Lancashire and South Cumbria Health and Care Partnership

Strategic Commissioning Committee (Formal)

Thursday, 15 July 2021, 1 pm – 3 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 SCC meeting held on 13 May 2021, matters arising and actions to agree	Chair	Approve	Attached
5.	Key Messages	Dr Amanda Doyle	Discuss	Verbal
6.	Enhanced Network Model of Acute Stroke Care – Full Business Case	Jack Smith	Approve	Attached
7.	New Hospitals Programme Case for Change	Jerry Hawker/ Rebecca Malin	Approve	Attached
8.	Quality and Performance Report	Julie Higgins	Discuss	Attached
9.	Lancashire and South Cumbria Medicines Management Group Commissioning Policy Positions	Brent Horrell	Approve	Attached
10.	Development of Lancashire and South Cumbria (LSC) Clinical Commissioning Policies	Brent Horrell	Approve	Attached
11.	Strategic Commissioning Committee Workplan 2021/22	Andrew Bennett	Approve	Attached
Reports from Sub-Committees				
12.	CCG Transition Board	Roy Fisher	Note	Attached
13.	Collaborative Commissioning Advisory Group	Andrew Bennett	Note	Attached
14.	Quality and Performance Sub-Committee	Julie Higgins	Note	Attached
Items for Information				
15.	Questions received for 13 May 2021 meeting	-	-	Attached
Any Other Business				
16.	Any Other Business	Chair	Note	Verbal

The next formal meeting of the Strategic Commissioning Committee for Lancashire and South Cumbria will be held on:-
Thursday 9 September 2021, 1 pm – 3 pm, MS Teams

Subject to ratification at the next meeting

Minutes of a Formal Meeting of the Strategic Commissioning Committee (SCC) Held on Thursday, 13 May 2021 via Microsoft Teams Videoconference

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Dr Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
Roy Fisher	Chair	NHS Blackpool CCG
Graham Burgess	Chair	NHS Blackburn and Darwen CCG
Dr Geoff Jolliffe	Clinical Chair	NHS Morecambe Bay CCG
Dr Richard Robinson	Chair	NHS East Lancashire CCG
Paul Kingan	Chief Finance Officer	NHS West Lancashire CCG
Dr Julie Higgins	Chief Officer	NHS East Lancashire CCG
Anthony Gardner	Representing Morecambe Bay Chief Officer	NHS Morecambe Bay CCG
Andrew Bennett	Executive Director of Commissioning	Lancashire and South Cumbria ICS
Gary Raphael	Executive Director of Finance & Investment	Lancashire and South Cumbria ICS
Dr Lindsey Dickinson	Clinical Chair	NHS Chorley & South Ribble CCG
Dr Sumantra Mukerji	Clinical Chair	NHS Greater Preston CCG
Dr Peter Gregory	Clinical Chair	NHS West Lancashire CCG
Denis Gizzi	Accountable Officer	NHS Chorley & South Ribble / Greater Preston CCGs
David Blacklock	Chief Executive Officer	Healthwatch Cumbria & Lancashire
Beth Goodman	Deputy Director of Commissioning	Fylde Coast CCGs
Kevin McGee	ICS Provider Collaborative Representative	Lancashire and South Cumbria ICS
Kathryn Lord	Chief Nurse Representative	Lancashire and South Cumbria ICS
Nicola Adamson	NHSE Commissioning Representative	NHS England & NHS Improvement - NW
Peter Benett	Representing Fylde and Wyre CCG Chair	NHS Fylde and Wyre CCG
Debbie Corcoran	Lay Member – Patient & Public Involvement	Lancashire and South Cumbria ICS
Clare Thomason	Representing Linda Riley, Grp Commissioning Support Representative	Midlands & Lancashire CSU
Jane Cass	NHS England Locality Director	NHS England
In Attendance		
Roger Parr	Deputy Chief Officer/Chief Finance Officer	Pennine Lancashire CCG
Brent Horrell	Head of Medicines Commissioning	Midlands and Lancashire CSU
Jerry Hawker	Executive Director and SRO – New Hospitals Programme	Lancashire and South Cumbria ICS
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Zoe Richards	Senior Programme Manager for SEND	Lancashire and South Cumbria ICS
Pam Bowling	Team Leader	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Affairs Co-ordinator (Minute Taker)	Lancashire and South Cumbria ICS
Public Attendees		
5 members of the public were present		

Routine Items of Business	
1.	**Welcome and Introduction** The Chair welcomed Committee members and members of the public, observing the meeting, to the formal meeting of the Strategic Commissioning Committee (SCC), held virtually via Microsoft Teams videoconference.

	A correction on the agenda was highlighted – Item 11, the title of the paper was incorrect and should read 'Development of Clinical Policies'. A number of written questions had been received in advance of the meeting; full written answers would be provided after the meeting. A number of questions were in regard to the New Hospitals Programme, community service development and the closing down of the CCGs. If any questions were unable to be answered, a response would be made as to when the answer could be provided with reference to a named member of staff who would provide the response. There were a number of questions around how the transition had been made from the JCCCGs to the SCC. This was in the context as in the Government's White Paper and subject to legislation would determine how governance would work in the future. As part of that the CCGs would not exist beyond 31 March 2022, the successor body would be a statutory NHS body for Lancashire and South Cumbria. The SCC would be a core committee of the ICS. Focus would be on strategic commissioning issues that would carry forward beyond March 2022. This was also an opportunity to begin to test how we could best come together and not lose sight on issues as we focus on organisational change.
2.	**Apologies for Absence** Apologies were noted from Adam Janjua, Ben Butler-Reid, Andy Curran and Linda Riley.
3.	**Declarations of Interests** **RESOLVED: No additional declarations of interest were declared.**
4.	**Minutes of the previous formal Joint Committee of Clinical Commissioning Groups (JCCCGs) meeting held on Thursday 4 March 2021, matters arising and actions** **RESOLVED: The minutes of the meeting were approved as a correct record.**
5.	**Key Messages** Amanda Doyle (AD) reported the following:- **Elective Recovery Programme -** Colleagues across the system had been working on the recovery of elective services and catch up with the backlog that had built up over the last year. Lancashire and South Cumbria had been named as an 'accelerator system' and would benefit from additional investment to enable the employment of a range of different means to reduce the waiting lists for a faster restoration. Kevin McGee and the Provider Collaborative would lead on this work. **COVID** – Rates in hospitals had continued to fall significantly. As of Tuesday, there had been no deaths across Lancashire and South Cumbria hospitals for 12 days. Occupancy of hospital beds with patients suffering from COVID remained low. Variants across Lancashire and South Cumbria were being monitored, particularly the variant from India where increasing numbers were seen in Blackburn with Darwen. Much work was being undertaken in this area around enhancing measures, testing, contact tracing, people following rules around isolation, getting tested and putting effort into targeting vaccination particularly with those hesitant to take the vaccine. Significant numbers were testing positive in the community, however, the number of people in hospital with the virus remained low. The vaccination programme was moving at pace, continuing to deliver 2nd doses as well as ongoing work with 1st doses. People over the age of 38 years were now being called. For the over 40 years of age cohort, an average of 75% had received their 1st dose vaccine.

	The Chair thanked all working on the vaccination programme which continued to be incredibly effective across the patch.
6.	**Quality and Performance Report** Roger Parr (RP) introduced the report and highlighted the following issues: - February A&E activity remained low in the report, however, numbers were now back to normal - The vaccination programme had made significant impact but data was showing that acute beds remained pressured with non-COVID admission starting to increase - The Cancer Alliance was working with stakeholders to ensure key ambitions were met; it was hoped that trajectories could be included in future reports. The key areas of risk remained to be access to diagnostics such as endoscopy and radiology, outpatient capacity for first appointments, service and workforce pressures with breast services, surgical capacity and wider workforce issues. Demand levels were continuing to increase as national social and lockdown restrictions were eased - Improved performance was seen in diagnostics - Referrals to secondary care were increasing - The national target to restore to 70% of elective activity levels in April would increase to 85% in subsequent months. February performance looked encouraging, however, more analysis was needed. Kathryn Lord (KL) reported that following discussion by the Quality and Performance Sub-Committee, an overall forward plan would be presented quarterly to the Strategic Commissioning Committee. A 'deep dive' relating to Referral To Treatment (RTT) times (for elective care) would be reported to the Committee in June. The expectation was that the sub-committee would undertake the deep dive prior to the Strategic Commissioning Committee in June, to enable a flow of information. KL highlighted the following issues: • Rates of nosocomial infections which care reviewed closely. • A pilot was being undertaken in East Lancashire Hospitals Trust around the approach to visiting patients - 7 wards were being reviewed to see the impact on infection rates when visitors were allowed. Following the pilot is was hoped that there would be evidence to demonstrate people could return to visiting, which would improve patient and staff experience. • There was a decrease in Covid outbreaks in the regulated care sector. • A revised trajectory had been set for deferred assessments for Continuing Health Care; slightly behind plan with 78 cases outstanding on 28 April. As of yesterday, 1 case was outstanding in the system. The CSU and CCGs continue to work together and the ICS workstream was fundamental to ensure the workforce was robust going forward. • Demand for CAMHS services is increasing and this is being reviewed closely. Safeguarding Deep Dive – Kathryn Lord confirmed that Designate nurses from across the system had worked together looking at key themes to provide a level of assurance about what is known. There had been an impact from COVID on safeguarding delivery and several areas of restoration were now required. There is evidence of later presentations, with an increase in child safeguarding reviews in relation to neglect. Staff had been affected, particularly on respiratory or intensive care units, where situations had been dealt with over a screen/ipad. Organisations were working to provide psychological support. Profile changes were being seen in sleep, dental decay, increased complexity around care challenges, around children and young adults on paediatric units and older adults in placements due to being unable to find areas to address needs. Experience of trauma and adverse experiences around physical health were being seen. People had worked incredibly hard and flexibly

	to ensure people can access services and to know where they could go for a service. Heads of safeguarding and professions had been working across the system with education and other providers, looking at strategic risks, profiling and mitigation strategies. It was noted that these issues needed to be addressed through close working between the NHS and Local Authorities. Members discussion included:- - Peter Gregory asked if it would be possible to be sighted on performance issues of services for patients living on the boundary of the ICS - A comparison where 3 ICS' in the North Region was received weekly through region - From a provider perspective, Kevin McGee asked if the report could be shared to the provider collaboration on a regular basis - The visiting pilot in East Lancashire was going well and an increase had not been seen in nosocomial infections or outbreaks - Further thought would be given to reporting the performance of the independent sector - Jane Cass asked if consideration could be made to include services commissioned by NHS England/Improvement e.g. breast screening, bowel cancer screening. The above points were noted and would be fed into future reports and ways of working. Andrew Bennett confirmed that the next deep dive would be on elective care, commenting it would be helpful to understand which partners were taking actions. Children's mental health and cancer would be future deep dives as they stand out in the performance report. The Chair commented that the elective care accelerator programme provided a great opportunity to increase recovery in elective care services. A lot of work was being undertaken across all organisations in addressing indicators; confidence should be taken in the ability to improve. In February 2020, there were no 52-week waiters, now there are very long waits. Significant deterioration had taken place during the pandemic; the system had shown how well organisations come together to deliver access to standards patients need.
7.	**New Hospitals Programme – Quarter 4 Update** Jerry Hawker (JH) stressed that the New Hospitals Programme was part of the wider ICS ambitions to improve hospital services, care in the community and population health, ensuring care was provided as soon as possible to ensure people are supported to stay healthier for longer periods. No decisions had been taken to date with regard to the New Hospitals Programme either in terms of facilities, services provided or locations. Open, transparent and inclusive engagement was planned with members of the public, patients and staff. Members were updated as follows:- - The previously circulated Quarter 4 update report was for the period January to March; significant events had taken place since the report had been produced - The update reflected ongoing discussions with the national team at the time of report, when it had been confirmed there would be greater flexibility in terms of the timeline to produce a strategic outline case and timing for the consultation. The ambition was to be in the best position to go to consultation as early as possible and continue to work through options available for potential to consult prior to Purdah in 2022. The decision on timing for the consultation would need to be a partnership between the ICS, NHS England and the New Hospitals Programme - The 'Big Chat', a form of engaging with staff and public, had now been launched. In the first 2 weeks since, over 3,000 members of staff engaged, sharing ambitions, ideas for the future, and

	concerns with how the programme would progress. The first staff summit had been held, with over 600 staff joining to listen about the New Hospitals Programme, sharing views and ideas - The New Hospitals Programme team is in the final stages of completing the Case for Change and formal communication and engagement strategy that would support the New Hospitals Programme. Thanks was offered to the team for preparing the documents. Following Strategic Commissioning Committee approval, the documents would be submitted to NHS England for the stage 1 assurance. It was hoped this would be completed by the end of May 2021.
8.	**Proposal for the development of the Acute Specialised Services Workplan for Lancashire and South Cumbria ICS** Nicola Adamson (NA) explained this was the first in a series of papers and discussions which start to set the scene in work that would need to be undertaken. Specialised Services included a range of services, including chemotherapy, neonatal services and artificial eye centre. Roughly, around a third of specialist services would need to be commissioned at national level, a third on the NW footprint and a third at ICS level. Subject to the legislative changes set out in the White Paper, further consideration is now being given to consider how the ICS could take on responsibility for commissioning specialised services. Lancashire and South Cumbria currently spends around £468m on specialised services and roughly about a third is spent on providers outside of Lancashire and South Cumbria. There are a number of significant transformation areas of work which include services such as paediatric critical care. Specialised service commissioners expected to work closely in future with the developing provider collaboratives and the future of clinical networks would be reviewed and how they might be organised in the future consideration of ICS'. Kevin McGee (KM) reported that providers wanted to act quickly to respond to these changes as these could bring benefits to patients and families in travel and access. Recruitment and retention would be benefitted in terms of more specialist staff. **RESOLVED: That the Committee note the update and discussions for the way forward.**
9.	**Special Educational Needs and Disabilities (SEND) – End of Year Update and Assurance** Debbie Corcoran (DC) introduced the item as a progress update on SEND across Lancashire and South Cumbria and assurance on the the accelerated progress plan (APP) for SEND across Lancashire. Zoe Richards (ZR) explained that an action and plan continued to be implemented to respond to the recent SEND inspections. In Lancashire, 54% of actions have been delivered, 23% are ongoing and on target, 24% behind due to COVID/contracting issues. External assurance was available from DFE. DFE and NHS England recently undertook a monitoring visit, the outcomes of which would be confirmed in a formal letter. Partners found the visit to be positive with good feedback on progress being made. A monthly meeting was being held to review progress, ensuring support and challenge. 3 areas of risks had been flagged: • around engagement with adult services during transition. Whilst there had been improvement in children's services, transition from child to adult remained a challenge • commissioning gaps impacting on young people and SEND. • underpinning work in areas of work that require improvement; a complicated picture with different systems and providers.

	RESOLVED: That the Committee:- - **Noted the position for each local authority area in relation to SEND inspections** - **Noted the progress with the improvement areas** - **Noted and continued to support the priorities for delivery under the Accelerated Progress Plan for Lancashire** - **Noted the risks associated with the SEND priorities.**
10.	**Collaborative Commissioning Advisory Group – Terms of Reference (ToR)** Denis Gizzi (DG) reported that a session had been held with local authority colleagues for their views on revised terms of reference. Local authority colleagues had confirmed they would not be formal members of this group as there were other venues to conduct joint business with the NHS; however, they welcomed an open invitation to discuss specific matters. A Chair for the group was being sought. **RESOLVED: That the Strategic Commissioning Committee approve the Collaborative Commissioning Advisory Group draft Terms of Reference.**
11.	**Development of Lancashire and South Cumbria Medicines Management Group Recommendations – Clinical Policy Updates** Brent Horrell (BH) described the 3 policies that had been developed throughout March and April 2021. Glucose monitoring had been discussed by the JCCCGs at their March meeting and a policy development group had recently re-started after being paused for most of 2020. 1) gammaCore – A new policy for non-invasive nerve stimulation for the management of cluster headaches and migraines. Internationally this was being used in a number of areas. The policy defines its use in cluster headaches, exclusively in the North West in tertiary at the Walton Centre. The policy had been drafted with engagement from the Walton Centre, also being aligned with NICE guidelines. 2) Spinal Injections and Radiofrequency Denervation in low back pain. This was a revised policy, first in place in 2018, and had been amended due to criteria that did not fully align with NICE guidelines. Previously the policy allowed repeat frequency for radio frequency for 6 months, this had now been removed and repeat frequency denervation was not recommended. The policy had been considered against latest evidence- based interventions and aligned with NICE guidance. 3) Waiver of a condition with the Cosmetics Surgery Policy for blepharoplasty and brow lift surgery – The request came from an ocular plastic surgeon regarding the cosmetics policy, around blepharoplasty to support the current way services were running with getting services back up to full capacity. A minor change had been asked for in the wording so that patients do not need to be brought in for an assessment if not clinically appropriate. **RESOLVED: The Committee noted the content and approved the three policies listed above.**
12.	**Any Other Business** There was no other business.
Next Formal Meeting of the Strategic Commissioning Committee for Lancashire and South Cumbria:- Thursday 15 July 2021, 1 pm – 3 pm, MS Teams	

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	**15th July 2021**
Title of paper	Enhanced Network Model of Acute Stroke Care – Full Business Case
Presented by	Jack Smith – Director, L&SC Integrated Stroke & Neurorehabilitation Delivery Network (ISNDN) programme
Author	Jack Smith – Director, L&SC Integrated Stroke & Neurorehabilitation Delivery Network (ISNDN) programme
Contributors	Dr Amanda Doyle – L&SC ICS Chief Executive Andrew Bennett – L&SC ICS Commissioning Lead Gary Raphael – Chair, L&SC ICS Finance Advisory Committee Elaine Day – L&SC ISNDN Manager; Aaron Cummins – Chair, L&SC ISNDN Board Dr Deb Lowe – National Clinical Lead for Stroke Cath Curley – L&SC ISNDN Clinical Director Dr Andy Curran – L&SC ICS Medical Director Katherine Disley – Finance & Contracting Lead, Chorley and South Ribble NHS CCG and Greater Preston NHS CCG Fiona Ball – L&SC HEE Workforce Lead Phil Woodford – Chair, L&SC ISNDN Stroke Patient and Carer Assurance Group Gareth Jones – Senior Finance Lead NHS England and Improvement Hilary Fordham – Commissioner, Morecambe Bay CCG
Agenda item	**6**

Purpose of the paper
For decision
Executive summary
The Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) has undertaken a significant amount of development work to ensure that local stroke services comply with national best practice and deliver high quality outcomes for residents. This work has led to the creation of a business case which contains proposals to enhance the model of acute stroke care and rehabilitation in L&SC. The full business case inclusive is attached. A presentation by members of the L&SC ISNDN will take place at the meeting in public. The total additional recurring revenue cost to Commissioning for delivery of the enhanced model of care is £13.8 million. The additional capital expenditure required is £5.7 million. A phased investment plan over the next 3 years is proposed, correlating with the time required to develop the additional stroke specialist workforce for delivery.

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Further public engagement is recommended this year in advance of the planned operational changes to patient pathways for Morecambe Bay residents expected by 2023.

Recommendations

1) Approve the revenue and capital funding requirement

2) To instruct the ISNDN Board to take responsibility for implementation delivery under the assurance oversight of the L&SC Provider Collaborative Board

3) Approve the communication and engagement plan including further public engagement about the changes proposed to patient pathways.

Next Steps

The L&SC Provider Collaborative Board to provide quarterly updates to SCC on the progress of implementation over the 3 year implementation period.

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**
Equality impact assessment completed	x			
Financial implications	x			
Associated risks	x			

Report authorised by:	

Enhanced Network Model of Acute Stroke Care and Rehabilitation in Lancashire & South Cumbria

Full Business Case

July 2021

Version 1.0

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Document information	
Document title	Enhanced Network Model of Acute Stroke Care in Lancashire and South Cumbria - Full Business Case
Owner	Aaron Cummins – Chair of the Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network and Chief Executive of the University Hospitals of Morecambe Bay NHS Foundation Trust
Author	Jack Smith – Director of the Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN), Lancashire & South Cumbria Integrated Care System

Version	Editor	Changes made	Date
0.1	Jack Smith	1st draft	07.01.21
0.2	Elaine Day	Activity data and modelling update	03.06.21
0.3	Gareth Jones	Economic Case update	28.06.21
0.4	Katherine Disley	Financial Case update	05.07.21
0.5	Sharon Walkden	Management Case update	05.07.21
1.0	Jack Smith	Full case update	07.07.21

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Executive Summary

Reducing mortality and dependency due to disability after stroke remains a key strategic priority for the Lancashire and South Cumbria (L&SC) health and care economy in 2021. The shared vision of all stakeholders in our system, inclusive of stroke survivors, is to deliver sustainable and equitable acute stroke care to benefit close to 6,000 people across Lancashire and South Cumbria who attend the hospital emergency department with suspected stroke symptoms each year.

Although marginal gains have been made in recent years through increasing collaboration and knowledge sharing between system providers, only two out of five acute stroke services in our system are achieving a 'B' rating on the Sentinel Stroke National Audit Programme (SSNAP) for their local population only. This demonstrates an unwarranted variation and inequitable access to best-practice stroke care for the population.

As a system we are currently providing life-saving treatments including thrombolysis (clot busting intervention) and mechanical thrombectomy (clot retrieval intervention) at rates less than the national average and well below the national ambition laid out in the NHS Long-Term Plan. This indicates people are missing out on important treatments and our health and care economy is spending more on avoidable NHS care and Personal Social Service costs as a result.

This business case seeks to address the unwarranted variation and increase thrombolysis and thrombectomy rates to the national ambition. As a system we must come together to increase the speed and capacity with which our acute stroke and ambulance services can respond to stroke to save lives and reduce disability. Improved patient outcomes in the region of 36 more lives saved and 360 stroke survivors with less disability each year is expected.

Commissioner investment over a three year period is now sought to implement an enhanced Network model of care designed to optimise workforce capacity, stroke beds and ensure nationally recommended travel times to hospital emergency departments across our expansive semi-rural geography are not compromised. Levelling up the workforce and capital assets of three Acute Stroke Centres (one of which is a Comprehensive Stroke Centre), two Stroke Recovery Units and the North West Ambulance Service will cost local NHS commissioners an extra £13.8 million a year in revenue and £5.7 million in capital expenditure.

The economic benefits are compelling. A reduction in societal costs to the NHS, Social Care and patients and their carers is anticipated through more efficient ways of working as a Network, a significant reduction in Personal Social Service costs and increased productivity/employment attributed to the increase in people living independently after stroke.

