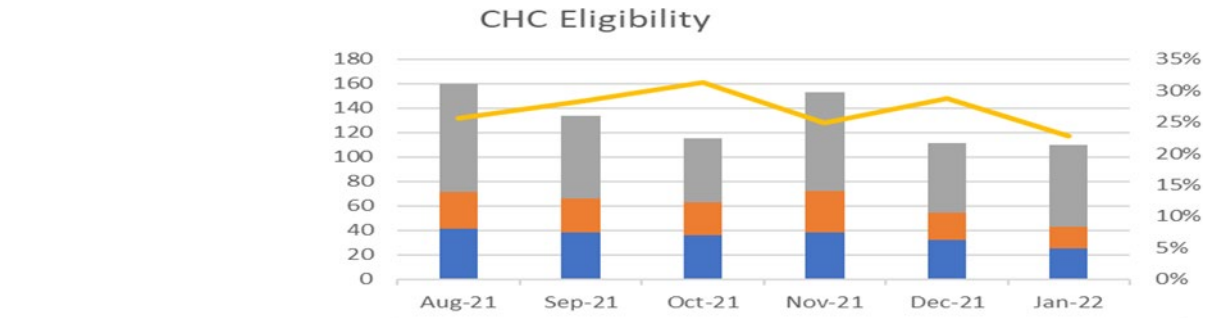


8.9.3. The pattern is the same across all CCGs with over 50% of overdue reviews being more than 12 months past the review due date, particularly FNC patients where the figure is over 60%

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

8.10. <u>CHC Eligibility</u>

	Aug	Sep	Oct	Nov	Dec	Jan
Blackburn with Darwen	43%	44%	0%	50%	45%	30%
East Lancashire	13%	36%	20%	19%	15%	14%
Chorley And South Ribble	18%	25%	62%	36%	33%	0%
Greater Preston	35%	16%	47%	11%	9%	21%
Fylde And Wyre	21%	13%	17%	17%	18%	29%
Blackpool	n/a	n/a	n/a	n/a	n/a	n/a
Morecambe Bay	24%	31%	25%	30%	48%	25%
West Lancashire	40%	33%	44%	25%	67%	60%



	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Non-eligible for CHC - Eligible for FNC	89	68	52	81	57	67
Non-eligible for CHC	30	28	27	34	22	18
Eligible Decisions	41	38	36	38	32	25
% Eligible	26%	28%	31%	25%	29%	23%

8.10.1. 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.

8.10.2. Future reports will break down the data into individual CCGs, which will enable us to assess whether different processes in different areas impact eligibility rates. BwD CCG have higher than the ICS average eligibility rate for 7 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:

9.1.1. Potential workforce attrition in view of pressures which is being addressed as a short-term issue and therefore being covered by short term contract or secondment arrangements. This impacts both commissioning and provider. Workforce pressures include some movement of staff, sickness, non-extension of secondment arrangements in both CCGs and Partnership Business Unit.

9.1.2. Workforce exploitation in the Regulated Care sector, with learning from Cheshire system is being considered by County Councils.

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

9.2.1. Increased referrals into PREVENT from MH, LD services, PREVENT – referrals predominantly are for individuals living with or experiencing MH and Neuro Development disorders - children, and adult (ill health and illness).

9.2.2. Consent, Mental Capacity and Best Interest Assessment is a theme in acute Hospital CQC assessments.

9.2.3. Safeguarding mandatory training in a number of providers/professional groups is non-compliant.

9.2.4. An increase in scrutiny from the Child Safeguarding National Review Panel.

9.3. Current area of focus

9.3.1. Delayed Court of Protection – DoL application numbers continue to be quantified and triaged. Note assurance continually via the review of applying least restrictive care.

9.3.2. Significant safeguarding resource into protecting children's vulnerability due to service/pathway/placement gaps.

9.3.3. 'Sudden Unexpected Death of a Child' service remains reduced to five days. Awaiting DoF within the network to review.

9.3.4. Maintaining Safeguarding Statutory functions.

9.4. Successes

A number of Safeguarding Star Awards have been received across the SUDC service, long service safeguarding practitioner and development of an e-Learning training for foster carers on addressing the health needs of Looked After Children.

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
	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Oct-21	Sep-21	Sep-21	Sep-21	Oct-21	Sep-21	Sep-21	Q2 21/22	Sep-21	Sep-21	Sep-21	Sep-21
Cheshire and Merseyside	4,504	12,480	45.0%	89.0%	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	6,750	19,715	47.0%	78.0%	98.0%	23.0%	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	2,740	8,580	52.00%	91.0%	99.0%	20.0%	21,100	59.4%	82.7%	8,230	67.5%	21.7%	4,986	1,000	10,515	62.0%	11.0%
North West	13,995	40,775	48.0%	85.0%	98.0%	26.0%	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
	Dec-21	Q3	Dec-21	Dec-21	Dec-21	Dec-21	Nov-21	Nov-21	Nov-21	Jan-22	Jan-22	Jan-22	Dec-21	Dec-21		Dec-21		Jan-22
Blackburn with Darwen CCG	208	797	57.0%	97.46%	100.00%	5.05%	1,695	–	–	–	–	–	594	–	–	–	–	308
Blackpool CCG	238	961	53.0%	97.38%	99.48%	6.88%	2,235	100.00%	67.0%	–	–	–	682	–	–	–	–	325
Chorley and South Ribble CCG	196	703	51.0%	78.46%	97.69%	38.46%	2,065	100.0%	–	–	–	–	412	–	–	–	–	455
East Lancashire CCG	445	1712	61.0%	97.90%	99.16%	24.18%	3,840	–	0.0%	–	–	–	969	–	–	–	–	563
Fylde and Wyre CCG	171	689	54.0%	96.43%	100.00%	26.58%	2,000	–	67.0%	–	–	–	541	–	–	–	–	242
Greater Preston CCG	362	1101	50.0%	87.10%	100.00%	30.38%	2,075	100.00%	25.0%	–	–	–	617	–	–	–	–	499
Morecambe Bay CCG	390	1345	62.0%	95.95%	99.66%	18.14%	3,065	100.00%	100.0%	–	–	–	–	–	–	–	–	–
West Lancashire CCG	205	632	51.0%	96.43%	100.00%	27.45%	1,430	0.00%	–	–	–	–	244	–	–	–	–	153
Lancashire and South Cumbria	2,215	7,940	57.0%	94.02%	99.43%	20.41%	22,450	88.0%	53.0%	1,338	64.1%	92.00%	4,059	1,429	–	91.30%	–	2,545
Target / Ceiling			>50%	>75%	>95%	<10.00%		>95%	>95%	<1110	>66.7%	>60%	9,123			>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:

- Activity to support delivery of the ambition are being discussed with each provider.
- Recovery plans to support delivery to be agreed March 2022
- Monthly monitoring of delivery now in place
- IAPT trainee numbers in line with NHSE/HEE recommended figures will be supported
- National NHSE lead attended delivery meeting and has provided a list of high impact actions to support delivery.
- National IAPT expert to support a review within 1 IAPT provider and share findings/ recommendations

11.2. Out of Area Placements (OAP) – whilst nationally the OAP position 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 Long Term Plan (LTP) ambition is to have zero OAPs by the end of 2021/22 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
- All patients placed out of area are overseen by local teams to ensure a timely and safe discharge
- External review underway within LSCFT to identify areas for improvement with regards to admission, flow through the trust and discharge
- Transformation projects underway across the system to ensure that liaison provision is in line with CORE 24 recommendations, roll out of the new IRS system, crisis and alternative capacity review is underway and community mental health provision review and implementation in its second year.
- Urgent Care transformation Steering group to be put in place to oversee transformation projects and delivery feeding into the All-Age Mental Health Transformation Group

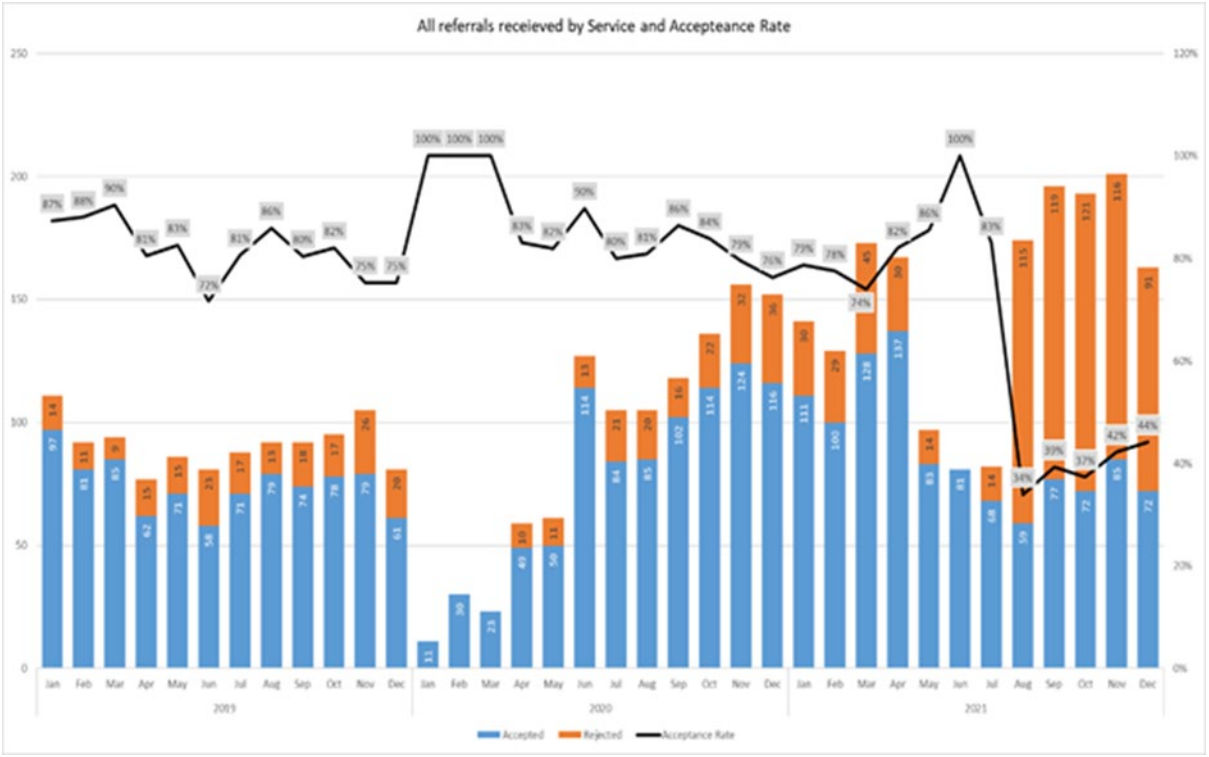
11.3. Physical Health Checks for people with severe mental illness – this key offer continues to be an issue across L&SC. The mortality rate for those patients with a mental health illness is much higher than those without. Actions taken:

- Monthly data now produced
- Digital offer under trial
- Monthly task and finish group developed to support a focus on ICP / practice-based issues, development of trajectory and monitoring of delivery
- Clinical Champion identified to support delivery
- Outcome measures to be tracked – reduction in mortality, reduction in hypertension
- Through the steering group a review of service offers will be undertaken to ensure that when patients are checked there is capacity to refer to support smoking cessation, weight loss and other elements associated with the checks

11.4. Suitable provision for Children and Young People (CYP) - There is a growing issue impacting Paediatric wards and Emergency departments as CYP are presenting and capacity to support them is limited both in specialist wards and in the community. Actions taken:

- Development of a system-wide escalation policy to support CYP to be supported in the community, discharged from unsuitable settings, reduce the risk of poor outcomes supporting the patient needs which may span more than one agency and numerous services, reduce disputes about leadership and the need for agency involvement and support a collaborative system and a positive culture around Children and Young People
- Funding has been allocated to the ICS which can be used to support the acute trusts and paediatric wards in training and supporting the clinical teams in enhancing their confidence and skills in supporting the emotional and wellbeing of patients admitted
- The CYP transformation plan will support additional crisis provision and through the review of the eating disorder pathway alternatives to admission and support in the community will be developed
- Actions related to the eating disorder pathway detailed below will also support the reduction in patients presenting

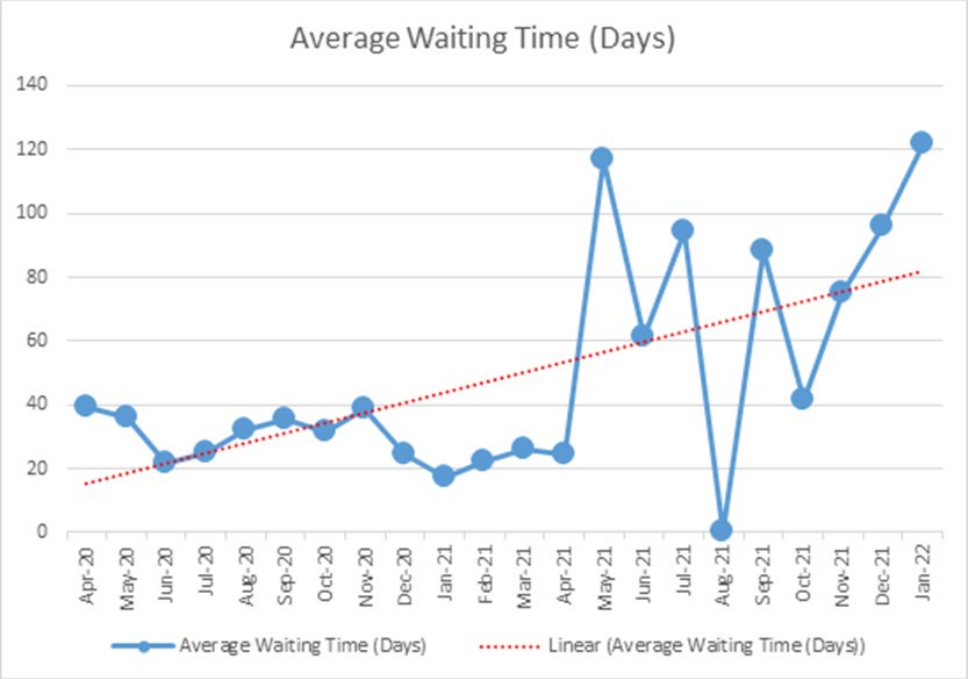
11.5. CYP eating disorder routine waiting time update – post pandemic has seen an increase in referrals and presentations for CYP with an eating disorder. This has been recognised nationally with access to specialist beds reported as an issue. The table below demonstrates the referrals into service, those accepted for treatment and those not accepted as being appropriate for the specialist service intervention.



11.5.1. The eating disorder service has seen a 64% increase in referrals of people of all ages but particularly for adolescents aged 11-15 where there has been an 81% increase; and young people aged 15-20 where there has been a 41.4% increase. There was an overall spike in referrals in June 2020 which has plateaued somewhat but continues to be problematic in terms of capacity. The eating disorder service continues to be overseen through a robust management approach. This is supported by a weekly oversight discussion with a clinician on each patient within an acute trust / alternative provider and community. The result is escalation where required, robust tracking of discharges and treatment plans and intervention as needed.

11.5.2. Those patients who have been referred on a routine basis as opposed to urgent for CYP have been supported by a sub-contracting arrangement with Spring North consortium which commenced October 2021. In the first phase 146 patients were transferred to Spring North to support a reduction in waiting times / list size. Having been reviewed 32 have been taken off the ED services waiting list, 53 are being allocated in order that the patients are supported with treatment through Spring North and 61 have been approved and being offered treatment. A further additional 26 patients have had an initial assessment by Spring North and an additional 35 are awaiting assessment.

11.5.3. The LSCFT service remains in place but Spring North were contracted to support a waiting list and time reduction whilst the LSCFT service continues to develop and expand. Due to capacity restraints the table below details the average waiting time which is rising.



- Investment into eating disorder service within LSCFT in 2020/2021
- Investment has been agreed to support further expansion of the service
- A pathway review is underway to ensure that it is in line with the investment and due to ongoing recruitment issues workforce expansion is in line with the FREED model and is supported by an MDT approach.
- A support offer for those patients who do not meet the current criteria is in discussion in order that patients are supported in a preventative way in anticipation that those presenting in crisis are reduced.

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 Q4 Trajectory
CCG In-Patients	58	36	+22
Secure In-Patients	38	38	0
Total	**97**	**74**	+22

12.1.1. The position as at the 10th February 2022 - currently 58 CCG inpatients, against a Q4 2021/22 trajectory of 36 (+22). 29 of these inpatients are placed outside of L&SC.

Table 3: Admissions of L&SC Adult inpatients since Q1 2020

Admissions	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
CCG Inpatients	5	8	14	11	18	18	19	0
Secure Inpatients	1	4	2	1	0	0	1	0

12.1.2. There were 19 people with a Learning Disability and/or Autism admitted into an inpatient bed during Q3 2021/22.

Table 4: Discharges of L&SC Adult inpatients since Q1 2020

Discharges	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
CCG Inpatients	16	8	11	16	11	10	13	0
Secure Inpatients	1	2	6	3	6	0	0	0

12.1.3. There were 18 CCG patients with a Learning Disability and/or Autism discharged into the community during Q3 2021/22, and no secure inpatients discharged.

12.1.4. Recognising that there are many patients which remain within a hospital setting, discharges remain problematic, and admissions are fluctuating. The following actions have been undertaken:

1) Weekly Discharge Facilitation Meetings are now in place chaired by Fleur Carney - ICS Director for MH/LDA and attended by discharge facilitation teams, Local Authority and CCG colleagues. The meeting supports the review of all in-patients and identify actions required to enable discharges, identify any barriers, and support escalation where required.

   Themes identified so far are:
   - Secure EDD's listed some of which are transfers to another hospital – not discharges into the community
   - COVID in the community placement/or delaying transition
   - 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 with no clear discharge plan

2) A new complex care framework is being developed which supports a new way of procuring and identifying providers to support the discharge of this population group – this will be in place July 2022.

3) A timeline has been developed which identifies a clear plan for all inpatients who are currently ready for discharge / nearing end of treatment to ensure that focus and pace is in place within the ICS to ensure new / identified accommodation and associated staffing support is being developed / in development / nearing completion to support a safe discharge into the community.
4) Oversight of the identified priorities for those patients with a learning disability / Autism continues through the LDA Improvement Board
5) Investment priorities are under review from 2021/ 2022 to ensure that the outcomes are being delivered and recurrent funding is required
6) Investment priorities for 2022/ 2023 are being discussed within the system to support funding allocations to those areas that will support the patient care required
7) Local Authority discharge grant allocations for 2021/22 are being reviewed and plan developed for the 2022/23 allocation
8) In patient capacity within L&SC for LDA patients remains problematic and has been escalated within the ICS, regionally and nationally to seek capital investment support for a new build of IP capacity.

12.2. Safe and Wellbeing Checks

12.2.1. 93x Safe and Well-being Reviews originally to be completed (CCG 58 Secure 35)

12.2.2. CCG

- 6 patients have been discharged – leaving 52 reviews
- 3 reviews not completed with dates booked February/ March 2022 (1 being repeated due to a patient hospital move, 1 partly completed, 1 cancelled due to COVID)
- 49 reviews have been completed by CCG colleagues
- 11 panels held reviewing 36 people
- Panels in place to review further 13 completed reviews
- Of those reviewed 13 now fully signed off
- 23 require further clarity prior to sign off
- 20 reviews required urgent escalation with reviewer to seek further clarity

12.2.3. Secure

- 18 of the Secure reviews are yet to start due to sickness / vacancies
- 3 reviewed in ICS panel – further clarification required
- 14 reviews are underway

12.3. Key concerns ICS Panel reviews

12.3.1. 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 Speech and Language Therapy, 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 with 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

12.4. Actions taken in relation to panel review

12.4.1. On reviewing the submitted report and if the ICS Panel requires further clarity, contact is made with the reviewers via email – if urgent clarification is required a Teams meeting is scheduled within a 2 week period.

12.4.2. A report is signed off once the feedback is received and the panel is satisfied / assured

12.4.3. Thematic review to be undertaken to share key findings through ICS governance frameworks and shared across providers / system

13. ICS/ICB Complaints, MP Letters, and PALS

13.1. Introduction

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

13.1.2. Current arrangements are that 6 of the 8 CCGs receive a service from MLCSU though some deal with MP correspondence directly; 2 CCGs have their own in-house service.

13.1.3. A task and finish group was established in summer of 2021 including representation from all L&SC CCGs, MLCSU and NHSE/I. This was productive and quickly agreed some principles for future delivery and a series of questions to address. These were summarised in a presentation to the ICS 'Design Authority' initially on 17th January 2022 with a more detailed paper being considered on 24th January 2022. The meeting agreed a series of recommendations which are set out below.

13.2. Recommendations to Establish a New Function

13.2.1. The Design Authority were asked to make some specific decisions to allow the next stage of development. They are explained below.

13.3. Scope of the Service

13.3.1. The current MLCSU service offer is Complaints, PALS, and MP letters though not all CCGs take up every element. There has been some discussion about how this should be delivered by the ICB. The recommendation was that they should be one, unified function delivered by a single team. The meeting agreed that the scope of the service is Complaints, PALS, and MP liaison. Note the change of terminology from 'MP letters' to 'MP liaison'. The service will work closely with other parts of the ICB as described below.

13.4. Function Leadership and the ICB structure

13.4.1. Complaints support in existing CCG structures is drawn from a variety of services including Nursing and Quality, Communication and Engagement, and Corporate Services. We know this pattern is replicated in other systems. There is no relevant guidance or any agreed best practice.

13.4.2. The current legislation provides that the 'responsible person' for complaints is the 'Chief Executive' of the NHS body. The regulations also allow the duties of the responsible person to be discharged by 'any person authorised by the responsible body'. In reality, this means the ICB can authorise a nominated Executive Lead. This is common practice in both commissioning and provider organisations and there is a negligible risk this would ever be challenged.

13.4.3. The Complaints, PALS and MP Liaison function needs an Executive Lead (either as an interim measure or indefinitely) to progress our work programme. **It was agreed that this function would be led by Jane Scattergood, as the Director of Nursing and Quality initially.** The incoming Chief Executive may have a view, but this will allow us to progress the actions set out below.

13.4.4. Following the meeting, a letter dated 26th January 2022 was sent to all CCG Accountable Officers from Andrew Bennett 2022 which:

- Confirmed the Director of Nursing and Quality t role as the Executive Lead for the system on an interim basis.
- Clarified that CCG Accountable Officers will continue to be responsible for signing off complaints until the until the end of June 2022.
- Asked for details of who delivers this function in the CCG currently (job titles, grades and hours spent on this activity).

13.4.5. The letter also communicated the expectation that this will be one function as soon as possible and operate as a single team by April 2022 at the latest.

13.4.6. A list of actions necessary to make further progress have been identified and include:

- Identify a deputy for the Executive Lead and business support. This post is instrumental in ensuring responses are signed and there is strong communication with the service.
- Agree a process which includes investigation, clinical review and sign off; it will need to set out what is done at place.
- Review the name for the function. Historically, in Lancashire it was described as 'Customer Care', but this should be looked at again.
- Create an ICB Complaints Policy.
- Progress the people work to establish an effective and high-quality team in a dedicated function which includes leadership and management.
- Working with Communication and Engagement colleagues, to agree how we will handle MP liaison and deliver this message to all local MPs.
- Ensure that there are clear ways to enquire and complain by post, email, phone and through the website on day one. This will include patient information materials inviting feedback and complaints.
- Establish the resource requirement for year one.

- Plan the transition including the transfer of open cases and how we will deal with legacy work.
- Keep in contact with NHSE/I to understand the proposals and timescales for integrating primary care complaints and enquiries and the impact on the ICB service.
- Explore options for a case management system and procurement.
- Agree a single style and set of standards for written communication.

13.5. Links to other Functions and Teams

13.5.1. CCG and MLCSU leads working alongside the Director of Quality and Nursing will engage with a range of other functions in the coming months to avoid any duplication and ensure arrangements are clear. The functions or services affected are:

- Governance and Corporate Functions
- Nursing and Quality
- Provider Complaint Handling
- Continuing Healthcare/Individual Patient Activity

13.6. ICS/ICB Complaints, MP Letters, and PALS Recommendations

The ICS Quality and Performance Sub-Committee is asked to:

13.6.1. To note the work undertaken to prepare for the transfer of this function and the future actions identified.

13.6.2. Agree to receive a progress report at a future meeting. Date to be agreed.

14. 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

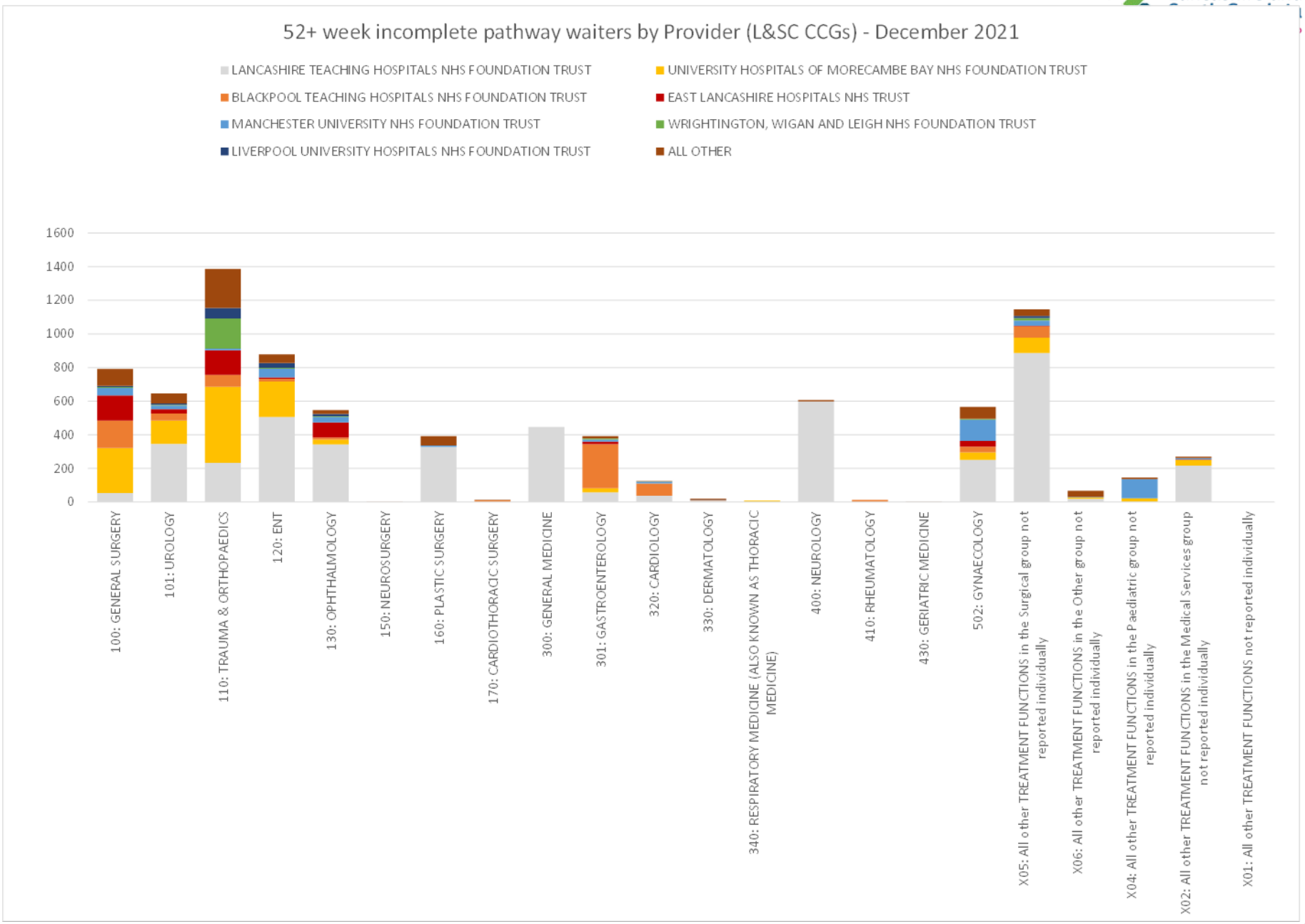
Glossary

A&E	Accident & Emergency	HOCI	Healthcare onset COVID-19 infection
AEDB	A&E Delivery Boards	IAPT	Improving Access to Psychological Therapies
AHC	Annual Health Check	ICB	Integrated Care Board
AHP	Allied Health Professional	ICP	Integrated Care Partnership
AMHP	Approved Mental Health Professional	ICR	Incomplete Referrals
ASD	Autism Spectrum Disorder	ICS	Integrated Care System
AZ	AstraZeneca	IPA	Individual Patient Activity
B CCG	Blackpool Clinical Commissioning Group	IPC	Infection Prevention and Control
BGH	Burnley General Hospital	LAMP	Loop Mediated Isothermal Amplification
BI	Business Intelligence	L&SC	Lancashire and South Cumbria
BSI	Blood Stream Infections	LeDeR	Learning Disabilities Mortality Review
BTHT	Blackpool Teaching Hospitals Trust	LOS	Length of Stay
BVH	Blackpool Victoria Hospital	LSCFT	Lancashire & South Cumbria Foundation Trust
BwD	Blackburn with Darwen	LTHT	Lancashire Teaching Hospital Trust
C&M	Cheshire and Mersey	MAS	Memory Assessment Service
CAMHS	Children and Adolescent Mental Health Service	MB CCG	Morecambe Bay Clinical Commissioning Group
CAS	Clinical Assessment 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
CYP	Children and Young People	MHST	Mental Health Support Teams
CYPEWMH	Children and Young People's Emotional Wellbeing and Mental Health	MLCSU	Midlands and Lancashire Commissioning Support Unit
CHEC	Community Health Eye Care	MRI	Magnetic Resonance Imaging
CHR	Clinical harm review	MRSA	Methicillin resistant Staphylococcus Aureus
CoP	Court of Protection	MSSA	Methicillin Sensitive Staphylococcus Aureus
CPA	Care Programme Approach	MSK	Musculoskeletal
CRG	Clinical Reference Groups	NHSE	National Health Service England
CSR	Chorley and South Ribble	NHSI	National Health Service Improvement
CT	Computerized Tomography scan	NW	North West
CTR	Care and Treatment Review	NWAS	North West Ambulance Service
CYP	Children and Young People	OAP	Out of Area Placement
D2A	Discharge to assess	PALS	Patient Advice and Liaison Service
DA	Domestic Abuse	PCN	Primary Care Network
DCA	Double-crewed Ambulance	PHE	Public Health England
DH&SC	Department of Health and Social Care	PHOM	Population Health Operating Model
DNA	Did not attend	PICU	Psychiatric Intensive Care Unit
DTA	Decision to Admit	PIR	Post Incident Review
ECDS	Emergency Care Dataset	PPE	Personal Protective Equipment
E. coli	Escherichia coli	QP	Quality Premium
ECRG	Elective Care Recovery Group	Q&P	Quality and Performance
ED	Emergency Department	RAS	Referral Assessment Service
EDi	Eating Disorders	RBH	Royal Blackburn Hospital