The purpose of this full business case is to:

1. provide a 3 year plan for enhancing the quality of, and reducing the variation in access to, acute stroke care and rehabilitation services provided across Lancashire and South Cumbria
2. secure the Lancashire and South Cumbria Strategic Commissioning Committee's approval of the capital and revenue funding to implement the enhanced network model of care proposed
3. confirm the governance arrangements for implementation
4. advise the Committee in public, the plan for further communication and engagement with stakeholders

1. Introduction

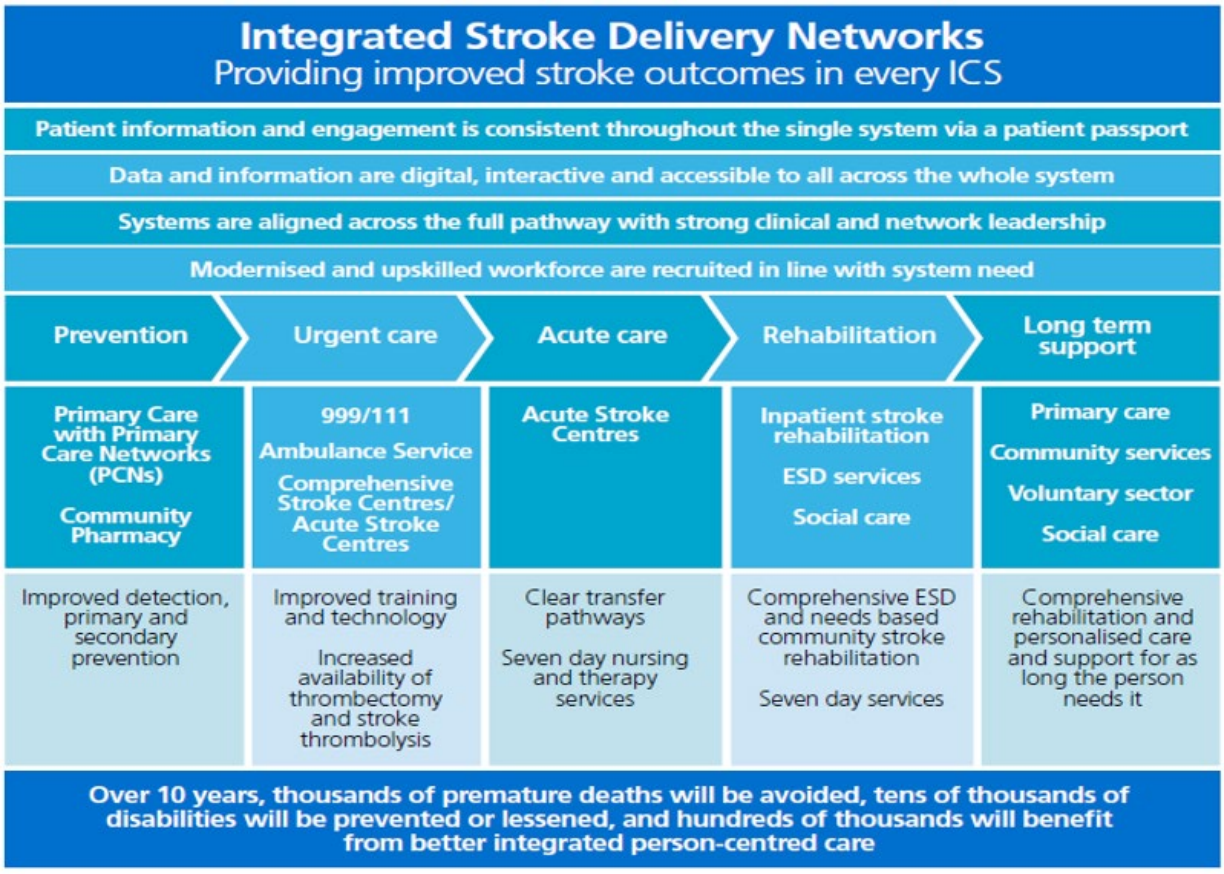
Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability. Approximately 100,000 people in the United Kingdom have a stroke every year, and 50% of stroke survivors will be left with disability (physical, communication, cognitive, psychological, visual, fatigue). It is a devastating disease for patients and their families and is estimated to cost the NHS around £3billion per year, with additional cost to the economy of £4billion in lost productivity, disability and informal care. Rapid assessment and treatment are known to save lives and improve chances of recovery.

Across Lancashire & South Cumbria in 2020/21 there were 6,409 presentations to hospital emergency departments with stroke-like symptoms of which 2,575 resulted in an admission with a diagnosis of stroke. Due to the predicted rises in the number of older people in the local population and the expected improvements in acute stroke care provision outlined in this business case, the number of stroke cases and survivors are expected to increase.

The Lancashire and South Cumbria Integrated Care System (ICS) is committed to improving stroke outcomes and reducing health inequalities for its population as stated in its 2021 Clinical Strategy.

The NHS Long-Term Plan clearly states that ICSs, through the establishment of Integrated Stroke Delivery Networks, are expected to lead the co-design and implementation of end to end stroke pathway improvement for their population. Figure 1 below outlines the scope of what our ISDN will be expected to deliver over the next ten years.

Figure 1 – Integrated Stroke & Neurorehabilitation Delivery Network framework



This business case solely focuses on improving the urgent and acute care elements of the stroke pathway over the next 3 years. By investing in the enhanced Network model, there will be more equitable access to important life-saving care 7 days a week and there will be an increased availability of treatments reducing long-term disability and costs to health and social care.

It is important to acknowledge however that reducing the burden of disease from stroke requires systematic interventions at the population level across all parts of the care pathway including primary and secondary prevention, urgent and acute stroke care, rehabilitation and long-term support.

Further information on the current and planned improvement activities for preventing stroke in Lancashire and South Cumbria is contained in the information sheet attached in Appendix H.

Significant improvements have already been made in the rehabilitation element through local CCG investment of £2.4 million in out of hospital high intensity community stroke rehabilitation teams at place commencing 2020/21. **This Committee can now be assured that these community stroke rehabilitation teams will be in place in advance of the planned implementation of the Network model of acute stroke care in 2021/22.**

The **long term support element** will become a key focus of the ISNDN in 2022/23 to develop strategic workforce plans to meet the challenge of the unmet psychological and social care needs experienced by many stroke survivors and their carer/families across L&SC.

2. Background

In 2018/19 the Lancashire and South Cumbria acute stroke pathway underwent a standardised review, model re-design and approval process which consisted of:

- **Case for Change** – endorsed by the L&SC Provider Chief Executives and CCG Accountable Officers in July 2019, noted by the Lancashire Health Scrutiny Committee in September 2019 and endorsed by the Joint Committee of CCGs in December 2019.

- **Model of Care** – supported by the L&SC Care Professionals Board in September 2019 and the North West Clinical Senate in January 2020; approved by the ICS Executive Team in January 2020; endorsed with recommendations at the Collaborative Commissioning Board in February 2020.

The full list of fora the Case for Change was presented at is available in Appendix A.

The **key drivers for change** described in the Case for Change document relate to:

- Unwarranted variation
- An out of date 'silo hospital system' design requiring transformation towards the updated National stroke service model specification.
- Patient flow is inefficient
- Staffing levels fall significantly short of nationally recommended levels

A key aspect of providing effective acute stroke care is the availability of qualified and experienced doctors, nurses and therapists when the patient most needs them, in the initial hyper acute phases of care (the first 72 hours/3 days of care), together with timely access to the latest medical advancements such as thrombectomy or thrombolysis. The national shortage of suitably qualified and experienced stroke specialists means that it is not possible to fully staff all existing acute stroke units and maintain this going forward.

Developing and implementing new models of acute stroke care to improve patient outcomes through delivering more accessible hyper-acute stroke care has recently been successful in other parts of the country i.e. London, Greater Manchester and North Cumbria.

New models of centralised provision of hyper-acute stroke care in urban conurbations such as London and Greater Manchester for example have delivered a 5% relative reduction in mortality at 90 days and reductions in length of hospital stay. A further 10% impact on the number of stroke survivors with reduced disability at hospital discharge has also been found.

Lancashire and South Cumbria however has its geographical challenges with a mixed urban and rural population. As such the typical centralised model approach does not favourably relate due to travel time and access limitations which would negatively impact clinical outcomes for local residents living in rural areas.

The key transformation priorities proposed in response to the Case for Change to meet the unique needs of the Lancashire and South Cumbria population are to:

Enhanced Network Model of Acute Stroke Care

Strengthen the front door:

- Ensure the presence of stroke triage nurses in Emergency Departments 24/7 to meet the patient, assess for stroke including brain scanning and ensure timely stroke treatment takes place – time is brain.
- Establish ambulatory emergency care pathways in all stroke receiving hospital sites to triage suspected stroke presentations and ensure both stroke and none stroke patients move from the hospital Emergency Department to the right care ensuring appropriate patient flow

Enhance acute services:

- Increase thrombolysis and thrombectomy rates towards national ambition
- Establish a network model of **a single Comprehensive Stroke Centre (CSC) at Preston, two Acute Stroke Centres (ASC) at Blackburn and Blackpool and Stroke Recovery Units (SRU) at all local acute hospital sites compliant with the national stroke service specification.**
- All existing stroke units in the system will remain open.
- Separate clinical pathways will be created for Morecambe Bay residents. Barrow in Furness residents will ambulance transfer from Furness General Hospital, following initial triage and treatment, to the Comprehensive Stroke Centre in Preston for 24 hour care for up to 3 days. Lancaster residents will be directly diverted to Preston for the whole triage and treatment process along with 24 hour care for up to 3 days.
- Repatriation policy will be created to ensure a safe return from Preston for Morecambe Bay residents to their local Stroke Recovery Unit for inpatient stroke rehabilitation or home with community rehabilitation.

Strengthen community services:

- Ensure system-wide coverage of community stroke rehabilitation teams in place to provide intensive therapy services to stroke survivors in their homes following hospital discharge.

3. Strategic Case

This strategic case describes in detail the case for change to a new model of acute stroke care. It describes the current model of care. It describes the additional features of the preferred model of care, the proposed benefits and risks of implementation.

3.1 Population Health

The Lancashire and South Cumbria system covers a population of around 1.8 million and the region is diverse, with areas of differing demography and local challenges. For most of the system, the quality of life for people with long term health conditions including stroke is worse than the average across England.

Across L&SC, approximately 20% of the population live in the 10% most deprived areas nationally, with Fylde Coast and Pennine Lancashire having significantly higher levels of deprivation compared with the rest of the local health and care partnerships.

All five local partnerships have areas that are amongst the 10% most deprived areas nationally and the latest information shows a decline since 2015. This means that Blackpool is now the most deprived borough in England, Burnley is ranked 11th and Blackburn with Darwen 14th. Barrow-in-Furness (44th) and Preston (46th) are in the top 20% most deprived authority areas in the country. Ribble Valley (282th) is the only district within the top 20% least deprived authority areas in the country.

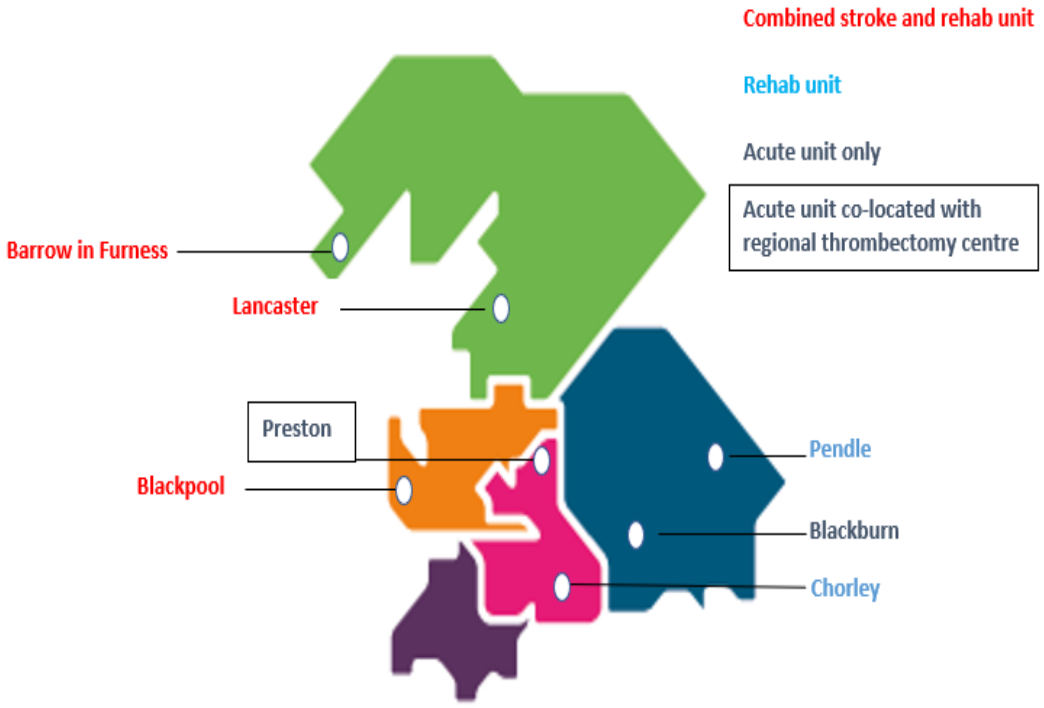
Inequalities exist between different population groups: men, older people, ethnic groups, and those of lower socioeconomic status have higher risk of stroke. Stroke risk is twice as high in the most deprived groups compared to the least deprived and the subsequent death is 26% more likely[1].

[1] Bray BD, Paley L, Hoffman A, et al. Socioeconomic disparities in first stroke incidence, quality of care, and survival: a nationwide registry-based cohort study of 44 million adults in England. Lancet Public Health. 2018;

3.2 Current model of care

Across Lancashire and South Cumbria there are five local stroke receiving hospitals (Blackburn, Blackpool, Furness, Lancaster and Preston) each providing varying levels of acute stroke unit care and inpatient rehabilitation to their local Trust catchment populations only – see Figure 1.

Figure 1 – L&SC hospitals providing acute stroke care and in-patient rehabilitation



The Regional Thrombectomy Centre is co-located with the Lancashire Teaching Hospital acute stroke service at Royal Preston. This service is currently open 8am-6pm, 4 days a week and is commissioned on block contract by NHS Specialised Commissioning. Implementation planning is underway to move this service towards providing a 24/7 service in a phased approach commencing with additional staff recruitment this November.

It is estimated that in 2020/21 there were 6,409 presentations to local hospital emergency departments with stroke-like symptoms of which 2,575 resulted in an admission with a diagnosis of stroke. The reason for the difference between number of presentations and stroke diagnoses is that patients may present with stroke-like symptoms caused by a disease other than stroke. These are referred to as stroke mimics, attributed most commonly to seizures, migraines and psychiatric disorders.

Although only confirmed strokes are inputted into the Sentinel Stroke National Audit Programme (SSNAP), a percentage of stroke mimics are also admitted into the stroke units for a brief stay until diagnostics confirm diagnosis, hence why the numbers expected into HASU beds is greater.

A breakdown by Provider is shown below:

Provider	A&E presentations	Confirmed Stroke admissions	Stroke Mimic
BTHT	1,521	507	1,014
RPH	1,420	710	710
RBH	2,256	752	1,504
RLI	762	381	381
FGH	450	225	225
Total	**6,409**	**2,575**	**3, 834**

Each of the acute stroke services' in-patient bed bases are commissioned separately and funded through payment by results stroke tariff. A breakdown by Provider is shown below.

Provider	Stroke Service Name	Acute Beds	Rehab Beds	Total
UHMB	Furness General	6	10	16
UHMB	Royal Lancaster Infirmary	6	14	20
LTH	Royal Preston	24	24	48
ELHT	Blackburn	23	24	47
BTH	Blackpool	20	19	39

All stroke receiving hospitals and the regional thrombectomy service are now being supported by **artificial intelligence software**. This innovation supports stroke clinicians in making more timely and accurate diagnoses of stroke. This also enables rapid image sharing with the Interventional Neuro-Radiologists at the receiving thrombectomy service in Preston, reducing time to treatment and improving patient outcomes. This innovative digital application is expected to contribute favourably to an increase in thrombolysis (8% towards the national ambition of 15%) and thrombectomy (2% towards the national ambition of 10%) rates over the next few years.

It is important for this Committee to note that a separate business case has been approved by the Lancashire Teaching Hospitals NHS Foundation Trust Board to expand the thrombectomy service to operate 24 hours a day/ 7 days a week to meet additional demand. This service currently runs 9am-5pm Monday to Friday. The separate thrombectomy service expansion business case is currently being reviewed by NHS Specialised Commissioning for funding decision.

The current model of care also possesses **Integrated Community Stroke Teams** in line with national stroke guidelines. In 2019/20 business cases to establish ICSTs were successfully approved by all CCGs to ensure essential capacity was available to receive the expected increase in stroke survivors with less complex disability as a result of the proposed enhanced Network model of acute stroke care. The positive impact of these community rehabilitation services can already be seen by the increased number of referrals to the team, a reduction in the number of patients moving to in-patient rehabilitation and a reduction in the length of stay on the stroke ward. Further and final recruitment of staff in the Central Lancashire and Blackburn with Darwen teams is due by the end of 21/22.

3.3 Case for change

The key drivers for transforming the model of acute stroke care in L&SC are:

- **unwarranted variation against best practice standards**
- **out of date system design**
- **inefficient patient flow**
- **workforce shortages**

3.3.1 Unwarranted variation in Provider performance against best practice stroke service standards (Sentinel Stroke National Audit Programme - SSNAP) affects patient outcomes, service costs and overall productivity.

The Sentinel Stroke National Audit Programme (SSNAP)[2] measures the quality and organisation of stroke care in the NHS and is the single source of stroke data in England. SSNAP performance is the basis upon which Providers and Commissioners can make informed decisions about where change is required in the configuration of acute stroke services to deliver the best quality of care for all patients.

All stroke units across the country are rated A-E, A being the highest performing. A higher performance rating indicates better outcomes for patients.

Figure 2 SSNAP performance data for Jan – Mar 21 by domain

Lancashire & South Cumbria												
Jan 21-Mar 21	Case ascertainment	Audit compliance	Scanning	Stroke Unit	Thrombolysis	Specialist Assessment	Occupational Therapy	Physiotherapy	Speech & Language Therapy	MDT Working	Standards by discharge	Discharge process
Blackpool Victoria Hospital	A	A	C	E	D	B	C	D	E	B	B	B
Royal Blackburn Hospital	A	A	A	D	C	B	B	B	B	B	A	A
Royal Preston Hospital	A	A	A	E	C	B	B	B	D	D	A	C
Furness General Hospital	A	B	B	E	D	B	D	D	C	C	B	B
Royal Lancaster Infirmary	A	B	B	E	E	E	D	D	E	D	B	B
Pendle Community Hospital - Marsden Stroke Unit	B	A	No Data	A	No Data	No Data	D	C	C	No Data	A	A
Chorley and South Ribble Hospital	A	A	No Data	A	No Data	No Data	C	B	C	No Data	A	C

The above table denotes issues with:

- Access to a stroke unit within 4 hrs of arrival. This is both a regional and national issue, often due to ED business, ineffective pathway, ineffective use of beds, non-ring fencing of beds.
- Thrombolysis rates are low, recognised locally and nationally, especially in Lancaster, reduced stroke consultant levels, lack of stroke nurses at the front door to pull patients through and late post stroke arrivals are rationale for this.
- Reduced levels of therapists but especially SLT & OT who are on the protected list of careers.

The aim of the L&SC ISNDN is for all of the above to turn green/become 'A' rated by April 2023 subject to investment required to implement the network model of care outlined in this business case.

[2] Sentinel Stroke National Audit Programme, School of Population Health, Kings College London, 2021

In 2020/21 L&SC provided 210 treatments of thrombolysis (only 8% of the estimated 15% ambition highlighted in the NHS Long-Term Plan). We would need to thrombolyse 140 extra patients per year to achieve 15% national target.

In 2020/21 the regional thrombectomy service provided 58 procedures (only 2% of the estimated 10% ambition highlighted in the NHS Long-Term Plan). We would need to undertake a further 198 extra thrombectomy procedures per year to achieve 10% national target.

3.3.2 Out of date system design requiring transformation towards the updated National stroke service model specification[3].

Each Trust has had a continuous stroke improvement plan in place since 2018 for improving their acute stroke care performance against the national clinical indicators of best practice stroke care (Sentinel Stroke National Audit Programme (SSNAP)). Prior to the impact of COVID only 2 out of the 5 acute stroke services in L&SC were maintaining an A level SSNAP status of best-practice acute stroke care. The population is not consistently receiving the high standard of care that they should rightfully expect. This results in different outcomes for different people.

Overarching SSNAP Trust Scores over time (all sites impacted by covid):

	Lancashire & South Cumbria																				
Site	Jul 15-Sep 15	Oct 15-Dec 15	Jan 16-Mar 16	Apr 16-Jul 16	Aug 16-Nov 16	Dec 16-Mar 17	Apr 17-Jul 17	Aug 17-Nov 17	Dec 17-Mar 18	Apr 18-Jun 18	Jul 18-Sep 18	Oct 18-Dec 18	Jan 19-Mar 19	Apr 19-Jun 19	Jul 19-Sep 19	Oct 19-Dec 19	Jan 20-Mar 20	Apr 20-Jun 20	Jul 20-Sep 20	Oct 20-Dec 20	Jan 21-Mar 21
National	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data
Blackpool Victoria Hospital	E	E	E	E	D	E	E	C	D	D	C	D	D	C	C	C	D	D	D	D	D
Royal Blackburn Hospital	E	E	D	D	D	C	C	B	A	A	A	A	A	A	A	A	A	A	A	B	B
Royal Preston Hospital	D	C	C	D	D	D	C	B	B	B	C	B	C	B	C	A	B	A	A	B	C
Furness General Hospital	D	D	D	D	D	C	C	C	C	D	D	C	B	C	C	C	C	C	D	D	D
Royal Lancaster Infirmary	D	D	D	D	D	D	D	D	D	C	C	C	C	C	C	D	D	D	D	E	D
Pendle Community Hospital - Marsden Stroke Unit	No Data	No Data	No Data	D	D	C	D	B	B	No Data	C	A	A	B	B	B	A	B	B	B	B
Chorley and South Ribble Hospital	D	C	B	C	C	D	D	B	B	No Data	B	A	B	A	A	A	B	A	A	A	B

It is clear from the SSNAP performance data that without a transformational change to a new model of care, involving collaboration between all hospital Trust Providers and supported by additional investment from Commissioners, further improvements to reduce clinical variation in health outcomes across L&SC after stroke is highly unlikely.