EIP	Early Intervention Psychosis	RDC	Rapid Diagnostic Centre
EL	East Lancashire	RLI	Royal Lancaster Hospital
ELCAS	East Lancashire Child and Adolescent Services	RPH	Royal Preston Hospital
ELHT	East Lancashire Hospitals Trust	RTA	Referral to Assessment
EMHPs	Education Mental Health Practitioners	RTT	Referral to Treatment
EOIs	Expression of Interests	S136	Section 136
ERF	Elective Recovery Fund	SARs	Subject Access Requests
F&W	Fylde and Wyre	SCC	Strategic Commissioning Committee
FDS	Faster Diagnostic Standard – is a new policy in which patients should have cancer ruled out or diagnosed within 28 days of referral	SCRs	Serious Case Reviews
FGH	Furness General Hospital	SJR	Structured Judgement Reviews
FoI	Freedom of Information	Type 1 A&E	The NHSE definition of a Type 1 A&E department is a consultant led 24-hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. The performance measure is the total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge.
G&A	General and Acute	UCC	Urgent Care Centre
GP	Greater Preston	UEC	Urgent and Emergency Care
GM	Greater Manchester	UECN	Urgent and Emergency Care Network
HAP	Health Action Plan	UHMB	University Hospitals of Morecambe Bay
HCAIs	Healthcare Associated Infections	US	Ultrasound
HCP	Health and Care Partnership	VCFSE	Voluntary, Community, Faith and Social Enterprise
HEC	Health Equality commission	WL	West Lancashire
HEE	Health Education England	WLIs	Waiting List Initiatives
HLSC	Healthier Lancashire and South Cumbria		

Appendix 1 : Over 52 week waiters for L&SC CCGs split by Specialty and Provider [December 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	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	ALL OTHER	TOTAL	% TOTAL
100: GENERAL SURGERY	54	267	163	149	46	6	6	101	792	9.4%
101: UROLOGY	346	138	42	26	22	5	7	60	646	7.6%
110: TRAUMA & ORTHOPAEDICS	233	453	70	147	10	179	63	231	1386	16.4%
120: ENT	506	211	15	10	51	6	27	52	878	10.4%
130: OPHTHALMOLOGY	342	29	13	90	31	5	14	23	547	6.5%
150: NEUROSURGERY	0	0	0	0	0	0	0	2	2	0.0%
160: PLASTIC SURGERY	328	0	0	0	8	0	0	56	392	4.6%
170: CARDIOTHORACIC SURGERY	0	0	11	0	0	0	0	2	13	0.2%
300: GENERAL MEDICINE	446	0	0	0	0	0	0	0	446	5.3%
301: GASTROENTEROLOGY	57	25	263	15	11	7	1	13	392	4.6%
320: CARDIOLOGY	37	0	74	0	11	1	0	3	126	1.5%
330: DERMATOLOGY	8	1	1	0	0	0	3	7	20	0.2%
340: RESPIRATORY MEDICINE (ALSO KNOWN AS THORACIC MEDICINE)	0	8	0	0	0	1	0	0	9	0.1%
400: NEUROLOGY	599	0	0	0	0	0	0	8	607	7.2%
410: RHEUMATOLOGY	0	1	12	0	0	0	0	0	13	0.2%
430: GERIATRIC MEDICINE	3	0	0	0	0	0	0	1	4	0.0%
502: GYNAECOLOGY	250	46	34	33	127	5	0	71	566	6.7%
X05: All other TREATMENT FUNCTIONS in the Surgical group not reported individual	887	91	67	3	31	15	13	38	1145	13.5%
X06: All other TREATMENT FUNCTIONS in the Other group not reported individually	20	8	0	0	3	0	0	36	67	0.8%
X04: All other TREATMENT FUNCTIONS in the Paediatric group not reported individu	0	22	1	0	114	0	0	9	146	1.7%
X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported i	217	33	0	3	8	0	0	8	269	3.2%
X01: All other TREATMENT FUNCTIONS not reported individually	0	0	0	0	0	0	0	0	0	0.0%
Grand Total	**4333**	**1333**	**766**	**476**	**473**	**230**	**134**	**721**	**8466**	**100.0%**
% TOTAL	51.2%	15.7%	9.0%	5.6%	5.6%	2.7%	1.6%	8.5%	**100.0%**	


52+ week incomplete pathway waiters by Provider (L&SC CCGs) - December 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
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
ALL OTHER
1600
1400
1200
1000
800
600
400
200
0
100: GENERAL SURGERY
101: UROLOGY
110: TRAUMA & ORTHOPAEDICS
120: ENT
130: OPHTHALMOLOGY
150: NEUROSURGERY
160: PLASTIC SURGERY
170: CARDIOTHORACIC SURGERY
300: GENERAL MEDICINE
301: GASTROENTEROLOGY
320: CARDIOLOGY
330: DERMATOLOGY
340: RESPIRATORY MEDICINE (ALSO KNOWN AS THORACIC MEDICINE)
400: NEUROLOGY
410: RHEUMATOLOGY
430: GERIATRIC MEDICINE
502: GYNAECOLOGY
X05: All other TREATMENT FUNCTIONS in the Surgical group not reported individually
X06: All other TREATMENT FUNCTIONS in the Other group not reported individually
X04: All other TREATMENT FUNCTIONS in the Paediatric group not reported individually
X02: All other TREATMENT FUNCTIONS in the Medical Services group not reported individually
X01: All other TREATMENT FUNCTIONS not reported individually

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

Lancashire and South Cumbria Health and Care Partnership

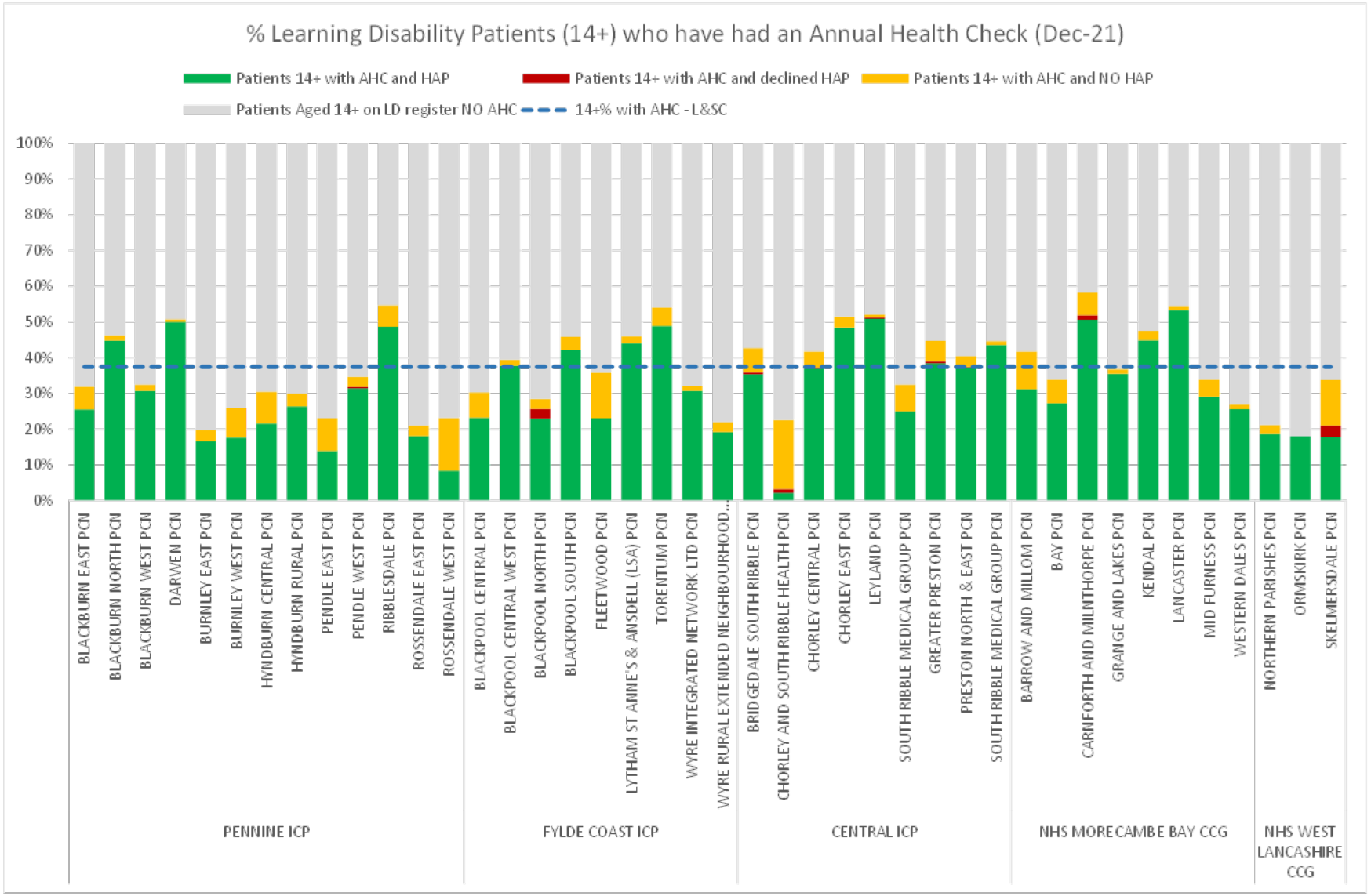
Treatment Function	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	EAST LANCASHIRE HOSPITALS NHS TRUST	TOTAL	% TOTAL
Oral Surgery Service	1723	29	11	123	1886	19.5%
Other - Surgical Services	952	100	67	4	1123	11.6%
Trauma and Orthopaedic Service	268	475	70	149	962	9.9%
Ear Nose and Throat Service	538	217	15	10	780	8.0%
General Surgery Service	59	280	169	151	659	6.8%
Neurology Service	611	0	0	0	611	6.3%
Urology Service	367	142	45	27	581	6.0%
Neurosurgical Service	539	0	0	0	539	5.6%
Ophthalmology Service	355	30	13	90	488	5.0%
General Internal Medicine Service	471	0	0	0	471	4.9%
Gynaecology Service	273	48	34	33	388	4.0%
Gastroenterology Service	60	25	268	15	368	3.8%
Plastic Surgery Service	341	0	0	0	341	3.5%
Other - Medical Services	242	33	0	3	278	2.9%
Cardiology Service	37	0	81	0	118	1.2%
Other - Other Services	21	8	0	0	29	0.3%
Other - Paediatric Services	0	25	1	0	26	0.3%
Rheumatology Service	0	1	12	0	13	0.1%
Cardiothoracic Surgery Service	0	0	11	0	11	0.1%
Dermatology Service	8	1	1	0	10	0.1%
Respiratory Medicine Service	0	10	0	0	10	0.1%
Elderly Medicine Service	3	0	0	0	3	0.0%
Other - Mental Health Services	0	0	0	0	0	0.0%
TOTAL	**6868**	**1424**	**798**	**605**	**9695**	**100.0%**
% TOTAL	70.8%	14.7%	8.2%	6.2%	**100.0%**	

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

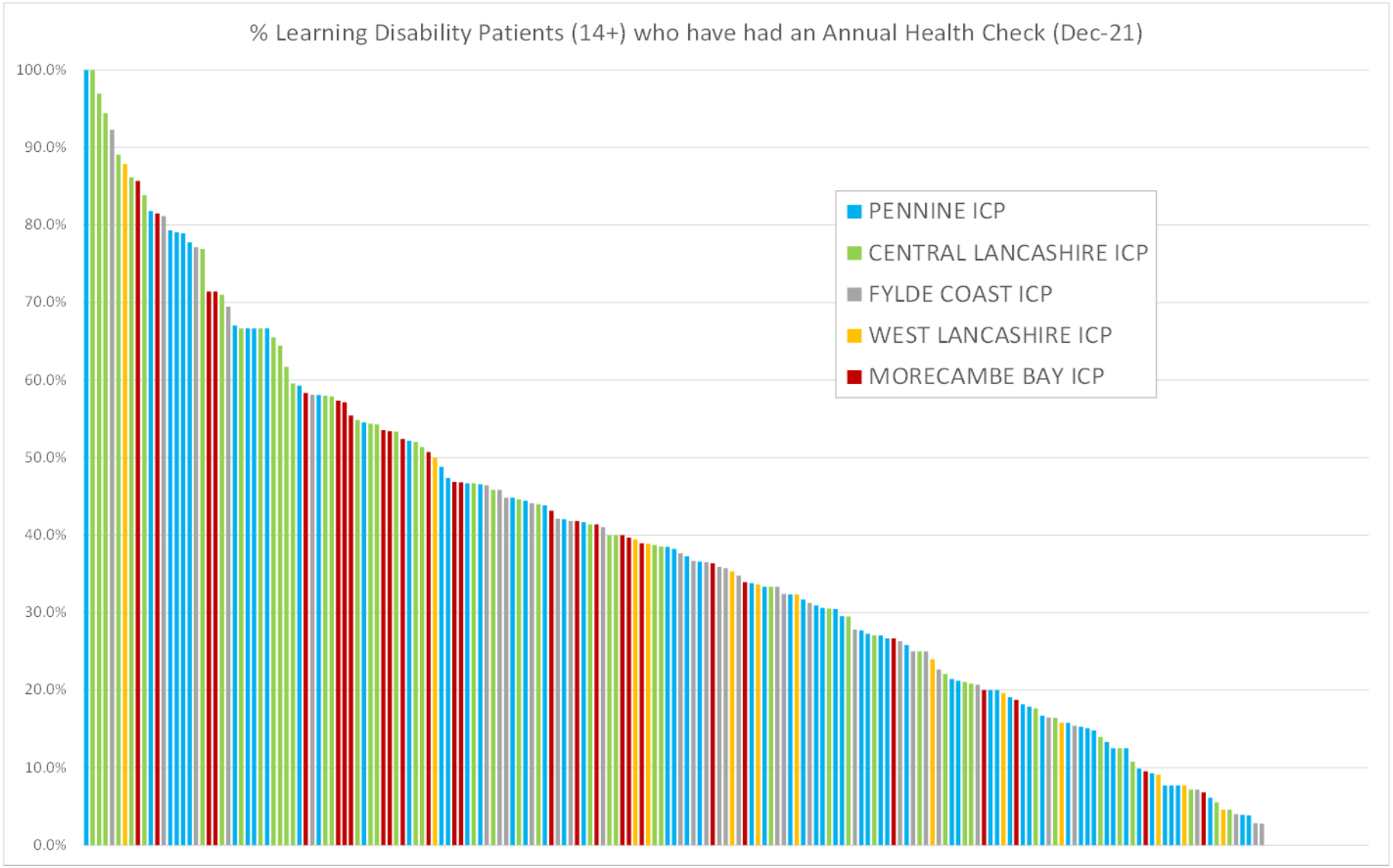
APPENDIX 3 : Incomplete Pathway Waiters – Top 20 providers with Independent Sector identified (Apr21 to Dec21)