Effective stroke care will only occur if the organisational structure facilitates the delivery of the best treatments at the optimal time. NHS England and Improvement state that investigations and interventions, such as brain scanning, thrombolysis and mechanical thrombectomy, can best be delivered as part of a 24/7 networked service, including Comprehensive and Acute Stroke Centres (CSC, ASC) of a sufficient size to ensure expertise, efficiency and a sustainable workforce.

[3] National Stroke Service Model, Integrated Stroke Delivery Networks, NHS England & Improvement, 2021

A volume of at least 600 acute admissions a year correlates with an adequate level of institutional experience and competence in providing hyper-acute treatments [4] and a volume of between 600 and 1,500 patients admitted per year has been recommended[5][6] based on cost effectiveness.

3.3.3 Patient flow is inefficient

Ambulatory care is recommended as an intervention to reduce pressure on NHS hospital in-patient services. Relevant to stroke, implementation of ambulatory care pathways for stroke in the Emergency Department has been shown to significantly reduce unnecessary patient admissions to acute stroke unit beds thus improving patient flow. This is considered essential at all stroke receiving hospital sites in the new model of care to ensure appropriate and timely access to acute stroke beds for those who need them, preventing pathway blockages and reducing length of stay in hospital

There is a lack of appropriate and timely access to acute stroke beds due to **a lack of consistent ambulatory emergency care for stroke** embedded across the system. In some acute stroke services there is a 2:1 ratio of stroke mimic presentations that should not receive admission to an acute stroke bed. In 2020/21, it is estimated that around 3,800 patients presented in the emergency departments with a "stroke-like" clinical picture caused by a disease other than stroke and attributed most commonly to seizures, migraines and psychiatric disorders.

Currently there is variation on how ambulatory care is staffed, but it is anticipated that consultant stroke nurses will be responsible for running these clinics. Evidence from the pilot ambulatory care projects demonstrated a reduction of inappropriate admissions, minimal impact on therapy, improved patient pathway and experience.

During an ambulatory care pilot at Blackpool Hospital between October 2018 and February 2019 of the 50 patients with stroke like symptoms who presented 46 were discharged on the same day following appropriate assessment and treatment and 4 were admitted.

ELHT also carried out a three month pilot who saw 29 patients with stroke symptoms of which 24 were discharged on the same day following appropriate assessment and treatment and 4 were admitted.

[4] Bray BD, Campbell J, Cloud GC, Hoffman A, Tyrrell PJ, Wolfe CD, et al. Bigger, faster? Associations between hospital thrombolysis volume and speed of thrombolysis administration in acute ischemic stroke. Stroke. 2013;44:3129-3135

[5] Hart S, Lowe D, Hargroves D, Doubal F. Meeting the future consultant workforce challenges: Stroke medicine, stroke medicine consultant workforce requirements 2019-2022. 2019 https://basp.ac.uk/wp-content/uploads/2019/07/BASP-Stroke-Medicine-Workforce-Requirements-Report-FINAL.pdf

[6] Rudd A. Stroke services, guidance for STP's on recommended standards for acute stroke services. https://www.england.nhs.uk/mids-east/wp-content/uploads/sites/7/2018/03/stroke-servicesconfiguration- decision-support-guide.pdf

Appropriately resourced Comprehensive and Acute Stroke Centres need to be commissioned to meet demand and improve patient flow in the system. Furthermore, delayed repatriation from the regional Thrombectomy Service due to limited acute stroke centre beds in the system, reduces this tertiary service's capacity to receive emergency transfers for mechanical thrombectomy, introducing significant clinical risk.

3.3.4 Staffing levels fall significantly short of nationally recommended levels

The provision of a well-led, appropriately trained and skilled workforce providing holistic and compassionate care to patients and their family/carers is the cornerstone of the care of people with stroke. The fifth edition of the National Clinical Guideline for Stroke, published in October 2016, provides a comprehensive examination of stroke care, encompassing the whole of the stroke pathway from acute care through to longer-term rehabilitation, and informs healthcare professionals about what should be delivered to stroke patients and how this should be organised, including recommended staffing levels.

Consultant requirements have recently been reviewed as recommended by British Association of Stroke Physicians 2019, they are measured in numbers of direct care contacts.

An estimate of the current stroke workforce numbers and shortages to deliver the current model of care is shown below.

Gap analysis of recommended qualified staffing levels for acute stroke services in current model

Role	L&SC WTE*	RCP WTE	Capacity Gap WTE
Consultant Stroke Physician	**12.5 (70 DCC's)**	**16.82 (104 DCC's)**	**-4.21 (34 DCC's)**
Nurse - registered	**161.37**	**166.73**	**-5.36**
Nurse - unregistered	**166.93**	**89.78**	**+77.15**
Occupational Therapist	**26.12**	**43.09**	**-16.88**
Physiotherapist	**26.30**	**44.69**	**-18.39**
Speech & Language Therapist	**11.0**	**21.28**	**-10.28**
Dietician	**0.7**	**9.59**	**-8.89**
Clinical Psychologist	**1.30**	**10.64**	**-9.34**
Orthoptist	**1.3**	**5.4**	**-4.1**

***L&SC staffing levels audit on 07/01/2021**

These figures clearly outline that there is a significant need to prioritise recruitment, retention and investment in staff for Stroke services across L&SC and this proposal allows us the opportunity to review and address some of our challenges.

Since 2011, L&SC has utilitised the regional Tele-stroke service to partly mitigate these shortfalls given the geographical issues and the insufficient investment available to staff all five local acute stroke services to the minimum recommended levels for 24 hours a day/7 days a week.

This **out of hours Tele-stroke service** runs from 5pm-8am Monday to Friday and all-day Sat, Sun and Bank Holidays. There is an out of hours stroke consultant rota currently covered with 15 stroke consultants from eight sites, reaching beyond the L&SC footprint into the rest of Cumbria. ELHT are

the current lead providers and are responsible for updating of governance and operational polices and equipment refresh on behalf of all the other sites.

Nationally, there is a shortage of stroke consultants and registered nurses - in particular Band 5s. There is also a shortage of allied health professionals including clinical psychologists, occupational therapists and speech and language therapists and orthoptists. All of which are on the National Shortage Occupation List for 2020. It is also important to note that dieticians are part of the generic hospital service and are not commissioned separately for individual stroke units.

As a response to these challenges the ICS Finance Advisory Committee recommended in May 2021 that a phased workforce plan should accompany the phased investment plan to ensure delivery of the proposed network to start in 2024.

This workforce plan will form the basis of an ICS stroke workforce strategy and will articulate the actions and interventions that the system will take to target closing the highlighted gaps and delivering the required future workforce.

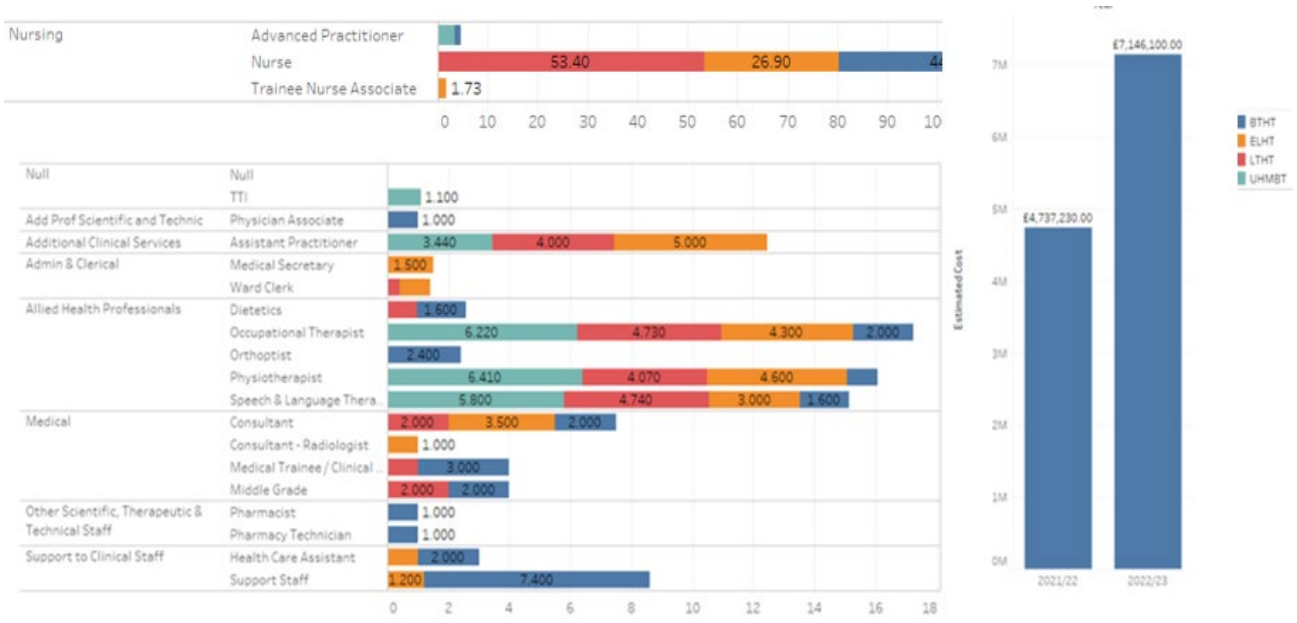
The L&SC ISNDN workforce work stream will be working closely with Health Education England and ICS workforce leads to solidify our understanding of the future supply stroke specialist staff. Using HEE STAR methodology, we will be exploring innovative ways to bolster workforce supply; navigating opportunities for upskilling; adopting and embedding new roles and new ways of working as well as improving the leadership capacity of the Stroke workforce.

The L&SC Stroke workforce strategy will be aligned to the themes below outlined in the *NHS People Plan: We are the NHS: action for us all*, published in July 2020:

- Looking after our people – with quality health and wellbeing support for everyone.
- Belonging in the NHS – with a particular focus on the discrimination that some staff face.
- New ways of working – capturing innovation, much of it led by our NHS people.
- Growing for the future – how we recruit, train and keep our people, and welcome back colleagues who want to return.

This approach will enable us to build robust transformation and optimisation options which will address both the needs of the workforce as well as delivering staffing structure required for improved Stroke provision across L&SC. We have an opportunity aligned to this business case to ensure we align workforce solutions to service delivery and the needs of our populations across the timescales of this service transformation and beyond.

The indicative workforce requirements for this transformation work, produced by Health Education England, are as follows:



Over the three years of expansion modelled there is a requirement for 232.2 additional staff to strengthen the front door to stroke services and get people on the stroke pathway quickly, sufficiently staff the Acute and Comprehensive Stroke Centres to provide the enhanced services 24/7 and strengthen the rehabilitation element. This equates to an estimated cost of £11,883,330. The numbers of staff vary by organisation, role and band with the highest number of staff needed within nursing roles, followed by AHP and then medical roles.

The indicative workforce requirements by Trust are as follows:

Medical workforce requirements (WTE):

Trust		
BTHT	2 Consultants, 2 Middle grades, 3 Junior grades	2 Nurse consultants
ELHT	3.5 Consultants	1 Nurse consultants
LTHT	2 Consultants, 1 Middle grade, 2 Junior grades	1.6 Nurse consultants

Nursing workforce requirements (WTE):

Trust	Qualified	Unqualified
BTHT	27.2	18.5
ELHT	25.9	1.73
LTHT	35.5	1
UHMBT	2.5	0

AHP workforce requirements (WTE):

	Bed based	Community	Total
TOTAL	66.5	47.1	113.6

Well organised and adequately staffed acute stroke unit care is consistently associated with improved outcomes following stroke[7] . The key features of an acute stroke service that should be provided throughout the in-patient care of the stroke patient are that it should be a geographically defined unit just caring for stroke patients, have a multidisciplinary team of clinicians who have stroke specific expertise and operating to agreed protocols.

A moderate increase in revenue for additional medical, nursing and allied health staff across the Network is now required.

3.4 Future model of care

A pictorial overview of the future model is presented below with a high level description of what is to be offered at each local hospital in Lancashire and South Cumbria.

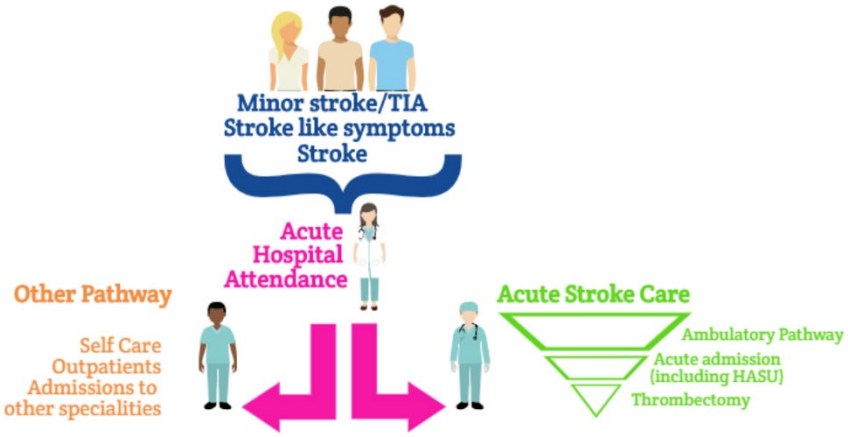
[7] Stroke Unit Trialists' Collaboration Organised inpatient (stroke unit) care for stroke. Cochrane Database Syst Rev. 2013 Sep 11;9:CD000197. doi: 10.1002/14651858.CD000197.pub3.

3.4.1 Ambulatory care pathways

To address the patient flow issue observed in the current model, the introduction of ambulatory care pathways in all local hospitals across Lancashire and South Cumbria is recommended by the L&SC ISNDN.

In ambulatory care shown in figure 3 below, patients are seen as outpatients if presenting with stroke-like symptoms, TIA or minor stroke. Within a "one-stop clinic" type approach, they are rapidly assessed, including therapy assessments, and receive all necessary diagnostics to determine whether they need to be admitted for specialist, hyper-acute stroke care, or can be discharged and followed up in clinic or discharged on to a more appropriate pathway, if needed.

Figure 3 – Ambulatory care pathway



Ambulatory emergency care pathways will be provided in all stroke receiving hospital sites to triage suspected stroke presentations from the hospital Emergency Department to the right care ensuring appropriate patient flow.

3.4.2 Optimal number of Acute Stroke Centres

A number of factors were taken into account when working out the optimum number and location of a Comprehensive Stroke Centre (CSC) and Acute Stroke Centres (ASCs):

- **Capacity of hospitals:** extensive bed modelling was undertaken to establish the right number of specialist hyper-acute and stroke rehab beds for the estimated incidence of suspected stroke presentations per annum (6,409 confirmed strokes and stroke mimics). The RCP and NHS E/I guidance recommend Comprehensive and Acute Stroke Centres should expect to admit between 900-1200 stroke patients per annum, therefore a three centre model (1 CSC and 2 ASCs) is considered as the ideal configuration for the network stroke services.

- **Access:** the location of stroke receiving hospitals needed to ensure all of the L&SC population received the right care within 60 minutes by blue light ambulance. The triage, treat and transfer model best serves residents where longer travel times involved namely Barrow in Furness.

- **Critical Mass:** Evidence shows that teams providing complex care to lots of people have the best outcomes for patients - therefore fewer, larger units are likely to provide better care for stroke patients.

- **GiRFT reviews**: The National Stroke team recommended that Royal Blackburn Hospital and Royal Preston Hospital became an Acute Stroke Centre and Comprehensive Stroke Centre respectively due to the number of stroke patients they manage and Preston's co-location with the regional thrombectomy centre.

To determine the preferred location of the second Acute Stroke Centre, a scoring evaluation exercise was undertaken in February 2021 by a panel consisting of a wide cross section of the stroke community who evaluated the Royal Lancaster Infirmary and Blackpool Victoria Hospital sites. Further information on the evaluation process is available in the Economic section of this business case.

From this exercise, the following site locations are proposed in this business case for enhancement by April 2023:

- Comprehensive Stroke Centre – Royal Preston Hospital
- Acute Stroke Centre – Royal Blackburn Hospital
- Acute Stroke Centre – Blackpool Victoria Hospital

The preferred three centre model has been shared at the following fora:

Date	Forum	Outcome
Dec 2019	Joint Committee of CCGs informal meeting	Endorsed
Dec 2019	Finance Investment Group	Indicative investment noted and guiding principles discussed
Jan 2020	North West Clinical Senate	Independently reviewed and endorsed clinical assumptions (Appendix B)
Jan 2020	ICS Executive Board	Approved
Mar 2021	ISNDN Network Board	Approved
April 2021	Provider Collaborative Board	Review of two centre model requested
April 2021	Finance Advisory Committee	Check and challenge on cost
May 2021	Finance Advisory Committee	Approval of a phased investment plan over three years
June 2021	NHS England & Improvement	Service change process need not be followed but an emphasis on engagement should be made
June 2021	Strategic Commissioning Committee informal meeting	Supportive of presenting business case at formal meeting in July
June 2021	Morecambe Bay CCG Executive Board	Broadly supportive with recommendations for further public engagement prior to implementation of patient transfer pathways
July 2021	Informal meeting with South Cumbria MPs	Broadly supportive with guidance to further consider impact on carers who may be disadvantaged by travelling out of area during the hyper-acute stroke care phase

It is important to note that the proposed 3 centre model was challenged by the L&SC Provider Collaborative Board in April 2021 and a review of a 2 site model was requested.

Royal Preston and Royal Blackburn hospital sites were modelled with Central Lancashire, Morecambe Bay and Fylde Coast patients transferring to Royal Preston Hospital and Pennine Lancashire patients attending Royal Blackburn.

Qualitative insights were sought from the Stroke Service Manager and the Medical and Surgical Directorate Managers at Lancashire Teaching Hospital (LTH), along with the National Clinical Director for Stroke, who reviewed the two site modelling outputs.

The comparative analysis revealed that a two centre model was neither clinically, operationally or financially appropriate. It would essentially become the largest acute stroke centre in England. Detrimental operational impacts to LTH and system financial risks were highlighted.

The recommendation in this business case remains therefore that the three centre model using a triage, treat and transfer pathway approach is preferred.

3.4.3 Triage Treat and Transfer pathway

The proposed Triage, Treat and Transfer pathway was collaboratively developed in 2019 and formally amended by the L&SC ISNDN Board in July 2021. The amendment was made to address the challenge from the National Clinical Director for Stroke that Lancaster residents should be attending their nearest Acute Stroke Centre, in this instance Preston Comprehensive Stroke Centre, directly rather than triage, treat and transfer.

The triage, treat and transfer pathway will serve Morecambe Bay residents due to the geography and travel times involved. Subject to appropriate capacity at the Preston Comprehensive Stroke Centre being available from April 2023:

Furness patients with suspected stroke symptoms will continue to be taken directly to Furness General Hospital Emergency Department for initial triage and treatment e.g. CT scans and thrombolysis if appropriate. They will then be transferred to Royal Preston's Comprehensive Stroke Centre for up to the first 72 hours of multi-disciplinary stroke specialist inpatient care, then will be repatriated back to Furness General Hospital's Stroke Recovery Unit for ongoing care and inpatient rehabilitation or discharged home with care from the Integrated Community Stroke Team.

Lancaster patients with suspected stroke symptoms will be taken directly Royal Preston's Comprehensive Stroke Centre, receive the 72 hours of multi-disciplinary stroke specialist inpatient care, then will be repatriated back to Royal Lancaster Infirmary's Stroke Recovery Unit for ongoing care and inpatient rehabilitation or discharged home with care from the Integrated Community Stroke Team.

3.4.4 Future state activity impact

The modelled activity based on 2020/21 data is shown in the table below:

	Hospital	*Furness General Hospital*	*Royal Lancaster Infirmary*	*Blackpool Victoria Hospital*	*Royal Blackburn Hospital*	*Royal Preston Hospital*
ACTIVITY NUMBERS	**ED**	450.0	0.0	1521.0	2256.0	2182.0
	HASU	0.0	0.0	729.0	1081.0	1724.0
	Acute	164.0	279.0	447.0	663.0	553.0
	Rehab	72.0	137.0	233.0	260.0	176.0

The future state bed requirements are shown in the table below:

	Trust	Ave LoS	*Furness General Hospital*	*Royal Lancaster Infirmary*	*Blackpool Victoria Hospital*	*Royal Blackburn Hospital*	*Royal Preston Hospital*
BED REQUIREMENT	**ED**						
	HASU	**3**	0	0	7	11	17
	Acute	**7**	4	6	10	15	13
	Rehab	**23**	5	10	17	19	13
	TOTAL	**33**	**9**	**16**	**34**	**45**	**43**

3.5 Equality Impact Assessment

A stroke can happen to anyone but there are some things that can increase the risk of a stroke. The main risk factors for stroke, relating to the equality protected groups are:

- Age
- Ethnicity - strokes happen more often to people from African and Caribbean families, as well as people from South Asian countries.
- Gender - Men are at a higher risk of having a stroke at a younger age than women due to a combination of behavioural and medical factors.

The modifiable risk factors for stroke e.g. medical conditions (high blood pressure, diabetes, atrial fibrillation, high cholesterol) and lifestyle factors (smoking, drinking too much alcohol and eating unhealthy foods) may also be more prominent with some protected characteristic groups.
The impact on the stroke patient's carers also needs to be considered.

Not all patients with stroke like symptoms will transfer to the CSC. It is estimated that 30% of the Furness patients presenting with stroke like symptoms will be discharged from the emergency department through the triage and ambulatory care pathways, 12% of patients will present after 48 hours and will stay in the local stroke unit and 5% of patients eligible for transfer for treatment will refuse and therefore stay in the local stroke unit. For the Morecambe Bay patients that transfer to Royal Preston for treatment at the Comprehensive Stroke Centre, the best possible outcomes will be

achieved through having MDT stroke specialist care and monitoring available 24/7 for the first 72 hours after admission. These outcomes include:

- a reduction in mortality and levels of dependency following an acute stroke
- a reduction in the length of stay of stroke patients in bed-based services
- enhanced recovery following a stroke
- a reduction readmission rates for stroke patients
- improve patient and carer experience and quality of life through improved functional outcomes and extended activities of daily living; and every person post stroke has a rehabilitation care plan, which includes personal goals.
- All patients will have equitable access and treatment regardless of point of entry to the health service, gender, age, ethnicity, disability, sexual orientation, religion or beliefs, marital status, pregnancy or maternity status, or gender reassignment status.

The stroke patient's family members and carers who live in the Morecambe Bay area will be most impacted upon by the increased distance for the first 72 hours when the patient is receiving treatment at the Royal Preston CSC. This will impact most on those who have no access to their own transport and/or have a low income.

The NHS Transformation Unit carried out travel analysis by creating a model to simulate the travel times. The analysis looked at how people in different age groups and ethnicities would be impacted by increased travel times. The findings showed that:

- Those aged 65 and over are the most impacted age group
- The white population are most impacted ethnicity.