PROVIDER	202104	202105	202106	202107	202108	202109	202110	202111	202112	MOVEMENT	SPARKLINE
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	38716	38593	40077	41329	42634	43172	43768	43638	44767	1129	
EAST LANCASHIRE HOSPITALS NHS TRUST	28062	29037	29114	30707	31570	33298	32163	32116	33062	946	
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TI	22424	22895	22839	21853	21953	23000	22696	22574	22759	185	
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	17965	18000	18503	18774	20222	21435	22004	21766	21884	118	
FULWOOD HALL HOSPITAL	4745	4964	5014	5089	5072	4893	4898	4769	4178	-591	
EUXTON HALL HOSPITAL	4666	5671	6065	5850	5159	4332	4076	3280	2984	-296	
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	3975	4297	4530	4582	4808	4932	4873	4738	4353	-385	
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	3868	4037	4134	4260	4248	4302	4510	4487	4470	-17	
LANCASHIRE & SOUTH CUMBRIA NHS FOUNDATION TRUST	2724	3227	3190	3922	4126	4608	4407	4116	4148	32	
SPIRE FYLDE COAST HOSPITAL	3860	3781	3815	3829	3120	2884	2679	2305	2189	-116	
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2853	2854	2967	3005	3018	3129	3150	3207	3333	126	
BMI - THE BEARDWOOD HOSPITAL	2367	2559	2542	2663	2820	3054	3110	3033	3132	99	
RENACRES HOSPITAL	1011	1437	1643	1605	1860	1920	2179	2088	1865	-223	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1027	1221	1364	1430	1507	1506	1667	1685	1655	-30	
AIREDALE NHS FOUNDATION TRUST	1096	1116	1107	1109	1190	1188	1258	1331	1373	42	
NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	674	669	725	771	789	757	1818	1800	1786	-14	
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	701	731	765	848	896	928	981	999	1013	14	
PENNINE ACUTE HOSPITALS NHS TRUST	749	778	841	907	894	927	0	0	0	0	
BMI THE LANCASTER HOSPITAL	508	540	525	539	538	569	578	598	604	6	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	311	678	711	734	778	801	817	80	79	-1	
ALL OTHER	4612	4648	4730	4661	4907	4941	4965	4820	4980	160	
Grand Total	**146914**	**151733**	**155201**	**158467**	**162109**	**166576**	**166597**	**163430**	**164614**	**1184**	
Main IS Providers	17157	18952	19604	19575	18569	17652	17520	16073	14952	-1121	
% TOTAL	11.7%	12.5%	12.6%	12.4%	11.5%	10.6%	10.5%	9.8%	9.1%		

APPENDIX 4 : Proportion of Patients aged 14+ on the Learning Disability register who have had an annual health check (Dec-21) – PCN Level



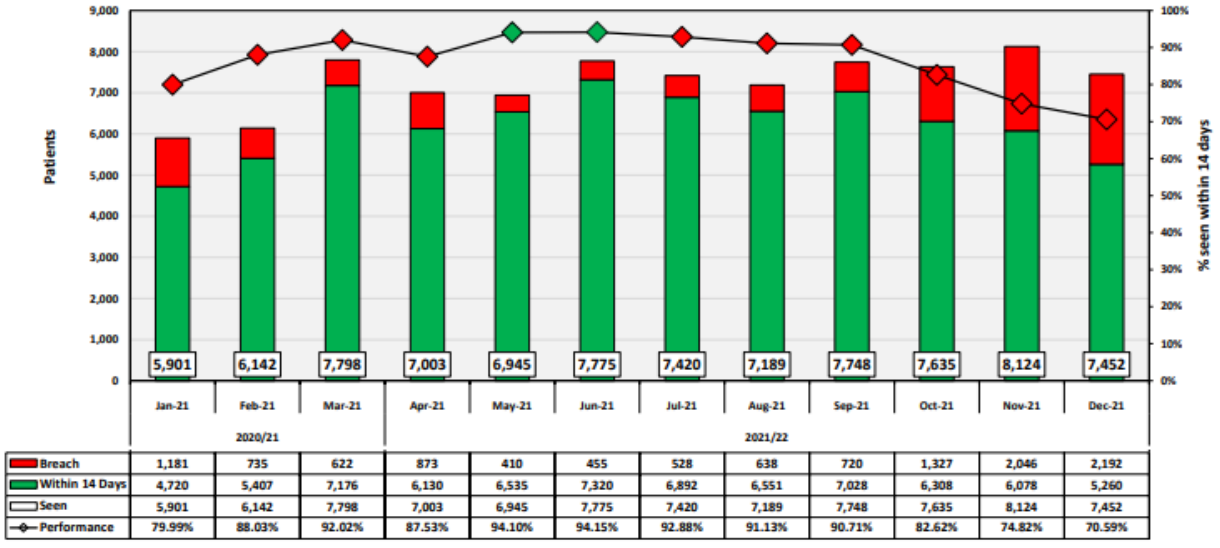
APPENDIX 5 : Proportion of Patients aged 14+ on the Learning Disability register who have had an annual health check (Dec-21) – Practice Level



% 2 Weeks Cancer – Urgent GP Referral – December 21

2 Week Wait Referrals (93% Standard)

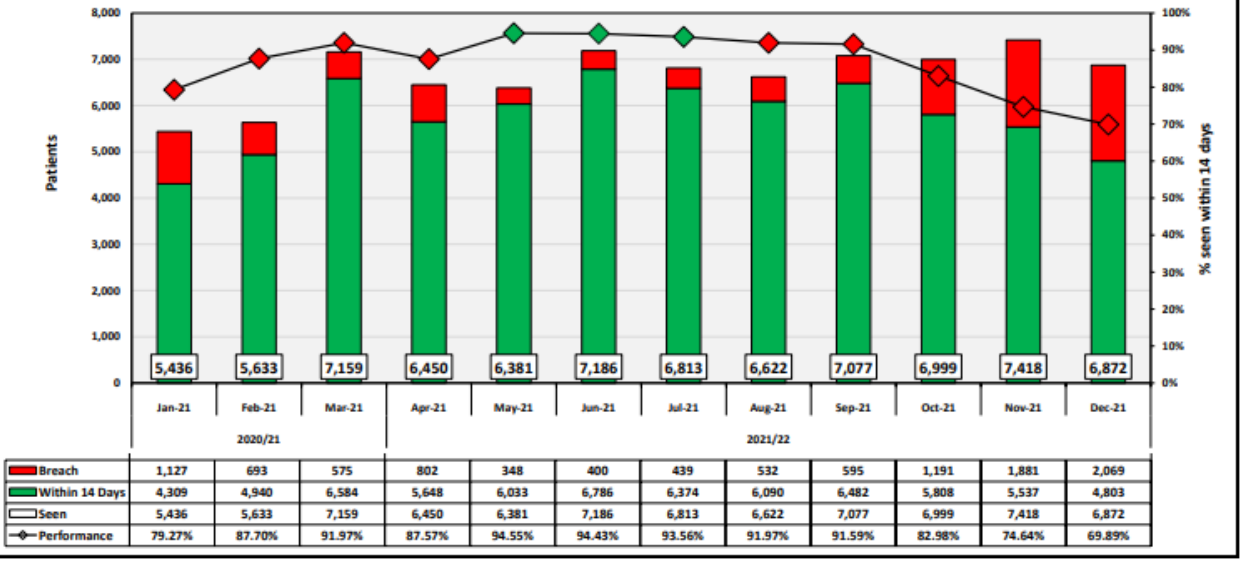
Cancer Alliance CCGs (Jan-21 to Dec-21)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	1,181	735	622	873	410	455	528	638	720	1,327	2,046	2,192
Within 14 Days	4,720	5,407	7,176	6,130	6,535	7,320	6,892	6,551	7,028	6,308	6,078	5,260
Seen	5,901	6,142	7,798	7,003	6,945	7,775	7,420	7,189	7,748	7,635	8,124	7,452
Performance	79.99%	88.03%	92.02%	87.53%	94.10%	94.15%	92.88%	91.13%	90.71%	82.62%	74.82%	70.59%

CCG	Dec-21			Jan-21 to Dec-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	592	120	79.73%	6,308	706	88.81%
BCCG	784	227	71.05%	8,358	894	89.30%
CSRCCG	716	331	53.77%	9,181	1,393	84.83%
ELCCG	1,478	267	81.94%	16,312	1,679	89.71%
FWCCG	1,048	302	71.18%	11,431	1,264	88.94%
GPCCG	892	406	54.48%	11,526	1,703	85.22%
MBCCG	1,409	404	71.33%	17,386	3,005	82.72%
WLCCG	533	135	74.67%	6,630	1,083	83.67%
CA CCGs	7,452	2,192	70.59%	87,132	11,727	86.54%

Cancer Alliance Providers (Jan-21 to Dec-21)



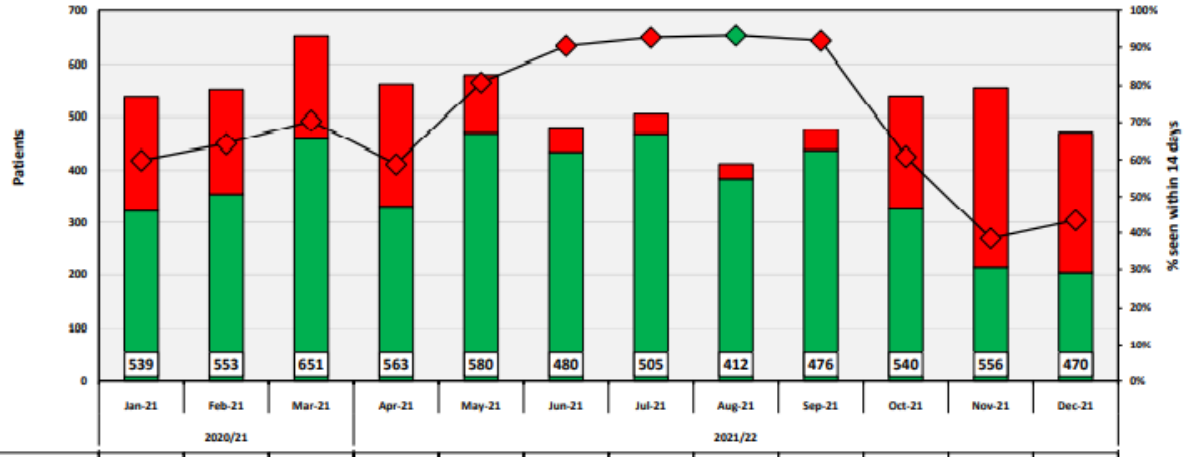
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	1,127	693	575	802	348	400	439	532	595	1,191	1,881	2,069
Within 14 Days	4,309	4,940	6,584	5,648	6,033	6,786	6,374	6,090	6,482	5,808	5,537	4,803
Seen	5,436	5,633	7,159	6,450	6,381	7,186	6,813	6,622	7,077	6,999	7,418	6,872
Performance	79.27%	87.70%	91.97%	87.57%	94.55%	94.43%	93.56%	91.97%	91.59%	82.98%	74.64%	69.89%

Provider	Dec-21			Jan-21 to Dec-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	1,650	478	71.03%	17,576	1,861	89.41%
ELHT	1,975	377	80.91%	21,508	2,247	89.55%
LTH	1,742	777	55.40%	22,491	3,323	85.23%
UHMB	1,505	437	70.96%	18,470	3,221	82.56%
CA Providers	6,872	2,069	69.89%	80,045	10,652	86.69%

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

2 Week Wait Breast Symptomatic Referrals (93% Standard)

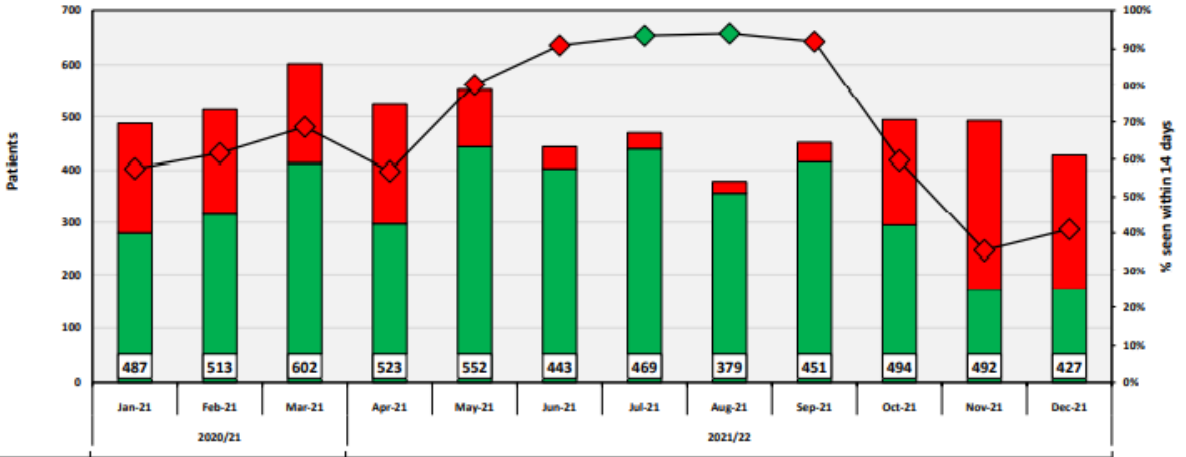
Cancer Alliance CCGs (Jan-21 to Dec-21)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	217	198	193	232	111	46	37	28	39	212	342	266
Within 14 Days	322	355	458	331	469	434	468	384	437	328	214	204
Seen	539	553	651	563	580	480	505	412	476	540	556	470
Performance	59.74%	64.20%	70.35%	58.79%	80.86%	90.42%	92.67%	93.20%	91.81%	60.74%	38.49%	43.40%

CCG	Dec-21			Jan-21 to Dec-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	48	25	47.92%	634	102	83.91%
BCCG	50	10	80.00%	790	168	78.73%
CSRCCG	41	35	14.63%	705	322	54.33%
ELCCG	119	47	60.50%	1,457	239	83.60%
FWCCG	53	18	66.04%	669	172	74.29%
GPCCG	43	36	16.28%	805	364	54.78%
MBCCG	86	83	3.49%	905	488	46.08%
WLCCG	30	12	60.00%	360	66	81.67%
CA CCGs	470	266	43.40%	6,325	1,921	69.63%

Cancer Alliance Providers (Jan-21 to Dec-21)



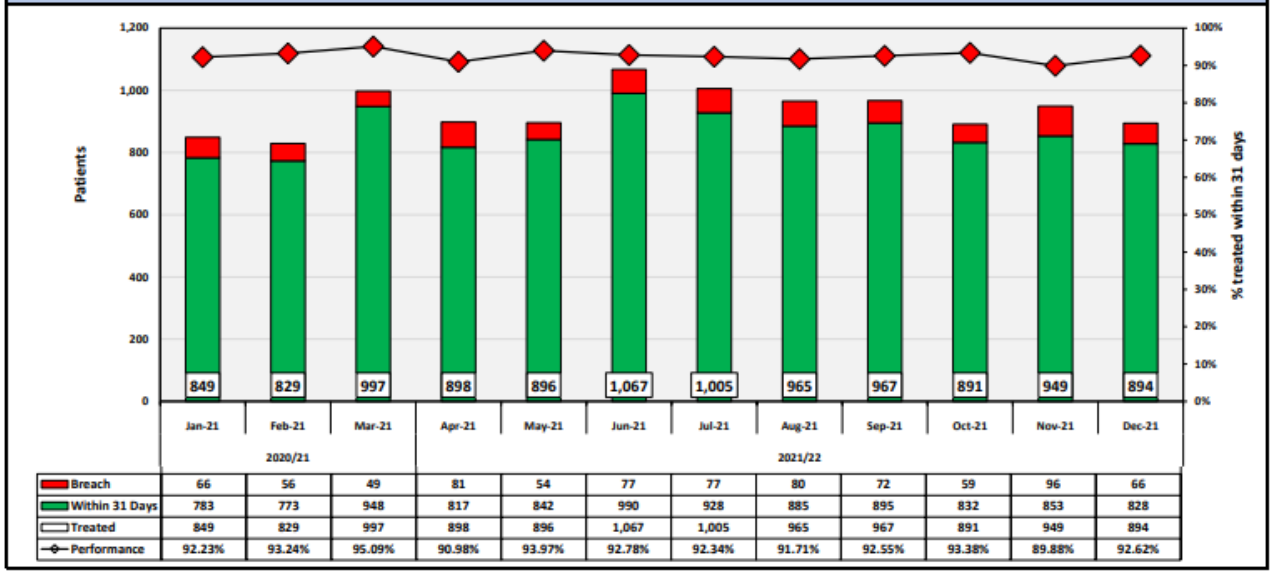
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	207	197	189	226	109	40	30	22	36	199	318	252
Within 14 Days	280	316	413	297	443	403	439	357	415	295	174	175
Seen	487	513	602	523	552	443	469	379	451	494	492	427
Performance	57.49%	61.60%	68.60%	56.79%	80.25%	90.97%	93.60%	94.20%	92.02%	59.72%	35.37%	40.98%

Provider	Dec-21			Jan-21 to Dec-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	97	22	77.32%	1,362	286	79.00%
ELHT	154	66	57.14%	1,958	301	84.63%
LTH	84	75	10.71%	1,551	712	54.09%
UHMB	92	89	3.26%	961	526	45.27%
CA Providers	427	252	40.98%	5,832	1,825	68.71%

% 31 Day Cancer – Definitive Treatment – December 21

31 Day First Treatment (96% Standard)

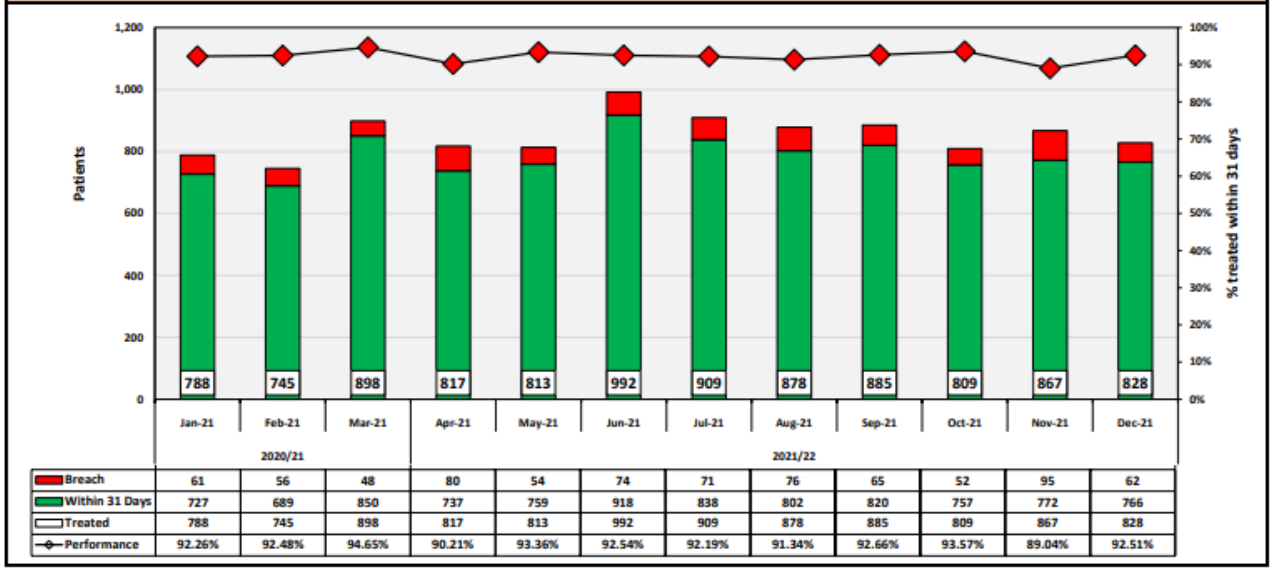
Cancer Alliance CCGs (Jan-21 to Dec-21)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	66	56	49	81	54	77	77	80	72	59	96	66
Within 31 Days	783	773	948	817	842	990	928	885	895	832	853	828
Treated	849	829	997	898	896	1,067	1,005	965	967	891	949	894
Performance	92.23%	93.24%	95.09%	90.98%	93.97%	92.78%	92.34%	91.71%	92.55%	93.38%	89.88%	92.62%

CCG	Dec-21			Jan-21 to Dec-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	56	6	89.29%	770	56	92.73%
BCCG	102	6	94.12%	1,248	72	94.23%
CSRCCG	104	11	89.42%	1,223	119	90.27%
ELCCG	155	8	94.84%	2,115	137	93.52%
FWCCG	141	10	92.91%	1,646	105	93.62%
GPCCG	101	11	89.11%	1,109	98	91.16%
MBCCG	185	12	93.51%	2,326	217	90.67%
WLCCG	50	2	96.00%	770	29	96.23%
CA CCGs	894	66	92.62%	11,207	833	92.57%

Cancer Alliance Providers (Jan-21 to Dec-21)



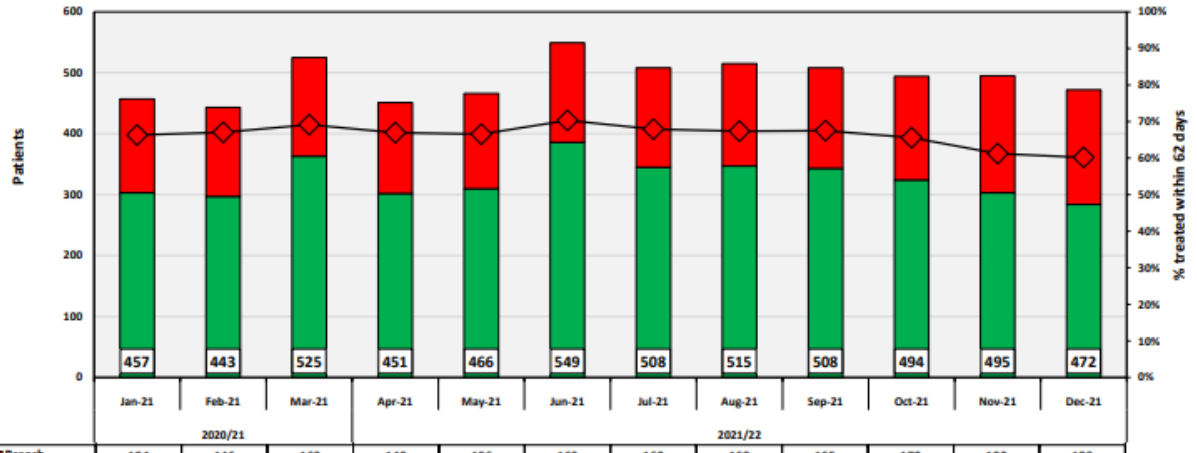
	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	61	56	48	80	54	74	71	76	65	52	95	62
Within 31 Days	727	689	850	737	759	918	838	802	820	757	772	766
Treated	788	745	898	817	813	992	909	878	885	809	867	828
Performance	92.26%	92.48%	94.65%	90.21%	93.36%	92.54%	92.19%	91.34%	92.66%	93.57%	89.04%	92.51%

Provider	Dec-21			Jan-21 to Dec-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	205	6	97.07%	2,404	53	97.80%
ELHT	166	10	93.98%	2,421	144	94.05%
LTH	302	39	87.09%	3,479	454	86.95%
UHMB	155	7	95.48%	1,925	143	92.57%
CA Providers	828	62	92.51%	10,229	794	92.24%

% 62 Day Cancer – December 21

62 Day Classic Performance (85% Standard)

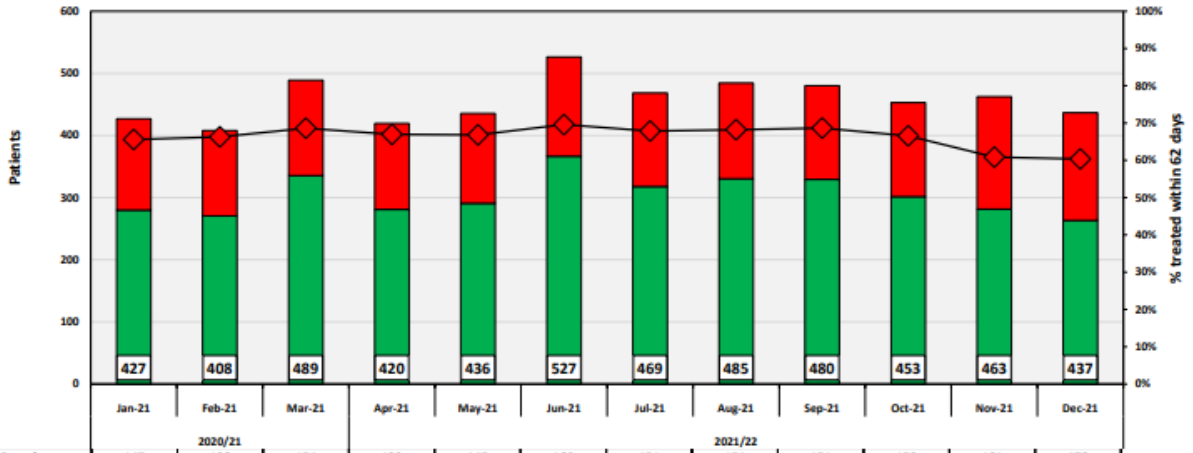
Cancer Alliance CCGs (Jan-21 to Dec-21)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	154	146	162	149	156	163	163	168	165	170	192	188
Within 62 Days	303	297	363	302	310	386	345	347	343	324	303	284
Treated	457	443	525	451	466	549	508	515	508	494	495	472
Performance	66.30%	67.04%	69.14%	66.96%	66.52%	70.31%	67.91%	67.38%	67.52%	65.59%	61.21%	60.17%

CCG	Dec-21			Jan-21 to Dec-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	21.0	6.0	71.43%	370.0	117.0	68.38%
BCCG	52.0	19.0	63.46%	638.0	201.0	68.50%
CSRCCG	55.0	25.0	54.55%	694.0	249.0	64.12%
ELCCG	77.0	34.0	55.84%	1,112.0	328.0	70.50%
FWCCG	72.0	28.0	61.11%	876.0	243.0	72.26%
GPCCG	62.0	26.0	58.06%	634.0	241.0	61.99%
MBCCG	99.0	35.0	64.65%	1,188.0	465.0	60.86%
WLCCG	34.0	15.0	55.88%	371.0	132.0	64.42%
CA CCGs	472.0	188.0	60.17%	5,883.0	1,976.0	66.41%

Cancer Alliance Providers (Jan-21 to Dec-21)



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Breach	147	138	154	139	145	160	151	154	151	152	181	173
Within 62 Days	280	271	336	281	291	367	318	331	330	302	282	264
Treated	427	408	489	420	436	527	469	485	480	453	463	437
Performance	65.57%	66.30%	68.61%	66.98%	66.82%	69.61%	67.88%	68.21%	68.65%	66.56%	60.86%	60.37%

Provider	Dec-21			Jan-21 to Dec-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	109.5	38.0	65.30%	1,348.5	358.0	73.45%
ELHT	87.5	34.0	61.14%	1,344.0	392.5	70.80%
LTH	147.0	71.5	51.36%	1,656.0	679.0	59.00%
UHMB	92.5	29.5	68.11%	1,142.0	412.0	63.92%
CA Providers	436.5	173.0	60.37%	5,490.5	1,841.5	66.46%

% 6 Week Diagnostic Waiters –December 21

ICS Level: Lancashire & South Cumbria

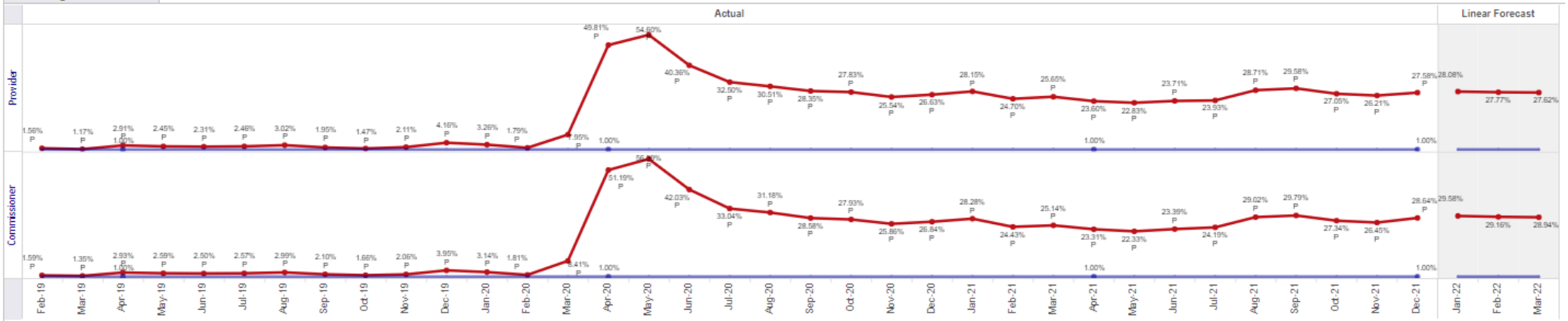
% of patients waiting 6 weeks or more for a diagnostic test

	Provider		YTD
Value	Dec-21	27.58%	25.97%
Target	Dec-21	1.00%	1.00%
Forecast	Jan-22	28.08%	25.97%

	Commissioner		YTD
Value	Dec-21	28.64%	26.52%
Target	Dec-21	1.00%	1.00%
Forecast	Jan-22	29.58%	26.52%

% Waiters 6 Wks Diagnostics

Organisation



ICS

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% Incomplete 18 weeks RTT – December 21