During engagement visits to the Stroke Association support groups in summer 2018, the programme team engaged with 132 attendees and 29 members of the Stroke Association team. There was general support for the proposed approach of developing acute stroke centres and the benefits that this type of model would bring. Attendees said that it would be a positive to have a specialist stroke centre as they felt it could provide consistent, good quality treatment, improve treatment times and patients' experiences and perhaps provide more personalised care. More recent engagement visits to Stroke Association support groups in July 2021 again provided support for the proposed model of care. The main concerns expressed were around the availability of car parking at Royal Preston.

Further work will be carried out to minimise the impact of increased travel. Older people may be more likely to have impairments which may affect engagement such as eyesight and hearing impairment, so this will need to be considered as part of the communications plan. CSC and ASCs will review their equality policy and how it supports different protected characteristics and their needs, especially transgender patients. Links will be made with key community groups for their input and update policy and practice where necessary.

The Comprehensive Stroke Centre will review how they support key visitors to the patients by offering advice with travel and ensuring those pathways for support are known to patients. Alternative and innovative methods used during the covid pandemic to assist with absence of visiting time and keeping loved ones in touch with a patient's progress can be explored. Resolving this issue may benefit

from collaboration with other Healthier Lancashire and South Cumbria programmes experiencing similar challenges.

These recommendations and any further equality needs and requirements of patients and carers will be monitored during implementation and built into the benefits framework for ongoing reporting. There will be meaningful representation from the protected characteristic groups most at risk of stroke and carers in engagement activities.

Overall the change to enhance services through the creation of the Comprehensive and Acute Stroke Centres network to serve the region should result in a positive effect due to the expected better outcomes for all patients.

3.6 Anticipated Benefits

As highlighted in the table below, saving lives and reducing disability are the key anticipated benefits of the proposed enhanced Network model of care. Economic benefits and improved patient experience along with a reduction in health inequalities are also anticipated. Further detail around anticipated benefits is in Appendix C.

Benefits of the Enhanced Network Model of Acute Stroke Care

Benefit type	Measurement
Reduce mortality	Save 32 more lives each year across LSC; 5% mortality reduction seen in London and Greater Manchester following reconfiguration of 24/7 hyper acute stroke units (Ref 1)
Improved clinical outcomes	Increase in LSC thrombolysis rate from 8% to 15%; n=140 extra patients per year Increase in LSC thrombectomy rate from 2% to 10%; n= 198 extra patients per year
Reduce disability after stroke	361 more stroke patients will be discharged with reduced disability/dependence, MRS score < 2. (Ref 1) ; 1 in 5 patients will achieve functional independence following thrombectomy (Ref 2)
Positive patient experience	Improved qualitative patient feedback at hospital discharge and 6 months review
Reduced societal cost - NHS	£4,100 saving for each extra patient thrombolysed (Ref 2) at least same again could be assumed for thrombectomy £2.33 million saved in reduced length of hospital stay of 3 days per patient
Reduced societal cost – Social Care	Social care savings of £6,900 and 0.26 QALYs gained in total for each extra patient thrombolysed (Ref 2); at least same again could be assumed for thrombectomy
Reduced health inequalities	All patients in ICS footprint will have access to high quality hyper acute stroke care that meets national best practice standards. It is expected that assessment, treatment and care will be standardised across the sub-region thus reducing unwarranted variation.

1. Evaluation of reconfigurations of acute stroke services in different regions of England: A mixed methods study (2019), NIHR
2. Stroke Pathway Evidence Based Commissioning (2020) Kings College London

The key elements to realising these benefits are:

- Adopt a regional approach to patient pathways where there is a strong case for change and underpinning evidence, in order to better meet the needs of patients, drive improvement and increase the sustainability of services.
- Strong commitment, effective collaboration and leadership at all levels.
- Obtaining feedback from patients, family, staff and stakeholders to measure the success of the implementation of a new service model and the feedback gained can play a critical role in further developing services.
- The ISNDN and its partners continuing to play a pivotal role in continued development and improvement of stroke services within L&SC.

3.7 Reduced societal costs

The economic burden of stroke falls on different sectors of society. Every new case of stroke represents a significant cost to the NHS, social care services, the patient and their family. There are also indirect costs due to loss of productivity when stroke survivors and their carers can no longer work.

Numerous studies have explored the cost associated with stroke. It was estimated in 2017 that the average societal cost of stroke per person was £45,409 in the first year after stroke. An additional £24,778 per patient has been estimated for subsequent years (cost of prevalent stroke).

Economic analysis of stroke care in England, Wales and Northern Ireland[1] have found that increasing the proportion of patients receiving high quality stroke care in a specialist stroke unit including thrombolysis and early supported discharge into community stroke rehabilitation can save the combined health and social care system up to £6,400 per patient after one year and £17,400 after five years.

The National Stroke Programme has set the ambition for the NHS to deliver clot-busting thrombolysis to twice as many patients, ensuring 15% of stroke patients receive it by 2025 – the best performance in Europe. The thrombolysis rates of local acute stroke services across Lancashire and South Cumbria taken from the SSNAP Toolkit 2020 public report ranges from 6.4-11.9% (average 8.9%).

If 15% of eligible patients were thrombolysed in a year (the new national target), cost savings for the Lancashire and South Cumbria system are estimated to be:

Trust	NHS Cost Savings	Social Care Savings	Would need to thrombolyse an additional
LTHT	£206,800	£190,000	40 patients
BTHFT	£110,900	£103,000	35 patients
ELHT	£89,900	£82, 600	28 patients
RLI	£48,200	£44,800	29 patients
FGH	£26,100	£24,300	8 patients
Total Savings	£481,900	£444,700	140 patients

For every 100 patients treated with thrombectomy, 38 have a less disabled outcome than with best medical management, and 20 more achieve functional independence. The National Stroke Programme has set the ambition for the NHS to deliver clot-removing thrombectomy to 10% of eligible patients by 2025.
The thrombectomy rate of local acute stroke services across Lancashire and South Cumbria are 2%.
On average, one extra patient receiving thrombectomy would save the NHS £47,000 over 5 years. [8]

3.8 Risks

A risk log below will continue to be monitored by the ISNDN Board. The initial risks of implementing the enhanced Network mode of care are as follows:

Risk	Mitigation
Finance – affordability, given current system financial deficit.	FAC has supported the proposed phased investment and recognised disinvestment and additional efficiencies elsewhere will be required.
Clinical risk of transferring patients to the Comprehensive Stroke Centre (CSC)	The triage, treat and transfer model from Furness will ensure that patients receive time critical brain scan and recovery enhancing treatment before transfer for direct admission to the CSC.
Operational risk around patient pathways	All operational leads to agree the pathways for transferring and repatriating patients via the dedicated operational implementation group.
Workforce – cannot recruit or train staff in timescales	Working with and seeking advice from HEE, providers and national clinical director for stroke. Recruitment and training to take place over the next 2.5 years and the plan will be progressed by a dedicated workforce working group.
Families and carers' concerns around increased travel and transport for visiting in the first 72 hours .	Understand lessons learned from Carlisle experience. Patient and carer working group to explore potential solutions/ alternative methods Feedback obtained from SA groups. Wider public engagement planned.
Increase in ambulance activity both emergency and PTS with protracted journey times and the impact of system pressures.	Financial envelope available for vehicle and crew and estates cost. NWAS to define the demand and financial requirement. Potential use of UHMBT dashboard to obtain better quality data in relation to activity. Allow adequate time in project plan to procure additional vehicle and crew.
NWAS availability to respond to emergencies in timely manner – impact on programme and wider communities.	
Limited assurance on data quality to inform modelling for ambulance resource.	

[8] "Current, future and avoidable costs of stroke in the UK" Stroke Association

3.9 Dependencies and interdependencies

The following elements have been identified as programme dependencies:

- The community rehab teams being fully operational
- Triage nurse service in ED being fully operational
- Ambulatory care models being fully embedded
- Clear understanding of workforce arrangements and plans at each of the providers to enable and build a network approach to recruitment strategy
- Upskilling of stroke nursing workforce – a regional approach to education, training, research and development
- Agreement on bed bases for the proposed model
- Funding for set up costs – estates, equipment

The following elements have been identified as programme interdependencies:

- Expansion of thrombectomy services
- Access to diagnostics
- Access to vascular services
- Access to general medicine
- Healthcare Infrastructure Programme (HIP2)

3.10 Healthcare Infrastructure Programme (HIP2)

The Healthcare Infrastructure Programme (HIP), of which University Hospitals of Morecambe Bay and Lancashire Teaching Hospitals are part of the second phase (HIP 2), is concerned with the design and construction of a brand new hospital or hospitals for both Preston and Lancaster. The current environment in both hospitals is no longer fit for purpose and so they require infrastructure to be rebuilt rather than refurbished. However, no decisions have yet been taken in regards to the possible locations or service configuration/design.

Plans are to be submitted to the Department of Health over the next two years. Should these plans be successfully accepted, subsequent building work will be completed by 2030. All of the plans will be subject to public and patient involvement under established NHS and local authority governance arrangements. These include formal consultation with the public and stakeholders, and we expect those leading and involved in Stroke and neurological care to be active participants in this work.

There is no reason that existing programmes of work, such as enhancing the acute stroke care and rehabilitation model, should stop because of something that might happen in the next decade. Rather, programmes will need to be cognisant of building this potential positive change into their planning and, in doing so, reflecting the possible positive benefits for patients, carers and colleagues. This was recognised and acted upon by rejecting the capital option for a new build at Royal Preston Hospital site from an earlier version of the phased investment plan considered for this business case.

4. Economic Case

The purpose of the Economic Case is to set out the spending objectives and business needs in terms of the projects critical success factors (CSFs). The options under consideration are then assessed against the CSF's and an economic analysis undertaken to identify the preferred option.

4.1 Critical Success Factors

CSFs are the attributes essential for successful delivery of the project against which the initial assessment of the options for the delivery of the project is appraised. The CSFs in relation to the enhancement of acute stroke and rehabilitation services across LSC are as follows:

1. To deliver clinically sustainable, high quality SSNAP 'A-rated' Network of acute stroke services that are accessible to all LSC residents 24 hours a day, 7 days a week;
2. Robust stroke specialist triage and ambulatory care within RPH, RBH, BVH and FGH;
3. Appropriate ambulance cover for Morecambe Bay patient transfers and repatriation to and from the Preston Comprehensive Stroke Centre;
4. 7 day in-patient stroke rehabilitation service in all acute stroke services including RLI;
5. Integrated community stroke rehabilitation service available 6 days in all local areas, and;
6. Deliverable from an operational, workforce and financial perspective.

4.2 Potential Options

3 options were identified and assessed against the critical success factors:

- Option 1 – Do nothing / Business as usual
- Option 2 – 2 site model
- Option 3 – 3 site model

Option 1 was discounted on the basis that it does not deliver against CSFs 1 to 5.

Option 2 was discounted on the basis that the additional patient volume pressure on Preston Comprehensive Stroke Centre was deemed too high for this hospital's A&E and wider medical services. Significant estate expansion and additional investment in Diagnostic Imaging services would be required. Neither of which is possible in the current financial climate. This option poses an unmitigated risk to patient safety and therefore does not deliver against CSFs 1,2 and in particular CSF 6.

Option 3 was therefore chosen as the preferred option as it delivers against all of the CSFs.

4.3 Acute Stroke Centre site identification process

The National Stroke Clinical Team visit in 2017 confirmed that Royal Preston Hospital and Royal Blackburn hospital meet the criteria for a HASU and recommend that the ICS should consider this when designating Acute Stroke Centre sites.

The Lancashire and South Cumbria Integrated Care System's (ICS) Executive Team and the Collaborative Commissioning Board (CCB) in February 2020 agreed that a three site model must include Preston and Blackburn due to the existing stroke admission activity levels and Preston's co-location with the regional mechanical thrombectomy service. It was further agreed that an options appraisal must include a short-list of Lancaster, Blackpool or Furness hospital as the third Acute Stroke Centre location.

All sites were subject to hurdle criteria. “Hurdle criteria” are criteria that must be met in order for an option to be shortlisted for further consideration and were based on the national requirements for an Acute Stroke Centre. These are:

- The site must have the potential capacity to receive over 600 stroke patients a year
- 60 minutes or less travelling time from receiving unit to the Acute Stroke Centre site under the treat, triage and transfer model.
- The site must be an acute stroke unit.

Table 2 below show the travel time between sites.

	Site distance (miles) and normal (not lights and sirens) travel time (minutes)									
	RPH		RBH		BVH		RLI		FGH	
	Time	Miles	Time	Miles	Time	Miles	Time	Miles	Time	Miles
RPH			26	19.2	25	15.8	30	19.8	78	64.4
RBH	26	19.2			41	32.2	43	35.1	92	79.6
BVH	25	15.8	41	32.2			45	33	93	77.6
RLI	30	19.8	43	35.1	45	33			68	46.5
FGH	78	64.4	92	79.6	93	77.6	68	46.5		

Blackpool Vitoria Hospital and Royal Lancaster Infirmary met the requirements of the hurdle criteria and were both progressed to the scoring stage. Furness did not progress due to the travelling time to all the other sites and therefore was not part of further evaluation.

A scoring exercise was completed by a scoring panel of made up of stroke services’ stakeholders to identify the location of the second Acute Stroke Centre in Lancashire and South Cumbria. The scoring exercise took place between 19 February and 1 March 2021. Detail of the scoring panel is in Appendix D. Each member of the scoring panel scored the two options and a “Do Nothing” option based on how well they met the evaluation criteria within the themes of:

- Quality and safety
- Access
- Patient and Carer experience
- Value for money
- Deliverability

The scores submitted for each option were collated, and the agreed weightings applied to result in a final score for each option.

The result from the scoring exercise found the location of the second Acute Stroke Centre should be Blackpool Victoria Hospital. A summary of the collated results is available in Appendix E.

4.4 Economic Appraisal

An economic appraisal was undertaken to ensure that the preferred option delivers the best public value in relation to the other options under consideration. Costs and benefits for each of the options were appraised over a 10 year period to calculate the Net Present Social Value (NPSV) of each option.

The capital costs of the preferred option are £5.7m and additional revenue costs are £13.8m recurrently. The costs and sources of funding will be described in more detail in the financial case.

Quantifiable benefits arising from the preferred option total £150m over the 10-year appraisal period and are comprised of £17.5m length of stay reductions and £132.5m of societal benefits linked to reduced social care costs arising from thrombolysis and thrombectomy.

The benefit cost ratio of the preferred option is 1.59 as shown in the table below. This means that the benefits outweigh the costs by a factor of 1.59 from a purely economic perspective.

	Option 2 - 3 site option
Incremental costs - total	-£94,259.05
Incremental benefits - total	£149,871.42
Risk-adjusted Net Present Social Value (NPSV)	£55,612.37
Benefit-cost ratio	1.59

On the basis that Option 3, the 3-site model, delivers the highest NPSV and delivers against the CSFs the economic case concludes that this option as the preferred option. The financial and deliverability implications of this option will be explored in more detail in the financial and management case sections of the business case.

5. Financial Case

The following section will summarise the cost of delivering the current stroke service across L&SC for both providers and commissioners and will outline the anticipated financial impact of implementing the enhanced Network model of acute stroke care. In terms of the cost to commissioners of implementing the new pathway, the focus will be on the financial impact of the preferred option only. The financial oversight of this work has been provided by the Lancashire & South Cumbria Finance Advisory Committee, ICS Executive Director of Finance, CCG Chief Finance Officers and provider Directors of Finance.

5.1 Current Service Cost

The table below summarises the current cost to commissioners across the four acute providers.

	BTH		ELHT		LTH		UHMB		TOTAL	
SLAM Cost	Activity	Price £000	Activity	Price £000	Activity	Price £000	Activity	Price £000	ACTIVITY	INCOME £000
2021/22 *		£4,173		£6,920		£5,355		£4,765		£21,214
2019/20	590	£4,060	713	£6,732	605	£5,209	652	£4,635	2,560	£20,636
2018/19	699	£3,707	716	£5,790	482	£3,161	596	£3,140	2,493	£15,798
2017/18	535	£3,808	705	£4,201	617	£4,146	612	£3,357	2,469	£15,512
2021/22 Rehab Cost		£126		£576		£3,800		£0		£4,502
2021/21 Total Cost		£4,299		£7,496		£9,155		£4,765		£25,716

2021/22 cost based on 2019/20 uplifted to reflect current cost under block payment structure

In 2019-20, under the national payment by results tariff structure, the seven Lancashire & South Cumbria CCGs spent a total of £20.6m with the four main providers in respect of the coded activity for Stroke. The activity numbers charged via SLAM for primary diagnosis of Stroke have remained consistent over the three year period at approximately 2,500. However, the cost to commissioners over this timeframe has increased by £5m which is a reflection of improved data collection and capture of all co-morbidities and interventions generating the higher complexity tariff for patients.

In addition to the Stroke inpatient cost, commissioners have paid for the rehab element under local tariff arrangements. This brings the total inpatient pathway cost to £25.7m across the Lancashire & South Cumbria footprint.

In terms of how this commissioner cost compares to cost base of providers, the table below demonstrates that the in-patient and rehabilitation stroke service provides a good overall level of contribution to provider fixed costs.

	BTH £'000	ELHT £'000	LTH £'000	UHMB £'000	TOTAL £'000
Current provider service cost	£4,300	£4,879	£5,210	£2,655	£17,044
2021/22 In patient tariff income	£4,173	£6,920	£5,355	£4,765	£21,214
2021/22 Rehab income	£126	£576	£3,800	£0	£4,503
Total income	**£4,300**	**£7,497**	**£9,156**	**£4,765**	**£25,717**
Contribution	***£0***	***£2,618***	***£3,946***	***£2,109***	***£8,673***

5.2 Preferred Option

The predicted activity flows and financial impact for both capital and revenue have been based on the preferred option in relation to a 3 HASU model. Furness Hospital confirmed stroke patients will drip and ship to Royal Preston Hospital and Royal Lancaster suspected stroke patients will divert directly to Royal Preston Hospital as the Comprehensive Stroke Centre. East Lancashire Hospitals and Blackpool Teaching Hospitals will treat their own patients as Acute Stroke Units. Under this preferred option, the assumed activity flows are set out in the table below.

	A&E Activity						24%	0-3 days	4-10 days
Provider	Strokes	Mimics	TOTAL	RLI Direct to LTH	Confirmed Strokes	Discount MIMICS	Discharged from AMBC	Admit to HASU	Admits to ASU
BTH	507	1,014	1,521		465	264	243	642	480
ELHT	752	1,504	2,256		690	391	361	953	713
LTH	710	710	1,420	762	1,214	284	261	1,540	566
FGH	225	225	450		206	59	54	0	164
RLI	381	381	762	-762	0	0	0	0	279
	2,575	**3,834**	**6,409**		**2,575**	**997**	**919**	**3,135**	**2,202**

5.3 Financial impact of preferred option

A full baseline assessment has been undertaken of the current service cost for Stroke activity. The incremental cost of establishing the infrastructure and workforce requirements to deliver the future model has been estimated at £5.7m capital and £12.8m of recurrent revenue. Given the significant underlying deficit position of the Lancashire & South Cumbria ICS, this resource is not available for immediate investment. The collective finance community via the Finance Advisory Committee have agreed a phased approach to the investment to ensure the system has sufficient time to identify the resource over the three year period.

Prioritisation of investment has focussed on the elements of the new pathway that would deflect mimics/minor strokes via A&E Triage and Ambulatory diagnosis/treatment and also prompt discharge into community rehab and support teams. This will then have the benefit of 'right sizing' the inpatient capacity ready for investment in hyper and acute stroke pathways in subsequent years.

The phased investment plan for both capital and revenue it set out in the table below.

Year	Enhancement	Capital	Revenue	Total
2021/22	- Complete fully integrated community stroke rehabilitation recruitment – ***BwD CCG & Central Lancs CCGs only***		£943,100	
	- Blackpool hospital estate modification to enable provision of ambulatory care	£750,000		
	- Recruit stroke triage nurses – LTH, BTH and FGH		£242,900	
	- Enhance stroke specialist workforce to deliver 7 day ambulatory care – LTH, BTH, RBH and FGH		£606,700	
	- Increase hyper-acute stroke beds at Preston to facilitate 24/7 thrombectomy service (part SPEC COMM funded)		£484,900	
	Year total	**£750,000**	**£2,277,600**	**£3,027,600**
2022/23	- Enhance workforce to deliver 6 day in-patient rehabilitation – all sites including RLI		£2,395,600	
	- Additional Acute Stroke Centre equipment / ward reconfiguration	£2,330,400		
	Year total	**£2,330,400**	**£2,395,600**	**£4,726,000**
2023/24	- Expansion of Comprehensive and Acute Stroke Centre workforce to deliver 24/7 service – LTH, BTH and RBH		£6,528,600	
	- Additional Comprehensive and Acute Stroke Centre estates & equipment	£2,657,600		
	- Enhance workforce to deliver 7 day in-patient rehabilitation – all Trusts		£996,200	
	- Enhance NWAS resource to complete 4 patient transfers per day from UHMB to Preston and repatriation of HASU patients.		£1,650,000	
	Year total	**£2,657,600**	**£9,174,800**	**£11,832,400**
	TOTAL INVESTMENT	**£5,738,000**	**£13,848,000**	**£19,586,000**

A more detailed summary of investment by provider is attached at Appendix F.

5.4 Hosted Delivery Network

Aligned to the NHS Commissioning Reform objectives towards Strategic Commissioning of services at an ICS level by April 2022, this business case recommends the enhanced Network model of acute stroke care be **hosted by a single Trust and commissioned by the Lancashire and South Cumbria Strategic Commissioner from 2022/23**.

This will enable the potential sharing of resources across all Trusts to achieve better outcomes for patients and financial improvements, while retaining their original legal entity and minimising any stranded costs incurred.