ICS Level: Lancashire & South Cumbria

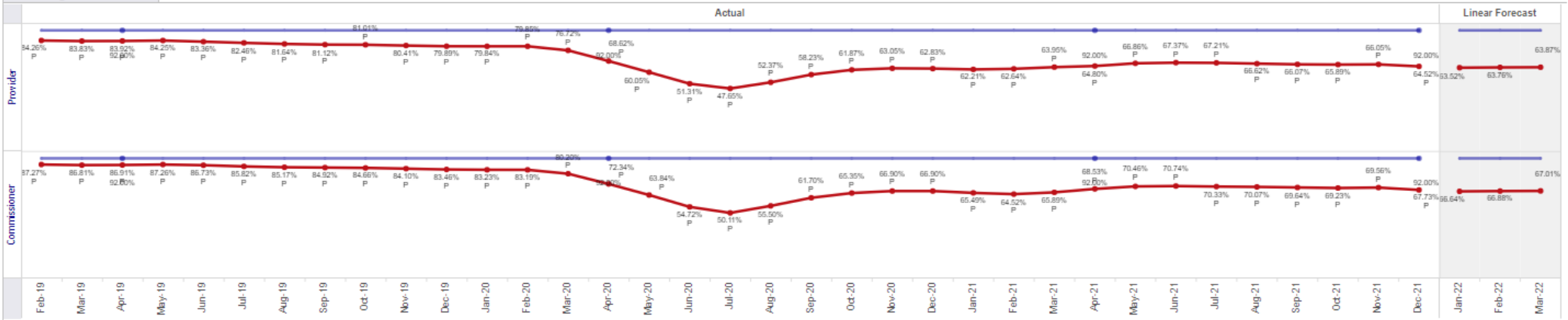
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

	Provider		YTD
Value	Dec-21	64.52%	66.14%
Target	Dec-21	92.00%	92.00%
Forecast	Jan-22	63.52%	66.14%

	Commissioner		YTD
Value	Dec-21	67.73%	69.10%
Target	Dec-21	92.00%	92.00%
Forecast	Jan-22	66.64%	69.10%

% Incomplete 18 Wks RTT

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations									
	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
		Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
Commissioner	67.73% Dec-21	70.22% Dec-21	66.49% Dec-21	51.25% Dec-21	64.52% Dec-21	71.41% Dec-21	65.12% Dec-21	77.05% Dec-21	71.98% Dec-21	72.90% Dec-21

	Lancashire & South Cumbria	Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
		Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
Provider	64.52% Dec-21	66.49% Dec-21	70.22% Dec-21	64.24% Dec-21	64.76% Dec-21	51.25% Dec-21	65.38% Dec-21	64.89% Dec-21	71.41% Dec-21	72.44% Dec-21	71.78% Dec-21	77.05% Dec-21	72.90% Dec-21

Total number of Incompletes RTT –December 21

ICS Level: Lancashire & South Cumbria

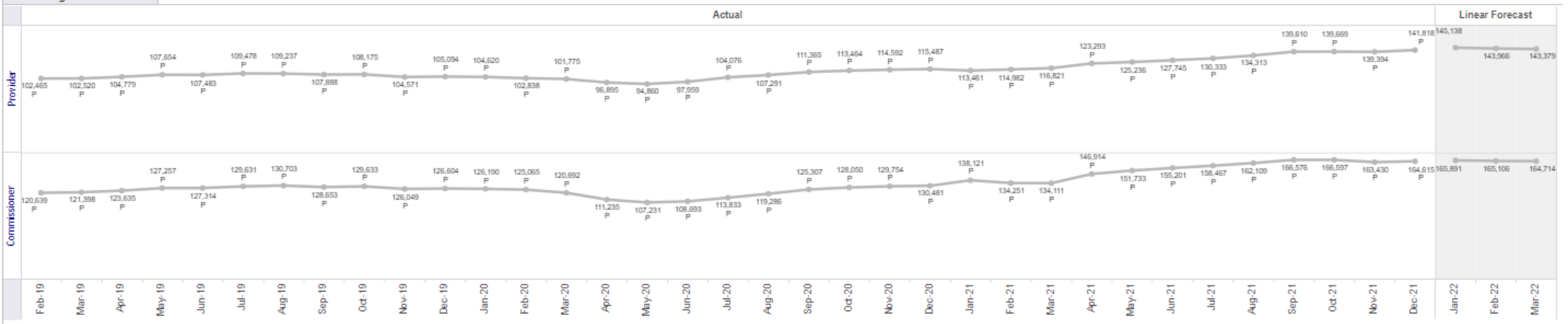
Total Number of Incompletes under and above 18 weeks RTT

	Provider	
Value	Dec-21	141,818
Target	Dec-21	
Forecast	Jan-22	145,138

	Commissioner	
Value	Dec-21	164,615
Target	Dec-21	
Forecast	Jan-22	165,891

Total no. of Incompletes RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Lancashire & South Cumbria

Commissioner: 164,615 Dec-21

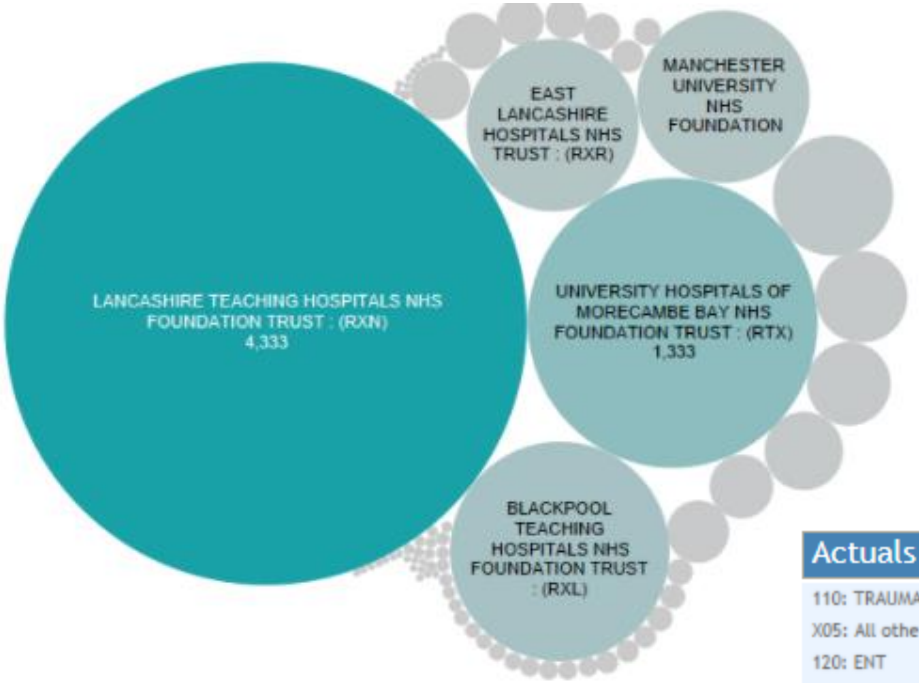
Provider: 141,818 Dec-21

Bay Health & Care Partners		Central Lancashire		Fylde Coast		Pennine Lancashire		West Lancashire
Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Provider	Commissioner	Commissioner
25,213 Dec-21	29,126 Dec-21	57,581 Dec-21	43,052 Dec-21	23,023 Dec-21	33,465 Dec-21	36,001 Dec-21	47,945 Dec-21	11,027 Dec-21

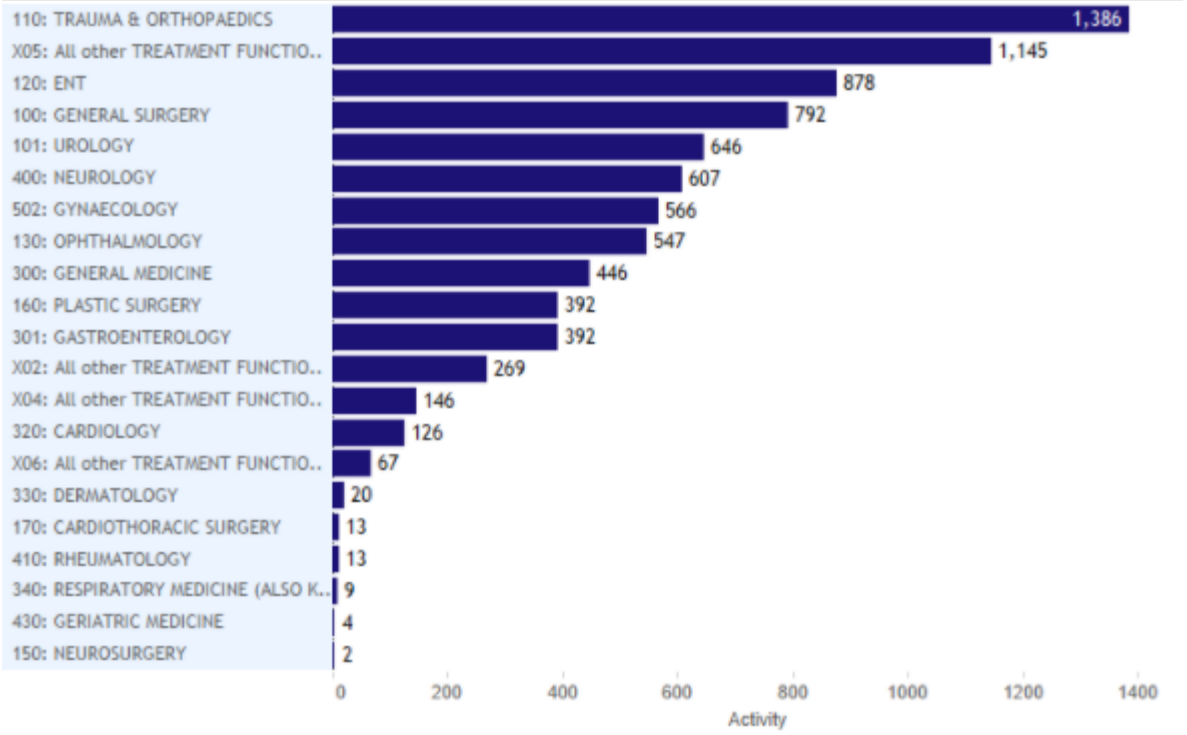
Bay Health & Care Partners		Central Lancashire			Fylde Coast			Pennine Lancashire			West Lancashire
Morecambe Bay CCG	UHMB	Chorley & South Ribble CCG	Greater Preston CCG	LTH	Blackpool CCG	Fylde & Wyre CCG	BTH	Blackburn With Darwen CCG	East Lancashire CCG	ELHT	West Lancashire CCG
29,126 Dec-21	25,213 Dec-21	19,536 Dec-21	23,516 Dec-21	57,581 Dec-21	15,781 Dec-21	17,684 Dec-21	23,023 Dec-21	14,730 Dec-21	33,215 Dec-21	36,001 Dec-21	11,027 Dec-21

Over 52 week waiters – December 21

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



Actuals by Treatment Function - Over 52 Weeks **



A&E : <4 Hour Waits % All Types – Jan-22

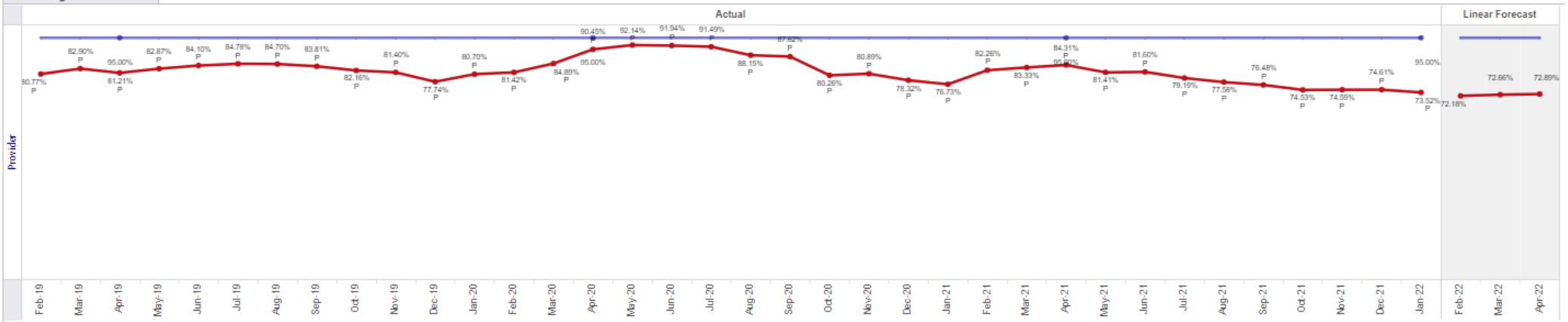
ICS Level: Lancashire & South Cumbria

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

	Provider		YTD
Value	Jan-22	73.52%	77.82%
Target	Jan-22	95.00%	95.00%
Forecast	Feb-22	72.18%	77.82%

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

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Provider

Lancashire & South Cumbria

73.52% Jan-22

Bay Health & Care Partners
Provider

72.50% Jan-22

Central Lancashire
Provider

74.70% Jan-22

Fylde Coast
Provider

78.18% Jan-22

Pennine Lancashire
Provider

68.48% Jan-22

Bay Health & Care Partners
UHMB

72.50% Jan-22

Central Lancashire
LTH

74.70% Jan-22

Fylde Coast
BTH

78.18% Jan-22

Pennine Lancashire
ELHT

68.48% Jan-22

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	10 March 2022
Title of paper	Lancashire and South Cumbria Medicines Management Group (LSCMMG) Commissioning Policy Positions – January-February 2022
Presented by	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU
Author	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU
Agenda item	**10**
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: - *Bevespi Aerosphere 7.2 µg/5 micrograms pressurised inhalation, suspension (glycopyrronium bromide/formoterol fumarate dihydrate) as a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD).* - *Trixeo Aerosphere 5µg /7.2µg /160µg pressurised inhalation, suspension (formoterol fumarate dihydrate/ glycopyrronium bromide/ budesonide), as a maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist* - *NICE Technology Appraisals (December 2021-January 2022).*

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 Medicines Management Group (LSCMMG)
Commissioning Policy Positions

January-February 2022

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:

- *Bevespi Aerosphere 7.2 µg/5 micrograms pressurised inhalation, suspension (glycopyrronium bromide/formoterol fumarate dihydrate) as a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD).*
- *Trixeo Aerosphere 5µg /7.2µg /160µg pressurised inhalation, suspension (formoterol fumarate dihydrate/ glycopyrronium bromide/ budesonide), as a maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist*
- *NICE Technology Appraisals (December 2021-January 2022).*

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:

- *Bevespi Aerosphere 7.2 µg/5 micrograms pressurised inhalation, suspension (glycopyrronium bromide/formoterol fumarate dihydrate) as a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD).*

Bevespi NMR SCC.docx

- *Trixeo Aerosphere 5µg /7.2µg /160µg pressurised inhalation, suspension (formoterol fumarate dihydrate/ glycopyrronium bromide/ budesonide), as a maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist*

  Trixeo NMR SCC.docx

- *NICE Technology Appraisals (December 2021-January 2022).* 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

Bevespi Aerosphere 7.2 µg/5 micrograms pressurised inhalation, suspension (glycopyrronium bromide/formoterol fumarate dihydrate) as a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD).

2.1 Bevespi Aerosphere was prioritised for review following identification during the horizon scanning process.

2.2 Public and patient engagement was not included in the review process for Bevespi Aerosphere as the inhaler is being offered as an additional treatment (device) option for the management of COPD.