5.5 Costs and ROI for the New Model of Care Components

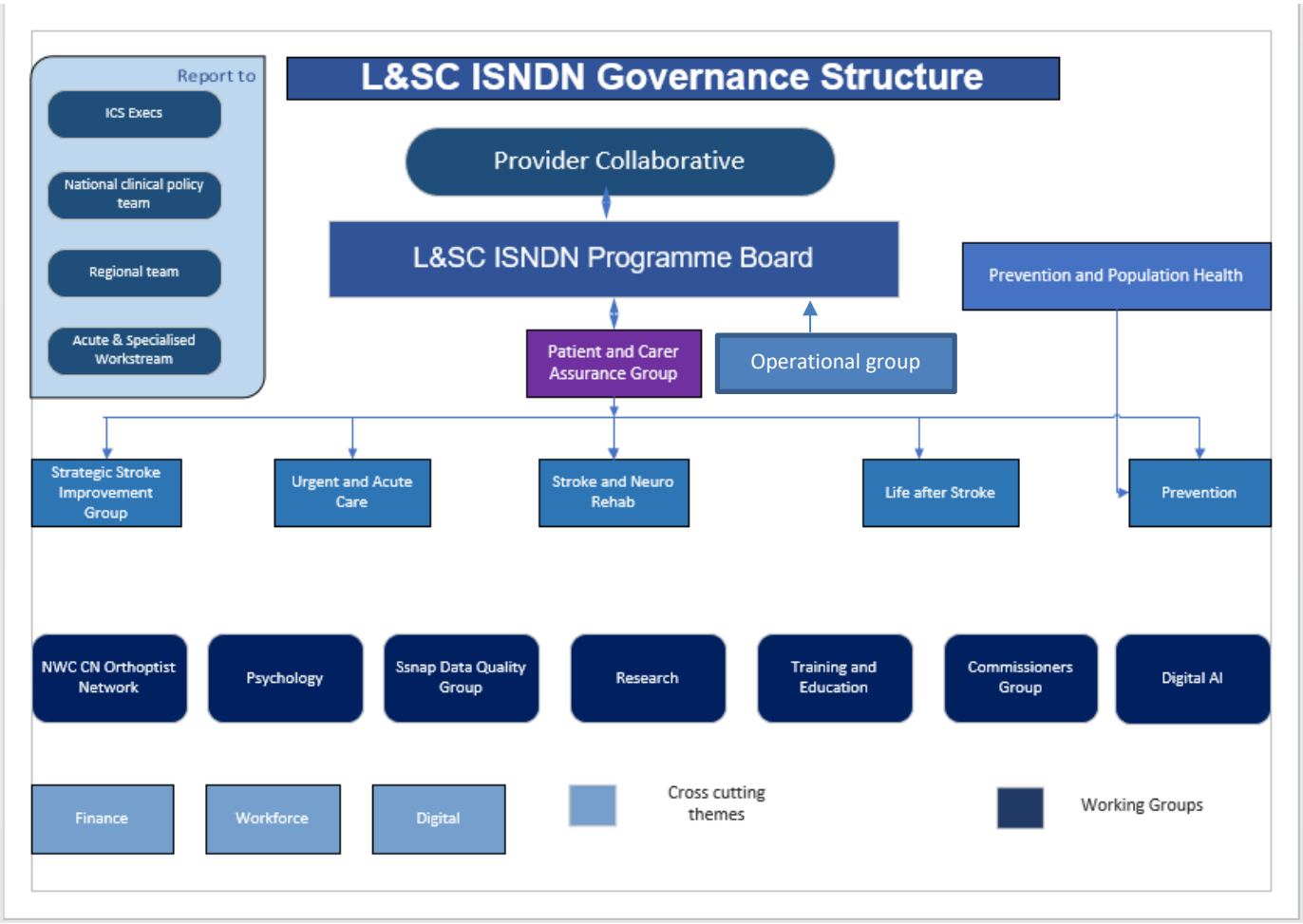
Component	Costs	ROI
ED Triage and Ambulatory emergency care pathway in all stroke receiving hospitals can filter up to 74% of stroke mimics away from an acute stroke bed to more appropriate pathways of care, reducing avoidable cost.	£606,700 staffing Ambulatory care £242,900 staffing ED triage £750,000 Estates	Savings – c.2837 patients in scope – equates to £2.27 million as a minimum
Enhancing the provision of hyper-acute stroke bed care (<72hrs) through investment in Acute Stroke Centre staffing will reduce mortality and disability and is cost effective. *References:* *National Audit Office, 2010* *Kings College, Draft evidence review, 2020*	Average increase per-patient cost of 32.3% in real terms (to £10,962 from £8,287 (2021/22),) this is the total cost of the inpatient spell **not** just the first 72 hours	Reductions in death (36 per year) and disability (for 361 patients per year). Estimated that the average number of *Consider: money being saved through lower rates of admissions to intensive care units, fewer admissions to long term nursing home care and reduced requirements for social support in the community.*
Increasing the number of patients who receive IVT will further reduce mortality and disability than the current model. *Ref: Royal College of Physicians Sentinel Stroke National Audit (SSNAP). Cost and Cost-effectiveness analysis. NHS England; 2016*	The cost of IVT treatment in England is estimated at £1,214 per patient (including cost of medication and staff time for administration)	For each extra patient receiving IVT, an NHS savings of around £4100 and health gains of 0.26 QALYs are expected during the first 5 years from stroke onset. For L&SC thrombolysing an additional 140 eligible patients would mean an NHS saving of £481,900 and social care saving of £444,700 and 36.4 QALYs.
Increasing the number of patients who receive IAT will reduce mortality and disability than the current model. *Ref: Ganesalingam J, Pizzo E, Morris S, Sunderland T, Ames D, Lobotesis K. Cost-Utility Analysis of Mechanical Thrombectomy Using Stent Retrievers in Acute Ischemic Stroke. Stroke.2015;46(9):2591-2598.*	The cost of IAT is £8,365 per patient (including the cost of the stent, the material and the procedure).	The incremental cost of £7,431 per patient was estimated to yield an additional 1.05 QALYs over 20-years period (about 3.8 QALYs for IVT alone versus 4.8 QALYs for adjunctive IAT).
Increasing the AHP staffing in Stroke Recovery Units (>72hrs) at all sites	£3.4 million	An additional 361 stroke survivors will experience reduced level of disability and increased return to independence. With the development of the ICSTs more patients will return home quicker from the CSC/ASC therefore in the longer term reducing the need for inpatient rehabilitation.

6. Management Case

This section describes the structures and processes for the programme management arrangements to ensure robust management throughout the life-cycle of the programme. This will then provide an established governance structure to support the service following implementation and during business as usual.

6.1 Programme Governance and Management

The implementation will be delivered by a dedicated Operational Implementation Group which will report directly to the ISNDN Board. The governance structure is illustrated below:



6.2 Programme Plan

The stroke programme management team has developed a high level implementation plan, subject to adjustment under the direction of the ISNDN Board, for the recommended preferred option to show how the transition would take place over three years, as advised by the Finance Advisory Committee.

The local ambition is to implement the new services as efficiently as possible whilst ensuring that quality and patient safety are not compromised. Planning principles will need to be agreed to support the development of a detailed implementation plan, including:

- reflecting the projected flows between hospitals and the impact on activity, beds, travel time and workforce over the transition period
- understanding the impact of a phased approach on the workforce, ambulance service and patients

- assessing the ability of site operational teams to accommodate the transition based on seasonal variation in demand and staffing shortfalls.

The key considerations to ensure successful implementation of the plans are securing the capital monies, the lead time for capital developments, the flows of activity between hospital sites (i.e. that capacity is ready in an ASC/CSC to successfully run the triage, treat and transfer model), the availability of the workforce to staff units, a robust and comprehensive communications and engagement plan and developing locally agreed mitigations to the areas identified in the Equality Impact Assessment and travel impact analysis.

The high-level outline plan is illustrated below.

		2021/22			2022/23				2023/24			
		Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
	Enablers											
1	Obtain agreement and endorsement of the model to be in implemented											
2	Develop Communications and Engagement plan											
3	Develop workforce strategy											
4	Secure the capital and revenue monies for 2020/21											
5	Secure the lead in time for 2020/21 capital development of estate modification to Blackpool hospital to enable provision of ambulatory care											
6	Establish acute stroke services workstream implementation group											
7	Establish working groups to lead on both the planning and development required to support changes to service provision.											
	Project priorities for 2021/22											
8	Complete full integrated community stroke rehabilitation recruitment across the											
9	Recruit stroke triage nurses to strengthen the region's ED front doors											
10	Recruitment to deliver 7 day ambulatory care across the region's ED front doors											
11	Increase hyper acute beds at Royal Preston to support expansion of thrombectomy											
12	Blackpool hospital estate modification for provision of ambulatory care											
13	Secure the capital and revenue monies for 2022/23											
	Project priorities for 2022/23											
14	Recruit workforce to deliver 6 day in-patient rehabilitation – all Trusts											
15	Procurement of the required Acute Stroke Centre equipment											
16	Ward reconfiguration at RPH											
17	Secure the capital and revenue monies for 2023/24											
18	Plan with NWAS to manage additional ambulance journeys											
	Project priorities for 2023/24											
19	Recruit workforce to deliver 24/7 services at ASCs and CSC											
20	Procurement of equipment to deliver 24/7 services at ASCs and CSC											
21	Ward reconfiguration at RBH											
22	Recruit workforce to deliver 7 day in-patient rehabilitation – all Trusts											
23	Plan for evaluation and realisation of benefits											

6.3 Benefits Framework and Management

The benefits framework outlines the methodology for collecting and reporting against different elements of the Programme. The framework describes four complementary methods of capturing progress against the process measures defined in the standards and measurement of improvements. These elements are as follows:

- **Readiness Assessment** - This self-assessment tool will be used to give assurance that key and mandatory elements are in place to support 'go-live'. The assessment will be split into sections to cover pre-live, implementation and post 'go-live' elements and will include the process standards developed during the design phase.

- **Clinical Dashboard (SSNAP)** – The existing SSNAP clinical dashboard will be used to measure performance of the new service model against standards.

- **Peer Review process** - An annual peer review process will be introduced utilising clinical champions. This will include site one-day visits where paper-based evidence for standards is required that are not already captured via the dashboard and readiness assessment.

- **Annual Report** - Outputs from the key elements of the framework, the readiness assessments, clinical dashboards and peer review will be collated into the ISNDN annual report detailing performance across L&SC. This report will identify performance against the keys aims of the programme.

6.4 Post implementation evaluation

An evaluation will be undertaken following full implementation of the new model of care to assess the effectiveness of the project in realising the proposed benefits as outlined in the model of care and Business Case. The following clinical elements will be used to evaluate the impact of the programme:

- Increase in specialist assessments
- Reduction in inappropriate admissions
- Increase in number of patients discharged through ambulatory care
- Reduction in door to needle time
- Increase in number of thrombolysis and thrombectomy procedures
- Decrease in length of stay
- Decrease in transfers to rehabilitation unit
- Increase in referral to ICSTs
- Reduction in level of disability
- Reduction in number of deaths
- Reduction in health inequalities

The national PROMS and PREMS are in the process of being developed. Once approved these will be used for measurement of patient experience. The Communications and Engagement plan will also include approaches to obtain, review and act upon patient, carer and staff experience.

6.5 Change management and communications

The ISNDN implementation steering group will manage the organisational and cultural changes arising from the implementation of the programme. These change management processes are interwoven into the governance of the programme, the programme plan and the readiness assessment within the benefits framework.

Communication during implementation will be managed by the L&SC communications team.
It is envisaged there will be regular communication through team brief and in the Trust staff bulletin. Regular meetings will be scheduled with staff working within Acute Stroke services and the regional Thrombectomy service to ensure they are appraised of progress.

Formal up-dates will be provided to relevant Trust Boards/Committees as per the Trust Governance structure.

External communication and engagement will be coordinated with the ISNDN utilising existing structures. The ISNDN will also work with the Stroke Association to ensure consistency of message and engage with established patient networks.

The engagement plan will include a multi – factorial approach to ensure the wider L&SC public and services are aware of the transformation. The first draft of the communications plan is shown in Appendix G.

6.6 Interdependencies

The programme interdependencies will be regularly considered through the ISNDN Board in order to make best use of existing and evolving resources as the programme continues to be implemented.
Where there is a risk related to interdependency, this is captured and managed in the risk log at Programme level and escalated as required.

6.7 Risk Management

The programme approach to risk management is embedded in the formal governance structure for the ISNDN 2021/22 Work Programme.

The risks and issues management framework provides a structured approach to allow enhanced strategic and business planning, and best practice approach to risk management to ensure:

- The value and benefits of risk and issue management are understood by all partners
- Roles and responsibilities are clear
- Risk management is applied in the day-to-day processes.

Strategies will be in place for the proactive and effective management of risk as outlined below.

The programme has mechanisms in place to ensure all stakeholders are able to identify and flag potential risks, with review process to ensure controls to minimise the likelihood of them materialising with adverse effects.

Risks can be raised at all levels then reviewed through the ISNDN Implementation Steering Group on a monthly basis. Key programme risks are managed by the programme team with designated owners and escalated and reviewed through to the ISNDN Board on a monthly basis.

The main programme risks are captured on a risk and issues log and are scored using a likelihood/ impact matrix.

Identified risks are categorised by work stream and assigned to the most appropriate person for ongoing management.

The ISNDN Manager will be responsible for ensuring that the register, including mitigating actions is updated monthly, and presented to the ISNDN Board.

All single provider risks will be reviewed and managed within existing internal governance frameworks and escalated within the programme if required. The ISNDN Implementation Steering Group will be able to generate actions and working groups to help resolve risks as well as ensuring shared learning across L&SC. In addition, meeting minutes detail any newly identified risks. Escalation of risks due to score, impact etc. is through ISNDN Implementation Steering Group to ISNDN Board.

Key risks to the implementation have been outlined in section 3.8.

Appendix A – Case for change engagement and decision making

The Case for Change was presented at the following fora:

Date	Forum	Outcome
Sept 2019	Lancashire Health Scrutiny Steering Group Committee	Group concluded that formal public consultation was not required and engagement activities proportionate to the number of patients affected by the proposed change had been undertaken during the design process.
Dec 2019	Joint Committee of CCGs	Request for the Full Business Case and supplementary information to focus and give assurance on: • The full financial impact of implementing the new model of acute stroke care • Equality Impact Assessment • Travel Impact Assessment • Community Stroke Rehabilitation Services – whilst this full business case relates to acute stroke care in hospital, assurance is required that high intensity community stroke rehabilitation services are in place.
Jan 2020	NHS England	Confirmation that the NHSE 5 Stage process was correct to follow in relation to the proposed service enhancements.
March 2020	ICS Executive Team	Stand down the stroke transformation programme and the development of the full business case in response to the action required to manage the COVID-19 pandemic.
Nov 2020	Provider Collaborative Board	Permission to resume action on the acute stroke transformation priorities, including the resumption of the development of this business case with implementation oversight to be provided by the newly formed L&SC Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN).

Appendix B – Assumptions used for New Model of Care

Lancs and Cumbria Stroke Services Modelling - Assumptions Log

#	Assumption	Source	NWCSCN agreed	Comments
	NWAS			
1	Ambulance modelling has been completed by NWAS and does not need to be considered in this model			
	AED			
2	Total number of confirmed stroke presentations in 2020/21 is 2575	SSNAP		FGH 225, RLI 381, Blackpool 507, Blackburn 752, Preston 710
4	The stroke to mimic ratio is 2:1 at BVH and RBH and 1:1 at all others	Group		
5	Under a drip and ship model, non HASU centres will assess stroke presentations in AED before transfer to HASU centre	Group		Non-HASU will exclude 50% of mimics. Some of these will still require admission but not to a
6	24% of patients will be discharged from AED under the TIARA model	Local pilots		
7	12% of patients will present after 48 hours and will stay in the local stroke unit	3 of the 5 pt level data		
8	5% of patients eligible for transfer for treatment will refuse and therefore stay in the local stroke unit	M'OD		
	Tertiary Centre			
10	10% of stroke presentations will be eligible for IAT	National targets		
11	IAT will be undertaken at Preston	Group		
	HASU			
12	Under a direct transfer model, 100% of patients will be taken directly to the nearest HASU	Group		
13	There will be a 72 hour stay at the HASU	Group		
14	Mortality rate at 72 hours is 3.3%	SuS		Confirmed with local data
15	Bed Occupancy is 85%	NICE guidance		
	ESD			
16	40% of patients discharged from the HASU will require ESD	National targets		
	ASU			
17	There will be a median length of stay of 7 days on ASU	Group		
18	24% will be discharged from ASU and not need rehab (either home or mortality)	SuS		Confirmed with local data
25	Patients will be repatriated from the HASU to their local ASU	Group		
26	Bed Occupancy is 85%	NICE guidance		
	Rehab			
27	There will be a median length of stay of 23 days on the rehab ward			FGH 72, RLI 137, Blackpool 233, Blackburn 260, Preston 176
28	Bed Occupancy is 85%	NICE guidance		

Appendix C - Benefits of proposed enhanced stroke network model of care

Reduction of health inequalities of healthcare	All patients in ICS footprint will have access to high quality hyper acute stroke care that meets national best practice standards. As the transformation programme will be operationally delivered by the ISNDN, unwarranted variation will be reduced through improved performance by all acute stroke care providers on SSNAP i.e. aspiration for all Providers to achieve and maintain A ratings.
	Reduction in inequalities in access, patient experience, quality of care and outcomes.
	Should acute stroke services be commissioned by a single commissioning organisation in the future, it is expected this will support further elimination of unwarranted variation.
Improved sustainability and resilience of acute stroke service	The stroke programme transformation will strengthen acute stroke care provision with the adoption of a regional approach for the stroke pathway across L&SC.
	Improved staffing levels - greater job satisfaction for stroke specialist staff.
	Work on standardisation of high quality practices will continue bringing about improved patient flow and standards of care.
	Attract and retain high quality specialist stroke work force with decreased reliance on locums.
	Improved patient flow between hyper acute, acute and rehabilitation phases.
Improved Clinical Quality – Clinical Effectiveness, Patient Safety and Patient Experience	The ASCs and CSC will have patient numbers of sufficient size (>600 stroke admissions per year) to provide sufficient patient volumes to make an acute stroke service clinically sustainable, to maintain expertise and to ensure good clinical outcomes.
	Enhanced patient safety through care delivered by skilled, adequate staffing levels and stable workforce.
	More integrated and coordinated care with enhanced communication between providers.
	Enhanced patient and carer experience, via the delivery of high quality stroke care in a timely manner from skilled experience team
Improvement in health outcomes	Reduction in in-hospital and overall mortality from stroke.
	Reduction in disability from stroke and improved quality of life for people who have had a stroke.
	Increase in thrombolysis rates from 8% towards 15%
	Increase in mechanical thrombectomy rates from 3% towards 10%
	A higher proportion of people who have had a stroke are able to return home to live independently and return to work.
	Reduction in number of patients newly discharged to care homes / requiring continuing health care.
Minimising Costs of acute stroke care	Reduction in length of hospital stay.
	Return on investment expected

Appendix D – Scoring panel membership

Title	Name	Organisation	Representation
Local Commissioning	Helen Rushton	Central Lancashire ICP	Commissioning
Local Commissioning	Jeannie Hayhurst	Fylde Coast ICP	Commissioning
Local Commissioning	Helen McConville	Morecambe Bay ICP	Commissioning
Specialised Commissioning	David Schofield	North of England Specialist Commissioning Team	Commissioning
Local Commissioning	Collette Walsh	Pennine ICP	Commissioning
Healthcare Public Health Consultant	Aidan Kirkpatrick	Public Health England - Lancashire	Commissioning
Healthcare Public Health Consultant	Dr Matt Saunders	Public Health England - Cumbria	Commissioning
Operational Manager	Susan Roberts	Blackpool Teaching Hospitals Trust	Management
Operational Manager	Michelle Montague	East Lancashire Hospitals Trust	Management
Operational Manager	Brian Boardman Connell	Lancashire Teaching Hospitals Trust	Management
Operational Manager	Neil Smith	University Hospitals of Morecambe Bay Trust	Management
Director of Clinical Effectiveness and Deputy Medical Director	Grahame Goode	Blackpool Teaching Hospitals Trust	Medical
Clinical Lead	Anis Ahmed	Blackpool Teaching Hospitals Trust	Medical
Medical Director	Jawed Husain	East Lancashire Hospitals Trust	Medical
Clinical Lead	Dr Nicholas Roberts	East Lancashire Hospitals Trust	Medical
Medical Director	Gerry Skailes	Lancashire Teaching Hospitals Trust	Medical
Interventional Neuro radiologist	Sid Wuppalapati	Lancashire Teaching Hospitals Trust	Medical
Clinical Lead	Dr Hari Bhasker	Lancashire Teaching Hospitals Trust	Medical
Medical Director	Dr Shahedal Bari	University Hospitals of Morecambe Bay Trust	Medical
Clinical Lead	James Barker	University Hospitals of Morecambe Bay Trust	Medical
Stroke Consultant	Gill Cook	University Hospitals of Morecambe Bay Trust	Medical
Clinical Nurse Specialist	Mark Delajaban	Blackpool Teaching Hospitals Trust	Nursing
Clinical Nurse Specialist	Catherine Curley	East Lancashire Hospitals Trust	Nursing
Clinical Nurse Specialist	Anu Thomas	Lancashire Teaching Hospitals Trust	Nursing
NWAS	Matt Dunn	NWAS	NWAS
Patient Transport	Nathan Hearn	Patient Transport Services	NWAS
Carer	Susan Schofield	Patient and Carers	Patient and Carers
Carer	Les Readfearn	Patient and Carers	Patient and Carers
Carer	Cheryl Nichols	Patient and Carers	Patient and Carers
Patient	Paul McCormack	Patient and Carers	Patient and Carers

Patient and carer	Jean Sherrington	Patient and Carers	Patient and Carers
Patient	Kay Rawcliffe	Patient and Carers	Patient and Carers
Patient	Phil Woodford	Patient and Carers	Patient and Carers
Patient	Derek Passmore	Patient and Carers	Patient and Carers
GP	Dr Gary Wallis	L&SC Primary Care representative	Primary Care
Allied Health Professions Lead	Nick Lane	Blackpool Teaching Hospitals Trust	Rehabilitation
Allied Health Professions Lead	Alison Turner	East Lancashire Hospitals Trust	Rehabilitation
ICS Rehab Clinical Lead	Sian Davies	ICS	Rehabilitation
ICS Rehab Clinical Lead	Helen Vernon	ICS	Rehabilitation
Allied Health Professions Lead	Claire Granato	Lancashire Teaching Hospitals Trust	Rehabilitation
Clinical Service Manager, Integrated Community Stroke Team	Yvonne Hastings	University Hospitals of Morecambe Bay Trust	Rehabilitation
Stroke Association Lead- North	Nikki Chadwick	Stroke Association	Stroke Association Lead- North

Panel members abstained from scoring.

Appendix E - Scoring exercise results

Option		1	2	3
Option description		Do nothing	Blackpool Victoria Hospital is the third Acute Stroke Centre	Royal Lancaster Infirmary is the third Acute Stroke Centre
Final Score		35.95%	69.31%	54.31%
Parameter		Option meets only some criteria	Option moderately meets the criteria	Option moderately meets the criteria
Recommendation		Not recommended but further investigation or evidence may be required	Option is recommended but review, mitigation or modification may be required to particularly low scoring criteria	Option is recommended but review, mitigation or modification may be required to particularly low scoring criteria
		% scored within Theme		
A	**Quality and safety**	27.35%	63.25%	41.03%
B	**Access**	42.09%	67.95%	62.39%
C	**Patient and carer experience**	52.35%	79.49%	76.50%
D	**Value for money**	18.80%	65.81%	35.04%
E	**Deliverability**	39.46%	70.09%	56.98%

Appendix F – Detailed costings by provider

	PRIORITIES	BTH requirements	BTH Estimated cost £000's	ELHT requirements	ELHT Estimated cost £000's	LTH requirements	LTH Estimated cost £000's	UHMB requirements	UHMB Estimated cost £000's	TOTAL £000's
YEAR 1 2021/22	Complete fully integrated community stroke rehabilitation recruitment – BwD CCG & Central Lancs CCGs only	Funding agreed with CCG and service in place	0.0	To invest in and strengthen BwD service offer	243.1	Central Lancashire CST - phase 2 to be implemented	700.0	Funding agreed with CCG and service in place	0.0	**943.1**
	Recruit stroke triage nurses – LTH, BTH and FGH	Additional Nursing assistants	59.5			24/7 Specialist nurses rota	91.4	Recruitment of ANP's	92.0	**242.9**
	Blackpool hospital estate modification to enable provision of ambulatory care	Capital requirement	750.0							**750.0**
	Enhance stroke specialist workforce to deliver 7 day ambulatory care – LTH, BTH, RBH and FGH	Nurse Consultant & HCA support	214.7	Nurse Consultant & HCA support	133.6	Nurse Consultant & HCA support	166.4	Nurse Consultant & HCA support	92.0	**606.7**
	Increase hyper-acute stroke beds at Preston for additional thrombectomy activity **(SPEC COMM COST)**					Middle grade & ward nursing support	484.9			**484.9**
	OVERALL TOTAL	**BTH**	**1,024.2**	**ELHT**	**376.7**	**LTH**	**1,442.7**	**UHMB**	**184.0**	**3,027.6**
YEAR 2 2022/23	Preparation for transition to become ASC and CSCs - estates and equipment	ECG, Scanners, Monitors	149.9	ECG, Monitors, hoist	180.5	Reconfiguration required for thrombectomy service and CSC	2,000.0			**2,330.4**
	Ensure all sites providing a 6 day rehab service	Physio & OT additional staff for 6 day service	146.3	Physio & OT additional staff for 6 day service	443.8	Physio & OT additional staff for 6 day service	766.6	Physio & OT additional staff for 6 day service	1,038.9	**2,395.6**
	OVERALL TOTAL	**BTH**	**296.2**	**ELHT**	**624.3**	**LTH**	**2,766.6**	**UHMB**	**1,038.9**	**4,726.0**
YEAR 3 2023/24	Expansion of Comprehensive and Acute Stroke Centre workforce to deliver 24/7 service – LTH, BTH and RBH (includes non pay requirements across all sites)	Clinical leads, ward nursing and support staff and pharmacy tech	2,730.1	Clinical leads, Radiologist, ward nursing & Support staff	2,342.1	Clinical leads, ward nursing & Support staff, Psychology support	1,456.4			**6,528.6**
	Expansion of Acute Stroke Centres - Blackpool and Blackburn sites. Preston - equipment only	IT & Specialist equipment	83.1	Capital Investment and IT equipment	2,204.5	Monitors and Orthoptic equipment	370.0			**2,657.6**
	7 day rehab service across all acute sites – workforce requirement pending.	Increased staffing to deliver 7 day service	223.2	Increased staffing to deliver 7 day service	154.8	Increased staffing to deliver 7 day service	144.0	Increased staffing to deliver 7 day service	474.2	**996.2**
	Enhance NWAS resource to complete 4 patient transfers per day from UHMB to Preston and repatriation of HASU patients.									**1,100.0**
	OVERALL TOTAL	**BTH**	**3,036.4**	**ELHT**	**4,701.4**	**LTH**	**1,970.4**	**UHMB**	**474.2**	**11,282.4**
	TOTAL INVESTMENT (YEARS 1 TO 3)	**BTH**	**4,356.8**	**ELHT**	**5,702.4**	**LTH**	**6,179.7**	**UHMB**		**19,036.0**

NOTE The estimated costs for workforce are based on mid point costs
Thrombectomy costs included above which will be funded by Specialised Commissioning as the responsible commissioner

Appendix G – Communications and engagement plan

Task Name	Due Date	Status	Comments
Comms and engagement resources			
Core narrative document	02/07/21	In Progress	02/07: JSchol has provided first draft of narrative and shared with team for comment. To be agreed by Jack Smith and Elaine Day along with Phil Woodford and John Barbour. To be shared with Directors of Comms across LSC Trusts and Heads of Comms in LSC CCGs.
Q&A document	02/07/21	In Progress	02/07: JSchol and PW provided first draft of FAQs. JSchol updating today and redistributing to the group.
Key messages	02/07/21		
Press Handling	02/07/21	In Progress	02/07: SR drafted lines and now with PW for review - Morecambr Bay related ICS Comms team to own press handling to cover whole region
Website and online information	Commence on 15/07/2021	In progress	
Graphic representation of proposal - turning the narrative into a more visual way of representing the narrative and ideally some of the Key messages	Commence on 15/07/2021	Not commenced	
Easy read materials to describe model	Commence on 15/07/2021	Not commenced	
Audience and stakeholders	05/07/2021	In Progress	Michelle to produce Morecambe Bay audience and stakeholder mapping - JS to consider wider Lancashire and South Cumbria.
Delivery & action plan for both pre 15 July and after	02/07/2021	In Progress	
Folder on Kahootz as repository for all resources and evidence	02/07/21	Complete	
Share any supporting materials	Ongoing	In progress	Save useful programme materials e.g. statements, briefings etc.in Kahootz folder for use as supporting documentation throught comms and engagement.
Plan for immediate engagement (pre 15 July)			
Agree core narrative document	05/07/2021	In Progress	Jeremy Scholey and Neil Greaves to co-ordinate agreement from JS and ED with involvement of group.
Contact Morecambe Bay MPs and offer discussions/update ahead of 15 July	02/07/21	In Progress	Meeting arranged at 4pm Fri 2 July. Jack Smith, Elaine Day, Phil Woodford, Aaron Cummins to attend
Contact Lancashire and South Cumbria MPs (excluding MB) with brief update ahead of SCC	06/07/21	In Progress	Recommended update letter ahead of 15 July SCC.
Lancs and Cumbria HOSCs	TBC	In Progress	Phil contacting both county HOSCs to arrange updates.
Inform HOSC Chairs in Blackpool and Blackburn with Darwen	07/07/2021	Not commenced	
UHMBT stroke pathway staff	05/07/21	In Progress	02/07: PW and LJ meeting with Shahedal 5pm today to ensure there a plan for engaging and communication with all UHMBT staff in the stroke pathway w/c 5 July and clinical lead Gill Cooke is involved.
Inform stroke pathway staff in Fylde Coast, Pennine Lancashire, West Lancashire, Central Lancashire	05/07/21	In Progress	NG to develop lines to be shared with Stroke staff across the system
Plan for wider engagement			
Attend and present an update at BwD and Blackpool HOSCs	TBC	Not commenced	
Develop single website for information about stroke pathway	15.07.2021	In Progress	Include messages for trust and CCG staff to link to website for consistent information
L&SC MPs			Letter to build on narrative, proposals taken to SCC on 15/07 re new model of services, key messages. Meetings with MPs on request with Jack Smith to attend with relevant trust CEO and CCG AO where appropriate.
Morecambe Bay GPs	15/07/21	In Progress	F2F briefings via Teams. Two or three sessions pre the 15th re proposal. Jack and Cath to provide availability. MJ arranging sessions.
GPs across the rest of Lancashire and South Cumbria	Post 15/07/2021		
Planning from outcomes of HOSC discussions	15/07/21	Not commenced	Planning for if any of the improvements are considered to a 'substantial variation' -conversations with HOSC and CCG
Primary care Patient User Groups	Post 15/07/2021	In Progress	MJ ascertaining best approach for involving these groups. JS to consider messages for groups across LSC.
BAE employees in Barrow	Post 15/07/2021	In Progress	MJ finding how to link with BAE occupational health colleagues
BTHT, ELHT, LTHT stroke pathway staff	Post 15/07/2021	Not commenced	NG to ontact LTH/BTH and ELHT about potential F2F briefings ahead of 15 July. Working with Shelley Wright and Naomi Duggan
Wider public - update stroke survivor groups across LSC	Post 15/07/2021	Not commenced	Engagement sessions using key messages and additional materials
Wider public - develop plan for reaching wider public	Post 15/07/2021	Not commenced	Engagement sessions using key messages and additional materials

Appendix H – Stroke prevention activities

Preventing strokes in L&SC – Information sheet

Improvement activities for **preventing strokes** are currently led by Public Health England and more locally in Lancashire and South Cumbria by the Stroke Prevention Alliance. Clinicians have identified the following factors as crucial to improving stroke prevention:

- Reduction in smoking rates
- Improvements in diabetes detection and care
- Better identification and management of high blood pressure and atrial fibrillation
- More wide use of statins

The Stroke Prevention Alliance has produced a five year strategy, it is now its second year, the targets within the strategy (see below) have been embedded in 80% of GP contracts, further work needs to be done on this:

1. Diagnosed 90% of all people estimated to have atrial fibrillation
2. Treated (with anticoagulation) 90% of those with atrial fibrillation who are at high risk of stroke
3. Diagnosed 80% of all people estimated to have high blood pressure
4. Treated (to NICE recommended blood pressure thresholds) 80% of those diagnosed with high blood pressure
5. Ensured that 75% of people aged 40-74 have had their cardiovascular disease risk assessed
6. Treated 60% of those at high risk (>20%) of developing cardiovascular disease over the next 10 years

This presents a societal challenge in the future which will require additional funding and policy support.

Public Health England has historically highlighted the considerable diagnosis and treatment gap that currently exists for these key risk factors along with an associated economic analysis:

The diagnosis and treatment gap across Lancashire and South Cumbria[i]

1. The diagnosis and treatment gap, 2015/16		
Hypertension	Estimated adult population with hypertension	433,900
	Estimated adult population with undiagnosed hypertension	175,900
	GP registered hypertensives not treated to 150/90 mmHg target	50,800
Atrial Fibrillation (AF)	GP registered population with Atrial Fibrillation (AF)	33,200
	Estimated GP registered population with undiagnosed AF	13,500
	GP registered high risk AF patients (CHA2DS2VASc >=2) not anticoagulated	7,200
CVD risk	Estimated adult population 30 to 85 years with 10 year CVD risk >20%	123,000
	Estimated percentage of people with CVD risk ≥20% treated with statins	49%

Although the associated economic modelling was undertaken just over three years ago, it nevertheless powerfully made the point that achieving optimal treatment of hypertension and high risk atrial fibrillation alone in Lancashire and South Cumbria could result in the prevention of more than 1000 strokes and 300 heart attacks as well as £18.2 million saved in treatment costs over a three year period. Although the economic modelling did not extend as far as the impact of improved cholesterol management it is hoped that this will be provided as the wider CVD Prevent Audit programme is rolled out though it is acknowledged that even this national audit has been significantly impacted by COVID19 in the same way that our local Stroke Prevention Programme has.

[i] Size of the Prize Data, Public Health England, 2017

Strategic Commissioning Committee

Date of meeting	**15/07/2021**
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	**8**
Confidential	**No**

Purpose of the paper
For information and discussion
Executive summary
The ICS Quality and Performance work stream continues with the first phase of an accountability framework for the ICS and ICPs to enable the reporting and improvement of health inequalities, Performance and Quality. This paper is from the Quality and Performance work stream that attempts to bring together collective oversight for commissioning. It provides a static summary of a dynamic report built in Aristotle and provides a high level ICS summary as well as insight into its constituent parts. The key next phase will be working to the dynamic reporting mechanism that will be required for the Quality and Performance Group which will report to the Quality and Performance Sub-Committee and Strategic Commissioning Committee.
Recommendations
The Quality and Performance Sub-Committee is requested to note the contents of this Quality and Performance Report and support its development.
Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

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

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

Report authorised by:	

ICS Quality and Performance Report

8th July 2021

1. Introduction

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

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

1.3. During June the new NHS Oversight Framework was published and future reports will be reset accordingly.

1.4. 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.

1.5. The focus areas in this month's report are in regards to Mental Health and Elective Care and progress on recovery. Next months focus areas are planned to be Urgent Care and Cancer.

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

1.7. The Q&P will escalate areas of concern into the SCC as necessary. This will be forward plan will be flexible so that agenda's that are escalating can be put on the Q&P agenda without delay.

2. Quality & Performance Indicators

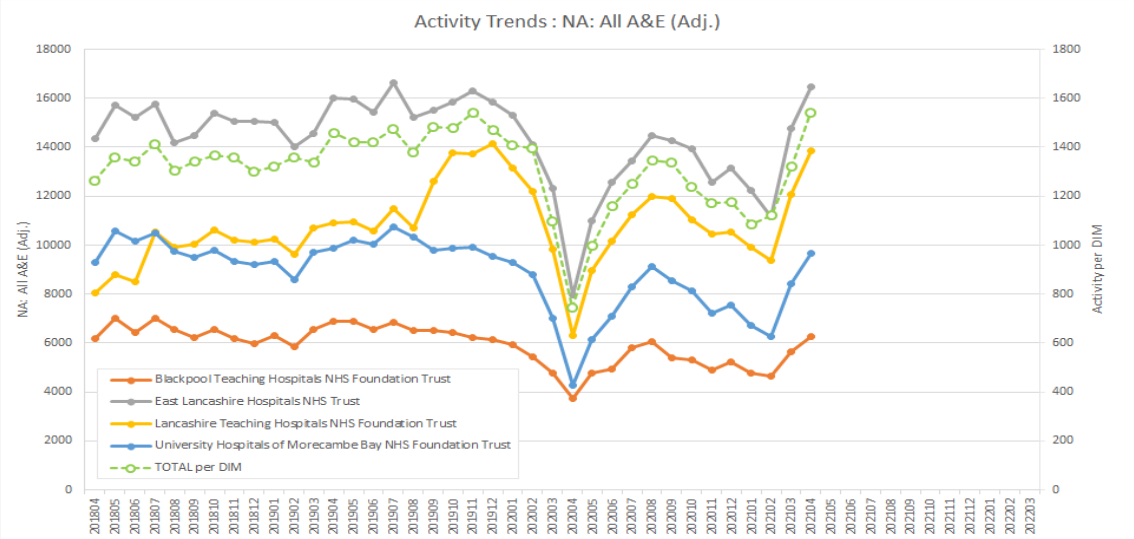
This month's report focuses on the following elements of Quality and Performance:

- Urgent Care
- Cancer Services
- Diagnostics
- Nosocomial Infections
- Individual Patient Activity and Continuing Healthcare
- Safeguarding
- CAMHS
- Adult Mental Health
- Learning Disabilities and Autism
- Elective Care Focus Area (separate attachment)
- Mental Health Focus Area (separate attachment)
- Glossary
- Appendices
    - Appendix 1: ICS Performance Metrics (separate attachment)

3. Urgent Care

3.1. Type 1 performance against the 4 hour standard continues to be a challenge, deteriorating in both April and May 2021. All providers across L&SC are following similar downward trends, although BTHT have experienced some improvement during May 2021.

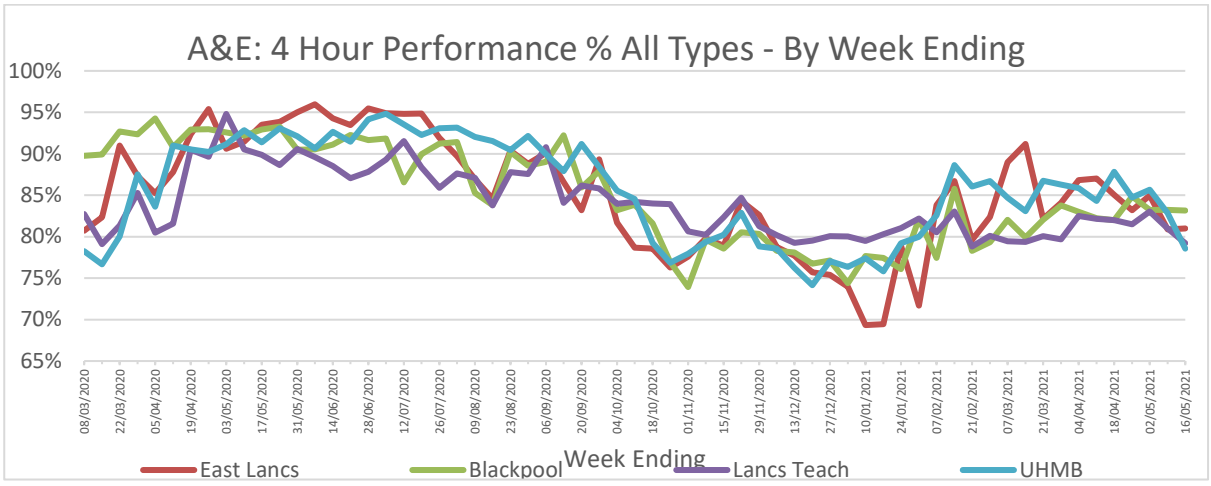
3.2. There has been an increase in Type 1 attendances since the beginning of March 2021, not mirrored by an increase in activity triaged into a cubical within majors. Morecambe Bay and Fylde Coast have seen more out of area attends as people seek to holiday in the UK. This suggests the increase in activity is of lower acuity attends, that could have been prevented if there able to be diverted to alternatives such as Primary Care, Community Services or out of hospital services, such as Urgent Treatment Centres. The graph shows attendances are now back to pre-pandemic levels.



3.3. The average number of G&A beds occupied has remained high since the beginning of the year. High attends, admissions and bed occupancy levels have a direct impact on flow across the system and continue to contribute to the challenging 4-hour performance.

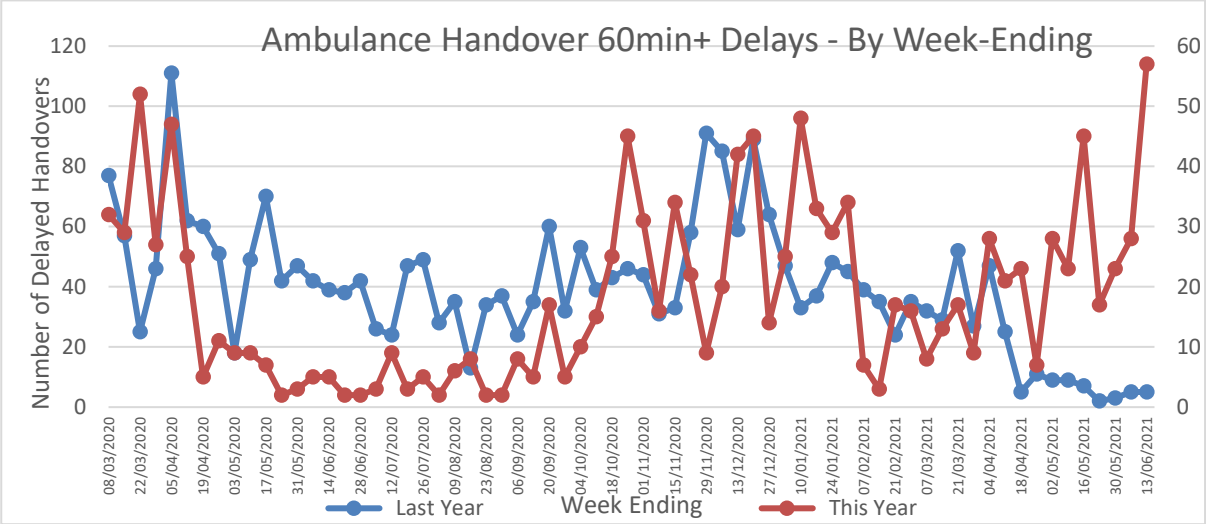
3.4. Pennine Lancashire have introduced 10 initiatives to improve performance and address any potential impact of quality and care while in Central Lancashire a Standardised Operating Procedure for long stays has been introduced to formalise safety and assurance checks.

3.5. The May 2021 position for all type A&E performance across L&SC was 81.9%. Cumulatively since April 2021 this is now 82.8%.



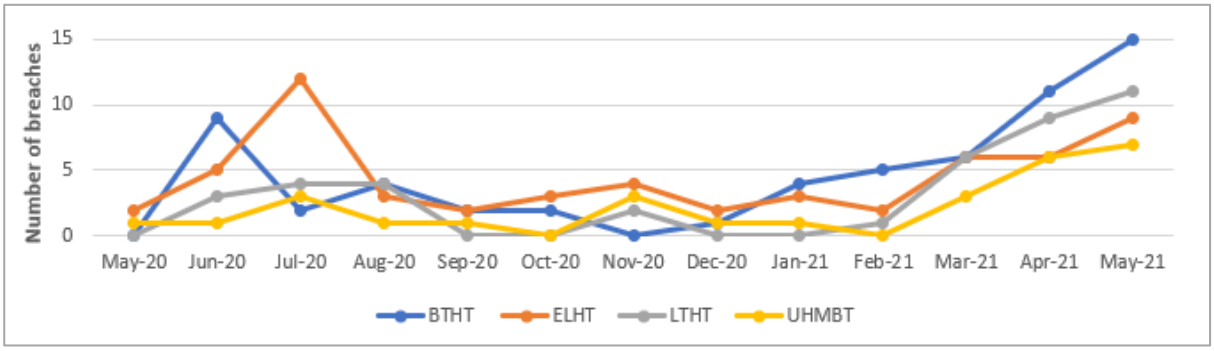
3.6. Ambulance Handover Times

High occupancy levels can impact on flow through our EDs and subsequently ambulance handover delays. Improvements continued in February and March, with relatively low numbers of handover delays. However, as occupancy levels remain high and attendances have increased, the number of 60 min handover delays has increased. The increase began in mid-April 2021 and continued to rise throughout May and into June 2021. The number of handover delays over 1 hour doubled from 30 to 60 (week beginning 14 June 2021), an increase of 100%. Cumbria and Lancashire turnaround time as of 14th June is just above the North West regional average. NWAS escalated to REAP Level 4 on 4th June 2021 and remains in place as of 22nd June 2021.