2.3 LSCMMG members agreed a Green RAG rating for Bevespi Aerosphere. Bevespi Aerosphere may therefore be initiated and prescribed in both primary and secondary care, however the LSCMMG agreed this RAG rating on the condition that Bevespi Aerosphere's place in therapy is defined within updated LSCMMG COPD guidelines.

2.4 No additional costs are anticipated from the prescribing of Bevespi Aerosphere. The device is available at the same cost as comparable inhaler devices. However, Bevespi Aerosphere is an aerosol inhaler creating a higher carbon footprint than non-aerosol alternatives. Bevespi Aerosphere is therefore recommended as an option once inhalers with lower carbon footprints have been considered.

Trixeo Aerosphere 5µg /7.2µg /160µg pressurised inhalation, suspension (formoterol fumarate dihydrate/ glycopyrronium bromide/ budesonide), as a maintenance treatment in adult patients with moderate to severe

chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist

2.5 Trixeo Aerosphere was prioritised for review following identification during the horizon scanning process.

2.6 Public and patient engagement was not included in the review process for Trixeo Aerosphere as the inhaler is being offered as an additional treatment (device) option for the management of COPD.

2.7 LSCMMG members agreed a Green (Restricted) RAG rating for Trixeo Aerosphere. Trixeo Aerosphere may therefore be initiated and prescribed in both primary and secondary care on the condition that triple therapy is reserved for patients who have failed to achieve or maintain an adequate response to an appropriate course of dual therapy.

2.8 Similarly to Bevespi Aerosphere, the LSCMMG agreed the RAG rating for Trixeo Aerosphere on the condition that the place in therapy is defined within updated LSCMMG COPD guidelines.

2.9 Like Bevespi Aerosphere, no additional costs are anticipated from the prescribing of Trixeo Aerosphere. The device is available at the same cost as comparable inhaler devices. Trixeo Aerosphere is an aerosol inhaler which will create a higher carbon footprint than non-aerosol alternatives. Trixeo Aerosphere is therefore recommended as a treatment option once inhalers with lower carbon footprints have been considered.

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

NICE Technology Appraisals (December 2021-January 2021).

3.1 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.

3.2 Three CCG commissioned NICE TAs were identified **Solriamfetol** for treating excessive daytime sleepiness caused by narcolepsy (TA758); **Cenobamate** for treating focal onset seizures in epilepsy (TA753); and **Sodium zirconium cyclosilicate** for treating hyperkalaemia (TA599 – updated guidance).

3.2..1 NICE do not expect the TA guidance for **Solriamfetol** and **Cenobamate** to have a significant impact on resources; that is, the resource impact of implementing the recommendations for each medicine 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 **Solriamfetol** and **Cenobamate** are further treatment options, and the overall cost of treatments will be similar. The

positioning of **Solriamfetol** within the current treatment pathway for narcolepsy will be made clear by the LSCMMG.

3.2..2 The updated NICE TA recommendations for **Sodium zirconium cyclosilicate** are not likely to create a financial impact for Lancashire and South Cumbria. This is because the guidance has only been altered to acknowledge that **Sodium zirconium cyclosilicate** is available in both primary and secondary care.

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

N/A

5. CONCLUSION

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

- *Bevespi Aerosphere 7.2 µg/5 micrograms pressurised inhalation, suspension (glycopyrronium bromide/formoterol fumarate dihydrate) as a maintenance bronchodilator treatment to relieve symptoms in adult patients with chronic obstructive pulmonary disease (COPD).*
- *Trixeo Aerosphere 5µg /7.2µg /160µg pressurised inhalation, suspension (formoterol fumarate dihydrate/ glycopyrronium bromide/ budesonide), as a maintenance treatment in adult patients with moderate to severe chronic obstructive pulmonary disease (COPD) who are not adequately treated by a combination of an inhaled corticosteroid and a long-acting beta2-agonist or combination of a long-acting beta2-agonist and a long-acting muscarinic antagonist*
- *NICE Technology Appraisals (December 2021-January 2022).*

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	10 March 2022
Title of paper	Development of Lancashire & South Cumbria Clinical Commissioning Policies – **Sacral Neuromodulation Policy**
Presented by	**Brent Horrell** Chair of Lancashire & South Cumbria CPDIG, and MLCSU Medicines Optimisation Lead
Author	**Julie Hotchkiss FFPH**, Consultant in Public Health, Midlands & Lancashire Commissioning Support Unit
Agenda item	11
Confidential	No

Purpose of the paper
To inform the SCC of the outcome of the review of the policy for **Sacral Neuromodulation** undertaken by the L&SC CPDIG and to assure the SCC of the process taken.
Executive summary
The Policy for Sacral Neuromodulation was drafted by CPDIG as a NEW Policy, developed in response to increasing IFR activity. The Policy was prepared for adoption across Lancashire and South Cumbria. This paper sets out the development process and includes the final recommended Policy for consideration.
Recommendations
That the SCC ratify the Lancashire and South Cumbria Policy for Sacral Neuromodulation.

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

Meeting	**Date**	**Outcomes**
CPDIG	17/02/2022	Approved and recommended for submission to SCC

Evidencing Due Regard / Legal and mandated compliance

Assessment complete?	**YES**	**NO**	**N/A**	**Potential risk/s identified?**	**Mitigating actions**
Equality Impact Assessment	✓			• No current equality risks identified • Query in previous EIRA regarding age criteria - children and <18	Review/monitor activity following implementation to identify any potential equality risks arising
Quality impact assessment completed					

Privacy impact assessment completed					
Financial impact assessment completed					

Conflicts of interest identified
None

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Associated risks				
Are associated risks detailed on the ICS Risk Register?				

Report authorised by:	

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: Sacral Neuromodulation

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. Sacral Neuromodulation Treatment Policy

3.1 This is a new policy that has been developed in response to the high number of IFR requests received for this procedure.

3.2 The evidence review found that the seven procedures that fall within the term Sacral Neuromodulation are high cost and have a high failure rate when not targeted to treat the specific conditions where there is evidence of effectiveness.

3.3 The use of Sacral Neuromodulation in the treatment of urinary and faecal incontinence is funded by NHSE and is therefore outside of the scope of this policy.

3.4 The policy approves the commissioning of Sacral Neuromodulation where specified criteria have been met and makes clear that the procedure is not routinely commissioned where the specified criteria are not met

3.6 Clinical Engagement concluded on 1 July 2021 with no objections or amendment requests received.

3.7 Public Engagement concluded on 19 November 2021. No responses were received.

3.8 An Equalities Risk Assessment – (Stage 2) was completed which identified the need to clarify the position regarding the treatment of children. Further consultation and investigation found that treatment for Children was funded by NHSE. The Policy was amended to apply to patients from 19 years of age.

3.9 Following completion of all development stages CPDIG gave approval for the policy to proceed to SCC for ratification on 17 February 2022

4.0 Conclusion

The SCC are asked to ratify the following collaborative commissioning policy:
Sacral Neuromodulation

Brent Horrell, Chair of the CPDIG
01.03.22

Document control: Sacral Neuromodulation Policy		
	Version Number:	**Changes Made:**
Version of: 19 February 2020	V0.1	First draft policy completed.
Version of: 20 May 2021	V0.2	Added criteria 1.1.3 - “for a permanent device, that a satisfactory trial with a non-permanent device has been completed”
Version of September 2021	V0.3	Added that scope is adults aged 19 and over (section 2.9) and reordered title to Sacral Neuromodulation Policy from Policy for Sacral Neuromodulation. OPCS Codes added.

Lancashire and South Cumbria Health and Care Partnership

Lancashire and South Cumbria CCGs

Policies for the Commissioning of Healthcare

Sacral Neuromodulation Policy

	Introduction
	This document is part of a suite of policies that the CCG uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
1	**Policy**
1.1	The CCG will only commission sacral neuromodulation (SNM) when the following criteria are satisfied:
1.1.1	• The patient has idiopathic chronic non-obstructive urinary retention
	AND
1.1.2	• the treatment is being carried out in a specialist unit by a clinical team who are experienced in the assessment, treatment and long-term care of patients with bladder dysfunction, and in the use of sacral neuromodulation
	AND
1.1.3	• for a permanent device, that a satisfactory trial with a non-permanent device has been completed
1.2	The CCG will not routinely commission the use of SNM for constipation, or any other pelvic condition, as it considers the use of this indication does not accord with the Principles of Effectiveness and Cost-Effectiveness.
2	**Scope and definitions**
2.1	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2.2	Sacral neuromodulation (SNM) also known as Sacral neurostimulation, Sacral nerve stimulation and Sacral nerve modulation, is a two-stage surgical intervention used for a number of conditions relating to function and symptoms in the pelvic area, particularly urinary incontinence (specified types), faecal incontinence (specific types), urinary retention, constipation, and pelvic pain due to e.g. interstitial cystitis, endometriosis, chronic anorectal pain. It involves applying an electric current to one of the sacral nerves via an electrode placed through the sacral foramen during an operative procedure. The electrode leads are attached to an implantable pulse generator, which stimulates nerves

	associated with the lower urinary tract or bowel. A trial with a non-permanent device is usually conducted, for 3 days to 4 weeks depending on device and protocol, and if positive results are found, a permanent device is fitted.
2.3	The scope of this policy includes sacral neuromodulation for urinary retention, constipation, and pelvic pain.
2.4	The scope of this policy does not include SNM for faecal incontinence and SNM for urge incontinence and urgency-frequency, as these are commissioned by NHS England.
2.5	The CCG recognises that a patient may have certain features, such as • having refractory constipation, or pelvic pain; • wishing to have a service provided for their refractory constipation, or pelvic pain; • being advised that they are clinically suitable for sacral neuromodulation and • be distressed by their refractory constipation, or pelvic pain, and by the fact that that they may not meet the criteria specified in this commissioning policy. Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.
2.6	For the purpose of this policy the CCG defines refractory as persisting despite trying a number or combination of pharmacological therapies at sufficient doses for sufficient time and when the patient is measurably disabled by the condition.
2.7	This policy reflects NICE Guidance IPG536 Sacral nerve stimulation for idiopathic chronic non-obstructive urinary retention[1].
2.8	This policy applies to adults aged 19 and over.
3	**Appropriate Healthcare**
3.1	The purpose of using sacral neuromodulation is to reduce the symptoms experienced; urinary retention, constipation, or pelvic pain.
3.2	The CCG regards the achievement of this purpose as according with the Principle of Appropriateness. Therefore, this policy does not rely on the Principle of Appropriateness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider the principle of appropriateness in the particular circumstances of the patient in question when considering an application to provide funding.

4	**Effective Healthcare**
4.1	The policy criteria relating to the use sacral neuromodulation relies on the Principle of Effectiveness as the CCG considers there is insufficient evidence to demonstrate it is effective in reducing the symptoms of constipation, pelvic pain or urinary retention (with the exception of idiopathic chronic non-obstructive retention) including neurogenic bladder or obstruction (not an exhaustive list).
5	**Cost Effectiveness**
5.1	The policy criteria relating to the use of sacral neuromodulation for the management of constipation, pelvic pain or urinary retention due to any other cause relies on the Principles of Cost-Effectiveness. Nevertheless if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the purpose of the treatment is likely to be achieved in this patient without undue adverse effects when considering an application to provide funding.
6	**Ethics**
6.1	The CCG does not call into question the ethics of sacral neuromodulation for the management of refractory constipation, pelvic pain or urinary retention due to any other cause and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient when considering an application to provide funding.
7	**Affordability**
7.1	The CCG does not call into question the affordability of sacral neuromodulation therefore this policy does not rely on the Principle of Affordability. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient when considering an application to provide funding.
8	**Exceptions**
8.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
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. Sacral nerve stimulation for idiopathic chronic non-obstructive urinary retention. Interventional procedures guidance [IPG 536]. Published 2015. www.nice.org.uk/guidance/ipg536

Appendix 1 OPCS Codes

OPCS Codes	Procedure
A70	Neurostimulation of peripheral nerve
A701	Implantation of peripheral nerve neurostimulator
A702	Maintenance of peripheral nerve neurostimulator
A703	Removal of peripheral nerve neurostimulator
A704	Insertion of neurostimulator electrodes adjacent to peripheral nerve
	Anatomical code
Z111	Sacral nerve

Date of adoption: 10 March 2022
Date for review: January 2025

Strategic Commissioning Committee

Date of meeting	**10th March 2022**
Title of paper	**Update Report from the CCG Transition Board**
Presented by	**Andrew Bennett, Executive Director of Commissioning, LSC ICS**
Author	**Dawn Haworth, Senior Programme Manager**
Agenda item	**12**
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. The February meeting of the CCG Transition Board focussed on the following areas which are summarised in the attached highlight report: 1. CCG Transition – sender and receiver update 2. HR and OD Workstream Update 3. Communications and Engagement CCG TB also considered a paper setting out proposed shadow IBC arrangements and received a verbal update on work to develop Clinical and Care Professional Leadership proposals. In addition, CCG TB noted that two risks had a post-mitigation scores of 16. These relate to delays in identification of a single ESR and payroll provider (R0032) staffing capacity to effectively complete the CCG closedown and transition (R0055). It was considered that Risk 0055 had now become an issue and the group agreed to amend the risk and issues log accordingly.
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 for SCC

Lancashire and South Cumbria Health and Care Partnership

High Level Summary Table

ROS Ref	Description	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
3	**System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place**	Debra Atkinson	On target - No concerns	On target for delivery by July 2022
12	**Transition from CCGs to ICBs: Equalities duties complied with, due diligence of people and property complete, consultation completed in line with TUPE requirements / COSoP guidance, staffing and property lists prepared and first day arrangements confirmed**	Adam Burgess Evans, Carl Ashworth, Helen Curtis	On target - No concerns	On target for delivery by July 2022
12.1	**Equalities duties**	Adam Burgess Evans	On target - No concerns	On target for delivery by July 2022
12.2	**People transfer**	Adam Burgess Evans	On target - No concerns	On target for delivery by July 2022
12.3	**Property transfer**	Helen Curtis	On target - No concerns	On target for delivery by July 2022
12.4	**First day arrangements**	Carl Ashworth, Debra Atkinson	On target - No concerns	On target for delivery by July 2022
N/A	**Ensure effective communication and engagement with all stakeholders, including those staff who are affected by the transition of activities associated with the closedown of CCGs**	Neil Greaves	On target - No concerns	Not Applicable