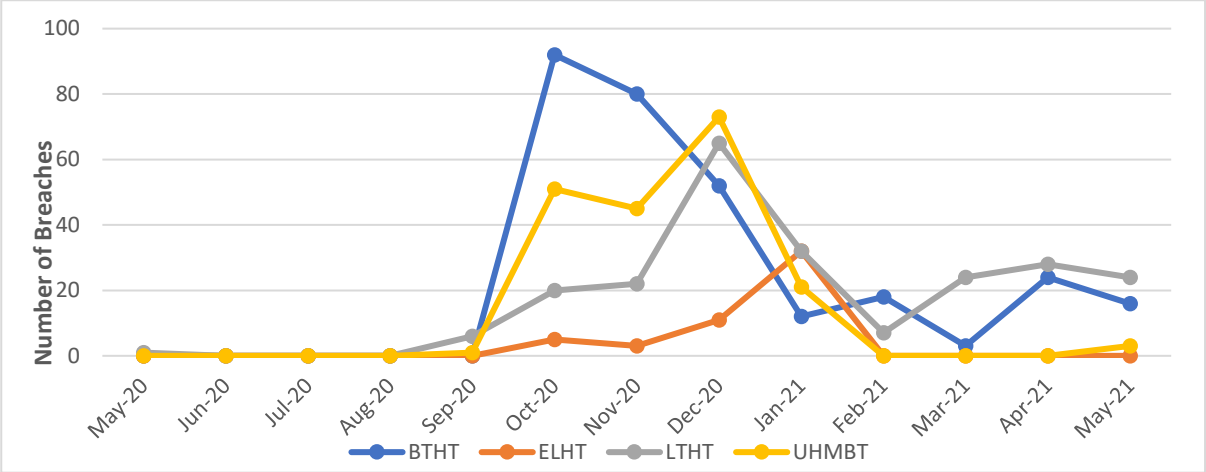
3.7. Mental Health 12 Hour Breaches

The significant acute Mental Health bed pressures across LSCFT continued throughout May and into June 2021. LSCFT have been at OPEL Level 3 since at least June 2020 (start of EMS+ reporting for LSCFT) occasionally escalating to OPEL Level 4, the last occurrence was on 9th June 2021.



3.8. Physical Health 12 Hour Breaches

The number of Physical Health 12 Hour Breaches for all trusts had seen a significant improvement since January 2021, of which, both UHMB and ELHT have maintained. The increase seen by both BTHT and LTHT in April 21 has continued throughout May 2021, although, beginning to show a slight downward trend.



3.9. COVID Recovery Performance

3.9.1. The first 2 weeks of June has seen an increase in COVID deaths in our hospitals compared to very low numbers in May. These numbers remain low compared to the wave 2 period from November 2020 to February 2021. The reported number of COVID patients in Regulated Care continues to remain low.

3.9.2. There was also a low number of COVID positive patients in L&SC hospital beds throughout May comparable to summer 2020. Numbers have increased in the first 2 weeks of June 2021, mostly impacting ELHT and LTHT. Numbers continue to be closely monitored.

3.9.3. On 17th June 2021 500 COVID related staff absences in the four acute hospital trusts were recorded across L&SC, the highest in the whole of April and May 2021. This number would be much higher if we included LSCFT, community services, primary care etc.

3.9.4. On 15th June 2021 over 74% of adults in L&SC had received their first COVID vaccination dose with 56% having received their second dose. The vaccination programme is now open to all over 18 year olds and have walk-in access.

3.10. Urgent Care Recovery Programme

3.10.1. Responsibility for Urgent Care currently sits with the Hospital Cell, who have worked with each trust to develop a detailed Urgent Care Recovery Programme for NHSE North West.

3.10.2. Each trust continues to implement/monitor the agreed final shortlist of initiatives, including detailed measurable benefits, with an implementation/monitoring process being coordinated via the GOLD hub.

3.10.3. In order to mitigate against the high occupancy levels all trusts across the ICS are experiencing, L&SC have agreed, in both the Hospital and Out of Hospital Cells, to run a 'L&SC Together week' across all provider services commencing 21st June 2021 providing focused support across the system to improve patient flow. When levels of occupancy are close to 90%, which they are, it very challenging operationally to deliver the kind of care we want to for all our patients. The 'L&SC Together Week', to help improve flow in our hospitals ahead of a potential further COVID surge, will focus on the following:

- Improving hospital occupancy where possible
- Reducing proportions of patients Not Meeting Criteria to Reside (NMC2R)
- Improving discharge rates before noon where possible
- Improving patient and staff satisfaction
- Supporting recovery of elective activity

- Improving ED performance and reducing associated ED crowding risks
- Improving Zero-day rates

3.10.4. L&SC GOLD Command (L&SC Hub) have co-ordinated the planning for the week and will take a lead role in managing, monitoring/evaluating impact, scalability of successful initiatives, and ensuring risk management. It is expected that a future report will quantify the impact of these initiatives.

4. Cancer

			Q2			Q3			Q4			Q1	
		Target	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Trend
Blackpool Teaching Hospitals	14 Day Target	93.0%	97.4%	96.3%	97.2%	96.2%	97.2%	97.6%	96.0%	97.6%	94.2%	85.1%	
	14 Day Target (Breast)	93.0%	94.0%	98.6%	96.1%	97.1%	95.1%	95.3%	94.4%	98.1%	64.9%	40.5%	
	62 Day Target	85.0%	82.7%	89.0%	76.7%	75.4%	78.6%	70.0%	72.9%	68.8%	73.1%	80.3%	
Lancashire Teaching Hospitals	14 Day Target	93.0%	89.1%	95.7%	96.0%	87.6%	80.5%	74.8%	72.0%	85.2%	92.6%	92.3%	
	14 Day Target (Breast)	93.0%	41.9%	87.1%	100.0%	82.8%	30.9%	2.3%	7.1%	38.2%	58.5%	57.3%	
	62 Day Target	85.0%	75.3%	70.2%	67.3%	55.8%	54.6%	64.4%	57.4%	53.0%	64.5%	59.2%	
East Lancashire Hospitals	14 Day Target	93.0%	91.8%	90.7%	93.0%	95.0%	95.0%	95.7%	94.2%	97.1%	96.6%	89.2%	
	14 Day Target (Breast)	93.0%	93.3%	95.7%	95.9%	96.5%	94.3%	88.1%	96.0%	99.3%	97.2%	84.0%	
	62 Day Target	85.0%	78.0%	80.5%	70.5%	72.1%	82.6%	72.9%	69.0%	79.0%	74.6%	70.6%	
Morecambe Bay Hospitals	14 Day Target	93.0%	81.8%	69.9%	51.3%	59.1%	59.3%	68.2%	56.5%	72.2%	83.8%	81.9%	
	14 Day Target (Breast)	93.0%	33.3%	20.0%	0.0%	4.7%	0.0%	4.0%	1.6%	4.2%	21.9%	20.3%	
	62 Day Target	85.0%	70.5%	66.9%	60.0%	60.1%	68.3%	67.6%	66.3%	69.1%	58.5%	56.0%	

4.1. The table above shows that in April 2021 L&SC performance against the cancer waiting times targets has been challenging; the only Trust which has improved performance since March 2021 is BTHT against the 62 day target. Although the Cancer waiting times targets remain NHS constitutional targets, and will continue to be monitored monthly, the Cancer Alliance have been advised that NHSE and Improvement will be monitoring cancer alliances specifically against restoration aims until Autumn 2021.

4.2. The challenges being experienced in performance are directly related to COVID-19 pressures and diagnostic capacity. These issues are being addressed via improvement plans monitored by the ECRG and targeted investment, particularly in relation to endoscopy, via the diagnostics programme board. Risks associated with long waiting cancer patients are manged by Trust specific deep dives and audits of the 104 day waiting lists.

4.3. L&SC Cumbria Cancer Alliance are ranked 1st out of the 21 Cancer Alliances in England in terms of restoration of urgent cancer referral numbers; however treatment volumes are not matching the referral numbers which can be seen in the performance figures. The table below shows the level of restoration in 2020/21 (up to April 2021) compared to 2019/20 for referrals and 1st treatments at providers in L&SC.

Trust	Referrals	1st Treatments
BTH	94%	96%
ELHT	91%	85%
LTHT	92%	83%
UHMB	95%	89%

4.4. The table below compares L&SCs April 2021 performance against North West Alliances and the England average performance; this includes monitoring against the faster diagnosis standard.

	2ww 1st seen standards		FDS	31 day treatment standards				62 day referral to treatment standards		
	Urgent	Breast Symptomatic	FDS	1st Treatment	Subsequent Surgery	Subsequent Drugs	Subsequent Radiotherapy	Urgent GP suspected cancer	Urgent screening	Consultant Upgrade
BTH	85.1%	40.5%	70.1%	98.4%	88.2%	100.0%	n/a	80.3%	37.5%	86.8%
ELHT	89.2%	84.0%	80.1%	89.3%	88.9%	98.8%	n/a	70.6%	91.9%	91.4%
LTH	92.3%	57.3%	100.0%	85.5%	69.9%	100.0%	99.5%	61.4%	75.0%	76.0%
UHMBT	81.9%	20.3%	84.6%	91.0%	100.0%	100.0%	n/a	56.0%	79.5%	90.2%
Cancer Alliance	87.5%	58.8%	77.8%	91.2%	82.0%	99.7%	99.6%	66.6%	79.3%	86.1%
North West	89.1%	63.4%	73.5%	94.8%	89.7%	99.5%	99.5%	73.4%	78.3%	85.3%
England	85.4%	62.1%	72.9%	94.2%	84.6%	99.0%	96.2%	75.4%	74.3%	83.2%
Operational Standard	93%	93%	75%	96%	94%	98%	94%	85%	90%	n/a

4.5. The table below compares L&SC CCGs April 2021 performance. West Lancashire CCG is included within this table however it is important to note that the majority of their patients attend acute trusts outside of L&SC for their cancer treatment.

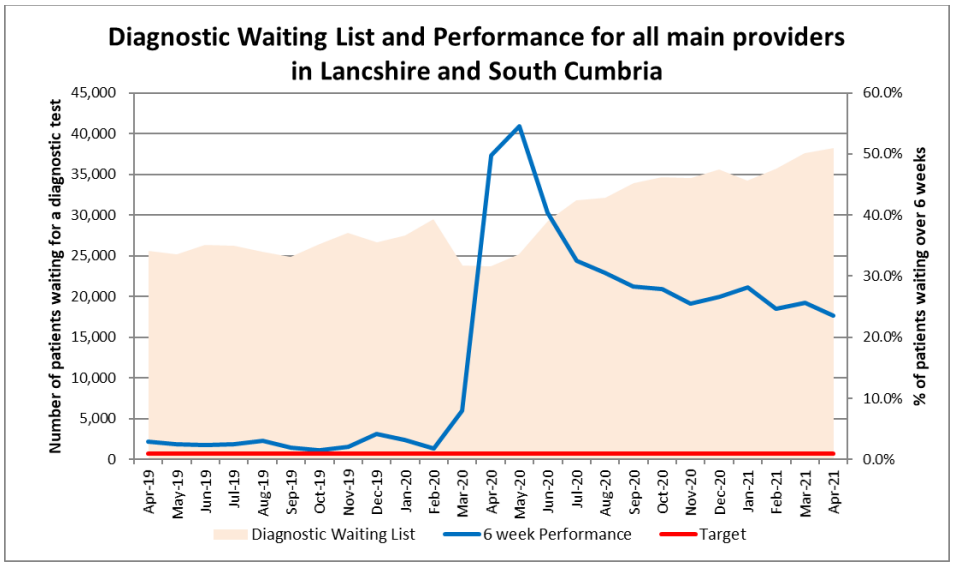
CCG	2ww	2ww Breast	28 Day FDS	31 Day 1st Treatment	Subsequent Surgery	Subsequent Drugs	Subsequent Radiotherapy	62 Day	62day Screening	62 day Upgrade
NHS BwD CCG	88.7%	78.2%	77.7%	90.0%	86.2%	100.0%	100.0%	59.4%	90.9%	82.6%
NHS B'pool CCG	83.1%	41.7%	68.4%	95.2%	79.3%	100.0%	100.0%	77.8%	80.0%	90.0%
NHS CSR CCG	91.9%	59.8%	77.3%	92.8%	87.9%	100.0%	100.0%	68.3%	0.0%	77.8%
NHS EL CCG	89.2%	84.0%	80.6%	91.7%	76.7%	98.3%	100.0%	78.1%	87.5%	95.6%
NHS F&W CCG	87.2%	37.4%	73.1%	93.4%	78.9%	100.0%	100.0%	73.5%	50.0%	77.8%
NHS GP CCG	92.3%	57.1%	100.0%	89.3%	78.9%	100.0%	95.6%	64.6%	100.0%	76.1%
NHS MB CCG	81.7%	20.0%	84.2%	85.5%	87.0%	100.0%	100.0%	52.1%	75.0%	89.4%
NHS WL CCG	88.5%	100.0%	71.5%	95.7%	83.3%	100.0%	100.0%	56.7%	90.0%	73.3%

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

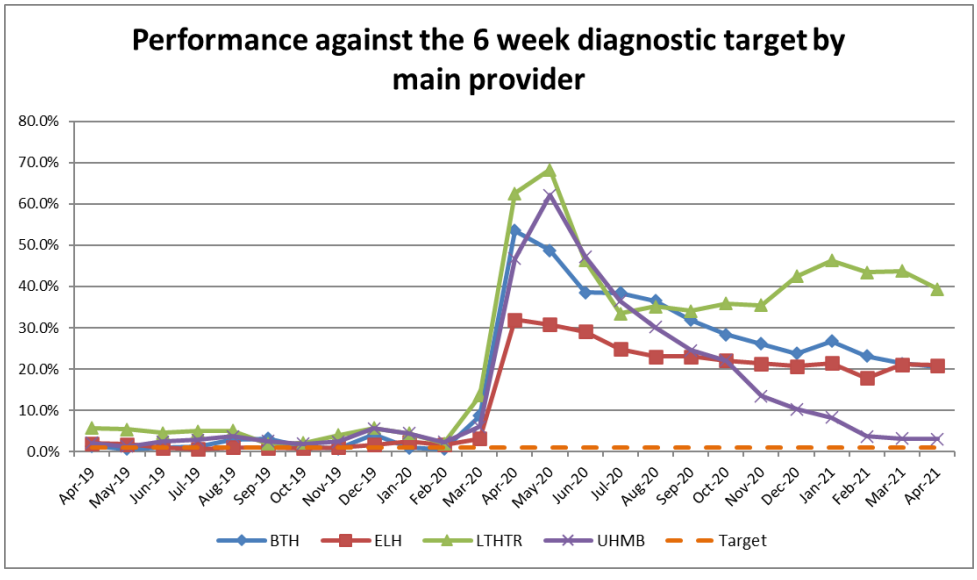
Cancer Waiting time Indicator	Cancer Alliance Ranking
2 week wait	10/21
2 week breast symptomatic	11/21
Faster Diagnosis Standard (FDS)	04/21
31 day 1st treatment	19/21
62 day referral for treatment	18/21

5. Diagnostics

5.1. The chart below shows the performance against the 6 weeks diagnostic target for all the main providers in L&SC. The information shows an improvement in the performance against the target in April 2021 for L&SC to 23.6%, still significantly above the 1% target. There continues to be an increase in the number of patients on a diagnostic waiting list, which is now over 38,000 for L&SC, the growth can seen in the lists at UHMB and ELHT.



5.2. Despite the increase in the number of patients on the waiting list, the performance has improved as identified above. The data at individual trust level shows there has been an improvement in performance at LTHT of 4 percentage points in the month, however it remains significantly above the remaining 3 providers who have all seen a slight improvement in their performance in the month.



5.3. A further breakdown of diagnostic activity shows that the performance is more problematic in Endoscopy than non-Endoscopy pathways.

5.4. The information shows that the improvement in the month at LTHT has been through non endoscopy activity, the proportion of patients waiting over 6 weeks for Endoscopy increased at LTHT. There continues to be proportionality more patients waiting over 6 weeks for Endoscopy across all providers than there are waiting for non-Endoscopy procedures. All 4

providers have seen improvements in the proportion of patients waiting over 6 weeks for a diagnostic procedure.

	% of patients waiting over 6 weeks (April 21)		
Provider	Endoscopy	Non Endoscopy	All Diagnostic Tests
BTHT	44% ↓	12% ↓	21% ↓
ELHT	31% ↓	20% ↑	21% ↓
LTHT	62% ↑	37% ↓	39% ↓
UHMB	10% ↓	3% ↔	3% ↓

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

5.6. There have also been additional plans developed for imaging as a consequence of the accelerator programme adopted by the ICS to enable delivery of 120% of the baseline elective activity. These plans include:

- Triaging areas by most risk/ highest waiting lists by clinical priority and chronology
- Validating waiting lists to ensure patients have not had their scan done through other means e.g. in inpatients or ED.
- Reviewing the estate and possible 'hook up' sites for mobiles near to existing healthcare facility so patients likely to access more easily.
- Staffed Mobile services from the independent sector, contracted to sites where maximum waits exist (CT, MR, US)
- Review outsourcing for reporting and MDT support.
- Securing administrative resource to manage outsourcing and book patients onto mobile units.
- Accelerating the development of Community Diagnostic Hubs

5.7. National guidance for clinical prioritisation of waiting lists for endoscopy and diagnostic procedures was published on 10th May 2021. It requires providers to validate their waiting lists based on the principles set out below:

- Diagnostic procedures need to be prioritised according to clinical need rather than waiting time.
- Patients should receive personalised communications that provide clarity on likely timescales. This should be supported with interim information and advice on managing their condition, and a specific contact point should they have questions about their upcoming care.
- Take a holistic approach to patient care and consider if there are alternative pathways that are appropriate, available and with capacity
- Local design and delivery of the validation process: core standards but local design and application with specialist advice
- Clinicians and organisations that have already started validating their waiting lists should not stop
- We must narrow rather than widen health inequalities: e.g. pro-active support for people whose first language is not English; appropriate arrangements for those with learning and behavioural difficulties; avoiding digital inequalities

5.8. The initial clinical prioritisation needs to be completed with appropriate coding by 30th July 2021.

6. Nosocomial Infections

6.1. At the time of writing (23rd June 2021) there was 41x nosocomial patients and 14x outbreaks across L&SC.

6.2. Due to the increase in community prevalence Lancashire has been identified for enhanced support following the rise in Variant of Concern (VOC) (Delta) leading to several actions being implemented some are listed below:

- surge testing
- increase in the number of vaccinations available via mobile testing and vaccination units.
- everyone in Lancashire, including children, are now being strongly encouraged to take a COVID-19 PCR test, whether they are displaying symptoms or not.

6.3. By undertaking the PCR test, positive results can be sent for genomic sequencing at specialist laboratories, helping identify the VOC cases and their spread the North West has a priority currently for this to occur.

6.4. The latest publicly available PHE data (to 16th June 2021) shows that the top 5 highest COVID-19 case rates in the UK (out of 380) are all in Pennine Lancashire. 10 out of the 15 highest case rates are in L&SC, including all districts of Pennine Lancashire, all districts of Central Lancashire and Blackpool.

6.5. As of 20th June 2021, the data shows that case rates in Pennine Lancashire and in Preston and South Ribble have started to fall, but that those in Morecambe Bay and the Fylde Coast (and Chorley) are still rising (though not as quickly as the week of 14th June 2021).

6.6. Although overall positive tests have levelled out this week, positives for those aged 60+ are up another 19%, particularly in Central Lancashire. 17-21 year olds are the highest carrier.

6.7. The number of COVID-19 patients in L&SC Hospitals as of 21st June 2021 was 131 which is a 38% increase in a week.

6.8. LTHT has seen the number of COVID-19 patients double again, up from 27 on 14th June 2021 to 63 as of 21st June 2021. Over half of the COVID-19 admissions and diagnoses at LTHT in the past seven days (14th-21st June 2021) were inpatients swabbed more than two days after admission, reflecting nosocomial infections. There have been 3x nosocomial outbreaks reported by LTHT which has resulted in wards being closed to admissions and visiting to the adult wards ceased. Early notification to NHSI was undertaken with the IPC team being assured with the actions implemented by the trust and confident the team are managing this appropriately. Additional improvement actions have been identified.

- Enable the automatic reporting of staff vaccination status by ward to undertake targeted promotion of vaccine
- Enable the automatic reporting for inpatient vaccination status to implement inpatient vaccination where possible
- Use of daily lateral flow tests and increase uptake of LAMP for staff
- Increase in cleaning within areas
- PCR tests for all admitted patients

6.9. The learning from this will be shared across the system.

6.10. The number of COVID-19 patients at ELHT is down over the past week, from 56 on 14th June 2021 to 51 as of 21st June 2021. An outbreak of COVID-19 has been reported on the Outpatient Unit at ELHT, 3 patients positive with confirmation of nosocomial acquired during admission.

6.11. LSCFT reported an outbreak of COVID-19 on an in-patient mental health ward at Pendleview on the week of 14th June 2021. 4x patients have tested positive further detail is awaited if identified on admission or acquired in hospital. Daily staff testing continues, and twice weekly IPC meetings are taking place with enhanced reporting mechanism for IPC enacted.

6.12. As expected, higher rates of COVID-19 on the Fylde Coast are now being reflected in increased numbers of COVID-19 patients at BTHT, up from 7 on 21st June 2021 to 12 on 23rd June 2021.

6.13. As of 21st June 2021, at UHMB there are still the same number of COVID-19 patients (5) as on 14th June 2021, though community rates in the Morecambe Bay area are now also increasing with the expectation that this will then impact on hospital cases.

6.14. Regulated Care has also started to experience an increase in both the number of outbreaks and incidents being reported across the sector. As of 18th June 2021, 14x homes were in outbreak across Lancashire compared with the previous week (11th June 2021) of 7x homes.

6.15. For those home in outbreak several actions are implemented.

- Multi-agency support meetings with the home
- All councils across L&SC are continuing to target all care homes where vaccination status is below the SAGE recommendations of 90% for residents and 80% of staff
- Weekly home testing continues.
- Promotion of online training for care home staff on PPE and RESTORE 2
- Access to resources and literature on Vaccination – 'myth buster' to promote the vaccine and increase uptake
- Care homes will be informed if the VOC (Delta) has been identified through PCR and genomic sequencing.
- Vaccination bus visiting care homes across Lancashire to administer either 1st or 2nd doses to staff.

6.16. As part of the outbreak meeting with the care home detailed information is being collated on the vaccination status of both staff and residents including the breakdown of dates for vaccine administration. Initial intelligence is suggesting that those individuals who have tested positive for COVID-19 and have been double vaccinated are either asymptomatic or displaying mild symptoms. This information is supporting Public Health England data collection on the efficacy of the vaccine.

6.17. On 16th June 2021, the Government announced people working in CQC registered care homes will need to be vaccinated with both doses. The decision follows an extensive public consultation with thousands of staff, providers, residents and families.