Detailed Updates

ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
3	**System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place**	ICB Draft constitution submitted and positive feedback received. Awaiting clarification of revised timeline for final submission	18/03/22	Debra Atkinson	On target - No concerns	On target for delivery by July 2022
3.6	ICB functions and decision map prepared and ready to be adopted on 1 July 2022 - 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	Place-based governance arrangements agreed. Work commenced in conjunction with design of Committees of the ICB and functions and decisions map Working with Primary Care Commissioners, Delta 7 and thiNKnow to develop publisc-facing version. Hosting national webinar on process / outputs in Fnbruary 2022.	18/03/22	Gary Raphael	On target - No concerns	On target for delivery by July 2022
	Proposals for operating model for those functions associated with transitional commissioning arrangements and/or that can accelerate new ways of working	Proposals for operating models nearing completion by functional leads. PBPs have considered functional operating models from a Place perspective. These two approaches now need to be aligned through a check and challenge approach during Q4 of 21/22	30/09/21	Gary Raphael	Not on Target - Significant concerns	Not Applicable
	Develop, agree and implement transitional functional allocation of resources	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. 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 December 2021 due to ongoing delays related to data sharing agreements.	31/03/22	Gary Raphael	Not on Target - Significant concerns	Not Applicable
	CCG teams only operating at sub-system level where LSC plans to establish a significant place-based function at that footprint (as described in 1.b.)	Some teams have moved to a system/place model of working, but there are a number if functions/teams still operating within CCGs. This is linked to local requirements within CCGs, delays in the completion of Data Sharing Agreements and therefore delays in reviewing current resources available across the system, and operational demands linked to the ongoing pandemic response. The ICB Design Group (meeting fortnightly) is now reviewing proposals for new ways of working, especially during the transitional period from now to 1st July 2022.	31/12/21	Gary Raphael	Not on Target - Significant concerns	Not Applicable

DETAILED UPDATES						
ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
12	**Transition from CCGs to ICBs: Equalities duties complied with, due diligence of people and property complete, consultation completed in line with TUPE requirements / COSoP guidance, staffing and property lists prepared and first day arrangements confirmed**	Due to be completed on time	18/03/22	Adam Burgess Evans, Carl Ashworth, Helen Curtis	On target - No concerns	On target for delivery by July 2022
	Written assurance from CCG AOs to ICB designate CEs that due diligence processes have been completed	Due to be completed on time	11/03/22	Helen Curtis	On target - No concerns	On target for delivery by July 2022

DETAILED UPDATES						
ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
12.1	**Equalities duties**	Work programme led by ICS Transformation Lead to develop EDI strategy and approach	18/03/22	Adam Burgess Evans	On target - No concerns	On target for delivery by July 2022
12.1.1	Evidence of compliance with the Public Sector Equalities Duty, and wider equalities duties, in the transfer and establishment process	PIA / EHIA template HR framework now published.	18/03/22	Adam Burgess Evans	On target - No concerns	On target for delivery by July 2022

DETAILED UPDATES						
ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
12.2	**People transfer**	Consultation planning ongoing with preparation of ELI for transfer. Receiver development with regard to accepting staff ongoing To be delayed to April in line with ROS udpate	31/03/22	Adam Burgess Evans	On target - No concerns	On target for delivery by July 2022
12.2.1	Consultation completed in line with TUPE requirements / COSoP guidance and staff list shared by sending CCG(s) to receiving ICB(s) (designate Chief Executive) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])	Part of CCG Transition workstream and DD checklist - assurance received via CCG Transition Board that activities associated with this are on track	28/02/22	Adam Burgess Evans	Progress made - Minor concerns	On target for delivery by July 2022
	Employer consultation with staff started in line with TUPE requirements / COSoP guidance (as outlined in the HR Framework) - to be led by designate appointees for the ICB	Planning with regard to this is on track	17/01/22	Adam Burgess Evans	On target - No concerns	Not Applicable
12.2.2	CCG(s) staff due diligence completed and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD) - in line with relevant guidance (HR Framework and Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])	Part of CCG Transition workstream and DD checklist - assurance received via CCG Transition Board that activities associated with this are on track	03/03/22	Helen Curtis	Progress made - Minor concerns	On target for delivery by July 2022

DETAILED UPDATES						
ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
12.3	**Property transfer**		31/03/22	Helen Curtis	On target - No concerns	On target for delivery by July 2022
12.3.1	CCG(s) due diligence completed on all property (assets and liabilities, including contracts e.g. with CSUs) in line with guidance; and written assurance provided by the CCG's AO to the ICB's designate CE, with a copy to NHSEI's RD (where the AO and CE are the same person the written assurance should be provided to the NHSEI RD). List of property and liabilities from sending CCG(s) to receiving ICB(s) produced - in line with relevant guidance (Due Diligence Guidance [tab 2.2 of the Due Diligence Checklist])	Part of CCG Transition workstream and DD checklist - assurance received via CCG Transition Board that activities associated with this are on track. Due to be completed on time	31/03/22	Helen Curtis	On target - No concerns	On target for delivery by July 2022

DETAILED UPDATES

ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
12.4	**First day arrangements**		18/03/22	Carl Ashworth, Debra Atkinson	On target - No concerns	On target for delivery by July 2022
	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)	Not yet due	01/04/22	Debra Atkinson	On target - No concerns	Not Applicable
12.4.1	Appropriate arrangements 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)	Part of CCG Transition workstream and DD checklist - assurance received via CCG Transition Board that activities associated with this are on track	18/03/22	Carl Ashworth	Progress made - Minor concerns	On target for delivery by July 2022
12.4.2	First ICB Board meeting to note / approve (as appropriate): Constitution, governance handbook, appointments, key strategies, policies and delegation arrangements (covering both joint commissioning and formal delegations)	First ICB Board meeting intended for 1 July 2022.	01/04/22	Debra Atkinson	On target - No concerns	On target for delivery by July 2022
12.4.3	First day communications plan in place	Plan for development in place. Checklist agreed by regional NHSE team and being worked through locally.	28/02/22	Neil Greaves	On target - No concerns	On target for delivery by July 2022
	Branding and identity guidelines agreed and shared ahead of 22/23	Plan for development has been developed and being actioned by Communications and Engagement colleagues.	31/03/22	Neil Greaves	On target - No concerns	Not Applicable
12.4.4	ICB website in place	Plan for development has been agreed with CE colleagues which is to utilise the ICS website and develop a microsite within which will be branded within national guidelines which is efficient and low cost. There will be a review of this with a view to establishing an ICB website in the future. Awaiting further national guidance in relation to required content on the site. .	31/03/22	Neil Greaves	On target - No concerns	On target for delivery by July 2022

DETAILED UPDATES						
ROS Ref	Description	Update	Finish Date	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
N/A	**Ensure effective communication and engagement with all stakeholders, including those staff who are affected by the transition of activities associated with the closedown of CCGs**	Ongoing focus of ensuring open and transparent communications to staff most affected by the development of the ICB, a further series of colleague briefings took place in January to update on the establishment timeline extension in addition to regular communications internally.	31/03/22	Neil Greaves	On target - No concerns	Not Applicable
	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	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. Shared with leaders and staff. Work has commenced to develop a strategic narrative and supporting materials to support Provider Collaboration and build greater awareness and involvement of NHS Trust Board members and staff. This is being developed with involvement of a wide range of Provider Collaboration Board members and partners across the system.	31/03/22	Neil Greaves	On target - No concerns	Not Applicable
	Co ordinate 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	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	Neil Greaves	On target - No concerns	Not Applicable
	Oversight, planning and direction to support communications and engagement of system reform across LSC and consistent key messages for staff, providers, partners and public	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 Colleague briefing sessions in July, September and November, with the video shared after the session and FAQ document produced/updated to respond to questions raised. More Colleague Briefings scheduled for January. Updates to the website including documents, materials, glossary, videos with leaders and case studies (Sept 2021). Survey launched in September 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. Overall the engagement for the place-based partnership survey was low, but responses received can be used to create materials suitable for internal and external audiences, including highlighting the benefits of integrated care and suggestions for case studies to show how integrated care works well. Work is ongoing to develop a strategic narrative and supporting materials to support Provider Collaboration and build greater awareness and involvement of NHS Trust Board members and staff.	31/03/22	Neil Greaves	On target - No concerns	Not Applicable
	Broader MP/political engagement to show how we have listened to feedback, fronted by LSC Independent Chair and Chief Officer	Presentation given by Andrew Bennett at the Blackburn with Darwen HOSC meeting on 6 December. Planned activity to update MPs, Councillors and wider stakeholders before end of January 2022 regarding the timeline extensions. As detail emerges in Q4 we need to keep Political stakeholders updated to a greater degree.	31/03/22	Neil Greaves	On target - No concerns	Not Applicable

Risks & Issues

Risk / Issues No.	Risk or Issue	Risk / Issue Description	Date Added	Catagory of Risk/Issue	Agreed Mitigating Actions	Residual Risk Score
R0032	Risk	Risk that the transition of key systems and services e.g. ESR/Payroll, OH provider, NHS Jobs, will be unsuccessful or significantly affected due to the timescales associated with the transition.	24/05/21	HR & OD	System arrangements for key transactional processes need to be well planned and timely. Each of these may require a procurement exercise by the new ICS organisation unless nationally mandates services/solutions are proposed. Once a supplier identified, detailed and timely technical project and transiton plans are established to manage these process and transition. It is expected that VPD/ESR would need between 3 and 6 months to transact successfully. Work is ongoing nationally with IBM (provider of ESR) - assurance required on progress. Leadership identified within ICS as a 'receiver' to take forward ESR/payroll discussions with current providers. ICS exec advised of actions required to select/procure, a provider Potential conflict of interest so propose that this is done independent to workforce lead as CSU provide some of these services . Propose that this action is move to finance workstream with input from HR to manage this. Elaine Collier now progressing ESR and Payroll discussions with legacy CCGs in order to identify single provider Single provider not yet identified - finance leads considering options. Requirement to identify single provider urgently.	16
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	Further to discussion at the Exec Meeting on 14 Dec and despite work undertaken to reduce the risk, this risk is being maintained at 16 due to escalation to level 4 and the impact of implementation on vaccination booster programme. Further discussions took place at the Exec Mtg in January - highlighting the impact of the delay of policy implementation on staff resilience and capacity. work to be undertaken as part of reconciliation to programme plan for closedown that is now impacted due to delay.	16

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	**3 March 2022**
Title of paper	**Report from the ICS Quality and Performance Sub-Committee**
Presented by	**Kathryn Lord, Director of Quality and Chief Nurse, Pennine Lancashire CCGs**
Author	**Una Atton, Executive Support Officer, Pennine Lancashire CCGs**
Agenda item	**13**
Confidential	**No**

Purpose of the paper

This report is to provide the Strategic Commissioning Committee (SCC) with the most recent business discussed at the ICS Quality and Performance Sub-Committee meeting of 3 March 2022.

Executive summary

The key points to be brought to the attention of the SCC are issues noted by the Quality and Performance Sub-Committee on the following areas:

- **Continue Pressure on Emergency Departments**
- **Workforce Sickness Absence**
- **Delays in Starting Treatment – Risk of Patient Harm**

Recommendations

The SCC is asked to:

- Note the contents of the report
- Provide comments on the issues raised.

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

Meeting	**Date**	**Outcomes**
N/A		

Conflicts of interest identified

None

Implications

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

Are associated risks detailed on the ICS Risk Register?				

Report authorised by:	Caroline Marshall, Deputy Director of Quality and Deputy Chief Nurse on behalf of Kathryn Lord, Director of Quality and Chief Nurse, Pennine Lancashire CCGs

Report from the ICS Quality and Performance Sub-Committee

1. The following common escalations were reported to Sub-Committee via the ICP Escalation Report. These issues continue to raise concerns across all ICPs:

- Significant pressures remain in Emergency Departments with increasing numbers of 12 hour breaches, in particular Physical Health breaches;
- Workforce sickness absence continues to impact on flow and capacity across the system;
- Delays in patients starting treatment and an increase in referrals for treatment continue to create a significant risk of patient harm.

2. Recommendations

2.1 The SCC is requested to:

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

Una Atton
03.03.22

Strategic Commissioning Committee

Date of meeting	**10th March 2022**
Title of paper	**Collaborative Commissioning Advisory Group (CCAG) update**
Presented by	**Peter Tinson**
Author	**Jill Truby Committee Secretary**
Agenda item	**14**
Confidential	**No**

Purpose of the paper
To provide the Strategic Commissioning Committee with a summary of the most recent business discussed at the Collaborative Commissioning Advisory Group meeting held on 8 February 2022.
Executive summary
The CCAG met on 8th February 2022 and received the following reports: • Minutes of the Primary Care Programme Board • ICB Service Specification for Looked After Children and Care leavers • ND / ASD Pathway for Lancashire and South Cumbria Children and Young People • Proposed GP Quality Contact Approach for 2022/23
Recommendations
The SCC is asked to note the report.
Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed				
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:	Peter Tinson			

Lancashire and South Cumbria
Health and Care Partnership

Collaborative Commissioning Advisory Group (CCAG) update

1. Introduction

1.1 The Collaborative Commissioning Advisory Group (CCAG) met on 8th February 2022 and received the following reports:

- Minutes of the Primary Care Programme Board
- Integrated Care Board (ICB) Service Specification for Looked After Children and Care leavers
- ND / ASD Pathway for Lancashire and South Cumbria Children and Young People
- Proposed GP Quality Contact Approach for 2022/23

2. Reports

2.1 Minutes of the Primary Care Programme Board
The minutes of the meetings of the Primary Care Programme Board held 16th November 2021 were presented for noting. The CCAG noted the minutes.

2.2 ICB Service Specification for Looked After Children and Care leavers
The Committee received a report which highlighted the need to drive forward improved health outcomes and reduce health inequalities for our looked after children. An ICB health strategy is in draft form and that is also part of the vision to improve outcomes for this cohort. This specification itself does not, at this stage, incur any financial implications, but there may be further implications for funding as we move to develop the ICB draft strategy in terms of meeting our statutory responsibilities.

CCAG was asked to consider the paper and the proposed implementation of a single service specification for the ICB and to agree next steps in terms of formal agreement and how we can implement the specification going forward.

It was agreed that there was support for the specification presented and any funding requests would be submitted via the relevant ICB process.

The CCAG:

- Supported the proposed implementation of an ICB Service Specification for the Enhanced Looked After Children Health Teams.

2.3 ND / ASD Pathway for Lancashire and South Cumbria Children and Young People

The paper provided an update on the current position, with an indication of the options available for delivery of the previously approved neuro-developmental (ND) Pathway, with the development of an ND Service.

Funding was detailed in the paper but some of the funding request is non recurrent to help fund ASD waiting list initiatives

It was suggested that the best way forward was for it to be included in the report from the meeting that goes to the SCC and any funding request submitted via the ICB operational planning process.

The CCAG agreed in principle to support the paper.

2.4 Proposed GP Quality Contact Approach for 2022/23

The Committee received a presentation on the proposed GP Quality Contract Approach for 2022/23.

Highlights of the presentation included:

General practice contracting includes:

- Core contract paid at nationally set prices
- Local enhanced services (LES) – these are for services to be delivered at locally set prices and specifications
- Quality contracts – locally defined enhancements/quality indicators delivered at locally set prices
- All five Place Based Partnerships (PBP's) across Lancashire and South Cumbria have:
- individual quality contract arrangements in place for their practices, several Local Enhancement Services (LES) – individual to them and used to commission services from general practice over and above the core contract, such as additional diabetic services
- The quality contracts in each PBP have evolved significantly since they were introduced and there are vast differences in both content and financial investment
- ICB requested:
- Develop a 1-year proposal recognising further work will be required next year
- To move towards a standardised contract across all PBPs
- Undertaken engagement via sub cell and Primary Care Programme board

It was acknowledged that there is a much bigger piece of work to do during next year and into the year after looking at those differential investments.

CCAG commended the approach.

3. Conclusion

3.1 This paper is a summary of the CCAG meeting held on 8th February 2022.

4. Recommendations

4.1 The SCC is requested to:

1. Note the contents of the report

Jill Truby
28 February 2022