6.18. The new legislation means from October 2021, subject to Parliamentary approval and a subsequent 16-week grace period, anyone working in a CQC registered care home in England for residents requiring nursing or personal care must have 2 doses of a COVID-19 vaccine unless they have a medical exemption. It will apply to all workers employed directly by the care home or care home provider (on a full-time or part-time basis), those employed by an agency and deployed by the care home, and volunteers deployed in the care home.

6.19. Further consultation will be launched on whether to extend to other health and social care settings.

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

7.1. The core IPA/CHC service is still experiencing increased levels of activity in exiting the COVID-19 Scheme 2 work with all Deferred Assessments complete, six week Discharge to Assess requirement but are supporting all the discharge pathways as required and monitoring and reporting on breaches. This is however inevitably having an impact on the service's ability to handle incoming non discharge referrals and essential review activity and is reported to the ICS SRO/Leadership Team weekly.

7.2. The project to address the legacy Incomplete Referrals (ICR) is almost completed, following completion of the COVID-19 Deferred Assessments with a planned completion date of end June 2021. However, at the time of writing, there are 16 remaining cases to complete which are being jointly managed with LA colleagues. Weekly Assurance Reports are being submitted with calls held with NHSE/I CHC Regional Team colleagues, the programmes senior responsible officer and commissioning lead to give assurance on the delivery of the project.

7.3. A trajectory of new assessment cases to be completed within 28 days for the Quality Premium up to year end has been submitted to NHSE/I for the L&SC CCGs.

8. Safeguarding

8.1. Current area of focus:

8.1.1. Maintaining connectivity across all systems and networks as we reform is priority and working closely with Provider Heads of Safeguarding as Provider Collaborative develops.

8.1.2. The ICS with Partners continue to strive for improved outcomes for LAC and Care Leavers; it is important that this cohort are considered individually in order that they are supported to reach their full potential. An ICS LAC health strategy is in development to drive this agenda forward. A dental pilot is in the development stage in the East Lancashire footprint with partners and NHSE/I; this is due to commence in September 2021 with a view to full roll out across the ICS. There is now a named GP whom is aligned to the LAC priority area.

8.1.3. LPS Delivery Model approved at the May 2021 Collaborative Commissioning Board. Recruitment to LPS Project Lead to commence. Work plan, outcomes, KPIs and monitoring arrangements being finalised and will report into IPA programme. LPS Health Steering Group in place, ICS Designate Professional part of national LPS steering group.

8.1.4. Violence Reduction strategy and plans continue to build momentum across L&SC. Partners are currently developing a pledge statement which will lead us to become a Trauma Informed ICS at a minimum raising awareness among staff, organisations and communities of the wide impact of trauma and prevention of re: trauma. Multiple bids are in process with the aim to expand and build trauma informed communities and organisations, Emergency Department Navigators and Independent sexual and domestic violence specialist.

8.1.5. COVID impact and restoration response continues to be a key focus of the safeguarding partnership with Police and Local Authorities. Quantification of data is a key focus at present. Health are developing a strategic KPI dashboard in line with national team. This piece of work is detailed in view of the multiple data sources, data owners and time frame of availability of data. Neglect and Risk outside the Home have strategy delivery groups in place, reporting exceptions into the appropriate governance arrangement.

8.2. Exceptions to delivering objectives:

8.2.1. Post easing of lockdown restrictions there has been potential emerging trends and presentation of criminally exploited CYP across the North West. Safeguarding Partners are reviewing local data and trends across L&SC and by ICP locality area.

8.2.2. Though Health are an integral partner of the Domestic Abuse (DA) Partnership Boards. Health Partners have not yet collectively formulated their joint response to the DA Bill. Plans are in place to complete this by July 2021, and will then be discussed at DA Partnerships and brought for endorsement to the SCC.

8.2.3. CSR CCG are the lead commissioner for the Sudden Unexpected Death in Childhood (SUDC) seven-day service. Due to reduced capacity, a five-day service has been delivered for the months of May and June 2021. The provider is reporting by exception and there is no risk or impact to date. Full-service delivery is now anticipated in August 2021 and a risk mitigation plan is in place.

8.3. Successes:

8.3.1. L&SC ICS via Central ICP have committed to participation in the National Serious Incident Live Tracker pilot. If the pilot is successful this web based live incident tracker will facilitate timeliness of lessons learnt and ability to review learning that needs a service change and/or commissioning consideration of system redesign.

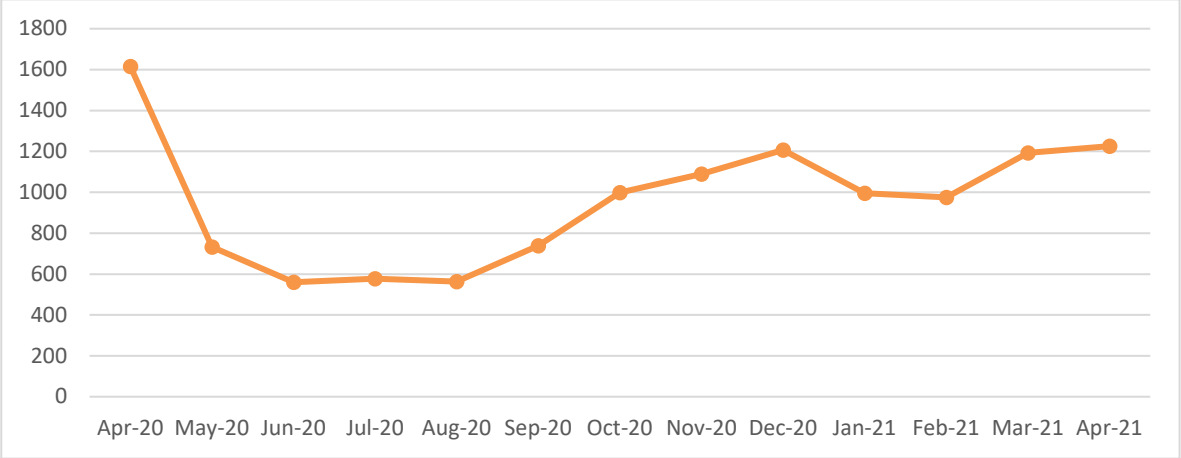
8.3.2. The Safeguarding Provider Heads of Service and Commissioning Designate Professionals continue to fuse strong networks with regional and national teams. We receive multiple requests from out of area systems to facilitate their understanding of our partnership working and ICS developments. We are additionally approached by DH&SC departments to assist in their thinking, recently supporting NHSE violence against staff, DH&SC Domestic Abuse, Violence Reduction Unit. The ICS was recently praised for its partnership work at the UK Parliamentary Select committee and referenced in the recent Wood Review of multi-agency safeguarding arrangements May 2021.

8.3.3. There is now an ICS GP Safeguarding Leads network led by Dr Karen Massey, Named GP for Safeguarding Children and Adults at Risk, NHS East Lancashire and Blackburn with Darwen CCGs and Named GP representative L&SC ICS. Each GP lead has agreed to align to one of the ICS Safeguarding objectives i.e. Domestic Abuse, Neglect.

9. Children and Adolescent Mental Health Services (CAMHS)

9.1. Waiting Lists

Waiting Times - No. of CYPs waiting for treatment



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

9.1.1. April 2021 Position

Overall, there has been a 3% decrease in the number of CYPs waiting for treatment at Providers BTHT, ELCAS and LSCFT, from 1,192 (March'21) to 1,151 (April'21). We are now receiving further data from ADHD North West and Barnardo's (My Time), therefore increasing the total number of CYPs waiting for treatment to 1,226 (April'21).

9.1.2. **BTHT** have seen an increase in the number of CYPs waiting for treatment compare to the previous month, from 635 (Mar'21) to 682 (Apr'21). The increase in caseloads can be attributed to the complexity of cases across CAMHS, CASHER and Youtherapy, causing young people to stay on caseloads longer, and a good DNA rate resulting in more attendances and fewer discharges due to non-attendance.

9.1.3. **ELHT** have seen a decrease in the number of CYPs waiting for treatment compared to the previous month, from 127 (Mar'21) to 109 (Apr'21)

9.1.4. **LSCFT** have seen a decrease in the number of CYPs waiting for treatment compared to the previous month, from 430 (Mar'21) to 360 (Apr'21)

9.1.5. **Quality** - The COVID-19 pandemic and associated social restrictions were expected to impact particularly on young people's mental health and emotional wellbeing. We are seeing above-typical referrals into CAMHS and this is impacting on increasing numbers of young people on waiting lists for the service. Although there have been no harms reported, there is an increase in complex cases and children going into crisis. A lot of placements are breaking down for looked after children and there is now a dedicated complex children's case manager within the Team who is supporting this cohort and working closely with the LAs. There has also been an increase in CYP with SEND, especially ASD. Mental Health in Schools Teams are in all schools, they are picking up a lot of the early intervention cases which will hopefully reduce the waiting list for specialist CAMHS and T4 beds. Families who have CYP with SEND have found it difficult since COVID, service provision has been increased for Action for ASD and ADHD NW to respond to this demand. Commissioners are working with parent carer forums and they all state that families are struggling. Support is being provided to families around anxiety, self-harm and depression. There is also the L&SC Healthy Young

Minds website that provides information for families. The LAs also have their local offers that families can find out what help is available to them in their local area.

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

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

9.2. Access

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

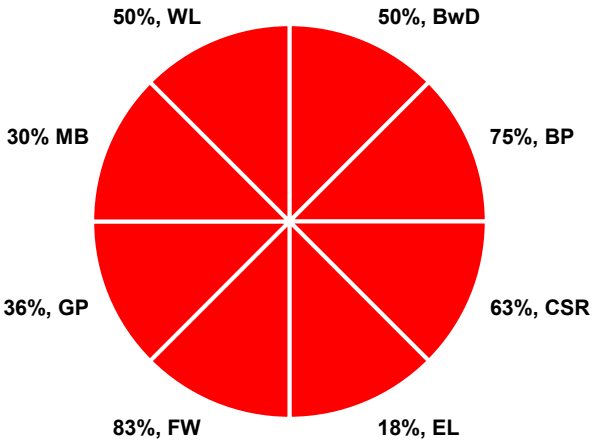
	Apr'20 -Mar'21 National Data (All Providers)		
	12 Month National Rolling Position	Prevalence	% Achieved
Blackburn with Darwen CCG	1,540	3,871	40%
Blackpool CCG	1,670	2,952	57%
Chorley & South Ribble CCG	1,730	3,227	54%
East Lancashire CCG	3,000	8,115	37%
Fylde & Wyre CCG	1,725	2,702	64%
Greater Preston CCG	1,515	3,975	38%
Morecambe Bay CCG/Bay Partnerships	2,790	6,084	46%
West Lancashire CCG/WCP	1,115	2,040	55%
Lancashire & South Cumbria Total	15,085	32,966	46%
Central Lancashire	3,245	7,202	45%
Fylde Coast	3,395	5,654	60%
Pennine Lancashire	4,540	11,986	38%

The 12-month rolling position (April 2020 – March 2021) demonstrates L&SC is achieving a 46% target overall which continues to exceed the National target of 35% by 11%. Local data collections suggest L&SC is achieving 48%, therefore 13% above the National target of 35% and only 4% below the local planned 2020/21 target of 52%.

9.3. Eating Disorders

CYP – Eating Disorders				Performance Data									
Measure	Data Source	National Targets	CCG/ICP	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21	Sparkline	Position
% of CYP with eating disorders (ED) seen within 1 week (urgent)	LSCFT	95%	**L&SC**	62%	50%	100%	100%	100%	100%	100%	46%		
			Blackburn with Darwen CCG	100%	-	-	100%	-	-	-	50%		
			East Lancashire CCG	67%	60%	100%	100%	100%	-	100%	18%		
			Pennine Lancashire ICP	71%	60%	100%	100%	100%	-	100%	24%		
			Blackpool CCG	-	-	-	-	100%	100%	100%	75%		
			Flyde and Wyre CCG	100%	-	100%	-	-	100%	100%	83%		
			Fylde Coast ICP	100%	-	100%	-	100%	100%	100%	78%		
			Chorley and South Ribble CCG	33%	-	100%	100%	100%	-	100%	63%		
			Greater Preston CCG	0%	-	-	-	-	100%	-	36%		
			Central Lancashire ICP	25%	50%	100%	100%	100%	100%	100%	47%		
			MBCCG/**Bay Partnership**	-	-	-	-	-	-	100%	30%		
			West Lancashire CCG/**West Lancashire WCP**	-	0%	-	100%	100%	100%	-	50%		
% of CYP with eating disorders (ED) seen within 4 weeks (routine)	LSCFT	95%	**L&SC**	70.9%	95.5%	96.2%	100.0%	98.3%	98.7%	94.6%	60.0%		
			Blackburn with Darwen CCG	75.0%	75.0%	66.7%	100.0%	100.0%	100.0%	71.4%	-		
			East Lancashire CCG	41.7%	85.7%	90.0%	100.0%	100.0%	92.3%	83.3%	60.0%		
			Pennine Lancashire ICP	55.0%	81.8%	84.6%	100.0%	100.0%	94.1%	80.0%	60.0%		
			Blackpool CCG	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	33.3%		
			Flyde and Wyre CCG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
			Fylde Coast ICP	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%		
			Chorley and South Ribble CCG	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%		
			Greater Preston CCG	87.5%	100.0%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%		
			Central Lancashire ICP	90.9%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	75.0%		
			MBCCG/**Bay Partnership**	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	57.1%		
			West Lancashire CCG/**West Lancashire WCP**	33.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	-		

% of CYP with Eating Disorders seen within 1-week (Urgent) Q4



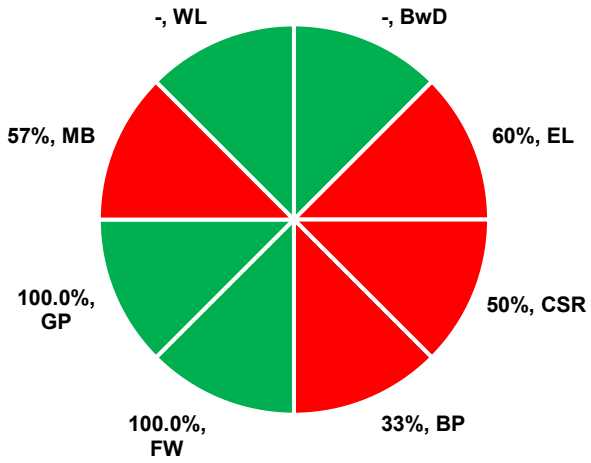
National Target – 95%
Local Target – N/A

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

9.3.1. Performance based on NHSE published data is showing L&SC have not achieved the 95% target for Quarter 4 with 46% and Quarter 4 Rolling 12-month position with 62%.

9.3.2. In Quarter 4, 70 urgent patients aged under 19 began treatment with the EDi service, 38 patients were not treated within the 1-week target. These were in Blackburn with Darwen (50%), Blackpool (75%), Chorley & South Ribble (63%), East Lancashire (18%), Fylde & Wyre (73%), Greater Preston (17%), Morecambe Bay (30%) and West Lancashire (50%). These were all due to exceptionally high demand and limited team capacity to respond to this.

% of CYP with Eating Disorders seen within 4 weeks (Routine) Q4



9.3.3. Performance based on NHSE published data is showing L&SC did not achieve target for Quarter 4 and the rolling 12-month position. In Quarter 4, 20 routine patients aged under 19 began treatment with the ED service. 8 patients were not treated within the 4 week target. These were in Blackpool (33%), Chorley & South Ribble (50%), East Lancashire (60%) and Morecambe Bay (57%). These were all due to exceptionally high demand and limited team capacity to respond to this, with a need to prioritise urgent high-risk presentations. The target of 95% was not met, L&SC have an overall 60%.

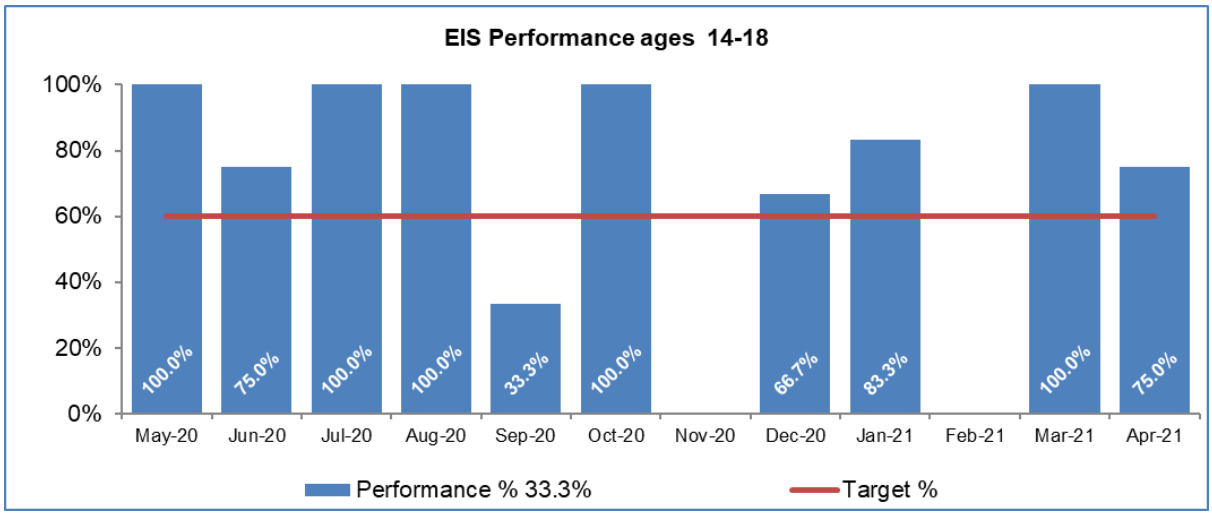
National Target – 95%
Local Target – N/A

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

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

9.4. Early Intervention to Psychosis (CYP)

% of people who started treatment within 2 weeks of referral

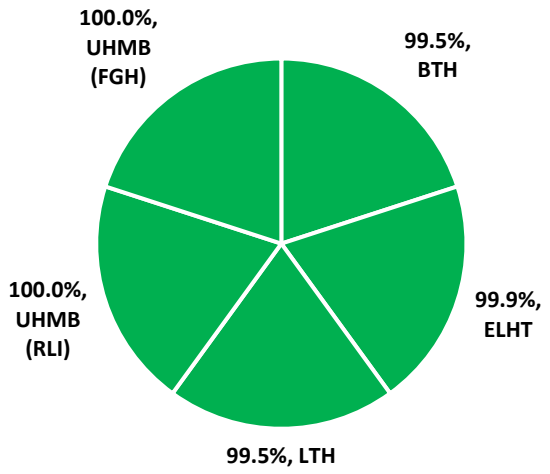


Performance – The teams achieved 75% in April 2021 which is 15% above the National target of 60%. 100% was not achieved this month due to one complex patient.

10. Adult Mental Health Section

10.1. Urgent Care

Mental Health A&E 4-hour Compliance in Q4 2020/21

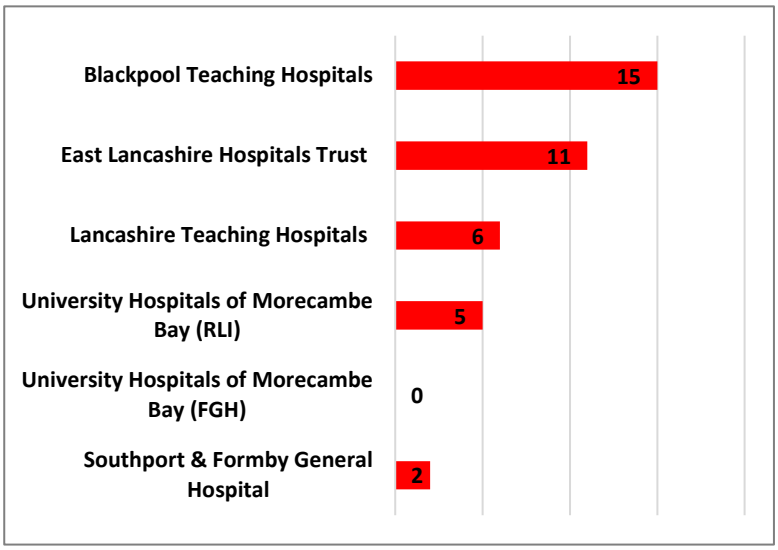


National Target – 95%
Local Target – 95%

10.1.1. Performance - All Trusts have met the 4-hour compliance target in Q4 2020/21. With significantly high levels of demand for MHLT in A&E and on the wards the maintenance of performance is encouraging regarding sustainability. Early indication that all areas are achieving compliance in Q1 2021/22.

10.1.2. Quality – The teams in A&E continue to monitor patient experience through the Friends and Family Test. Patient comments relate to COVID-19 concerns, where due to the busy nature of the unit it can be difficult to social distance. The 'L&SC Together Week' aimed at decongesting hospitals should have an impact on improving ED performance and reducing the associated ED crowding risks.

Mental Health A&E 12-hour breaches in Q4 2020/21



National Target – 0
Local Target – 0

10.1.3. Performance - The total number of 12-hour breaches in Q4 2020/21 were 39 which is an increase from 24 in Q3. The total number of patients seen by MHLTs increased in Q4 2020/21 by 8% compared to Q3 2020/21 and was 9% higher than Q4 2020/21.

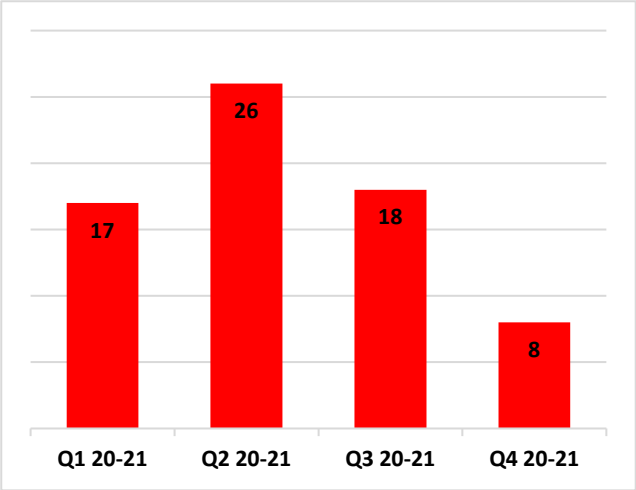
10.1.4. Quality – The teams have seen an increase in activity and acuity which has been partly attributed to the easing of lockdown restrictions. Monitoring of long waits and patient experience in A&E continues. The themes from the analysis of the breeches within the ED demonstrate that the main issues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

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

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

10.2. Mental Health Detentions

Number of Section 136 24-hour breaches in Q4 2020/21

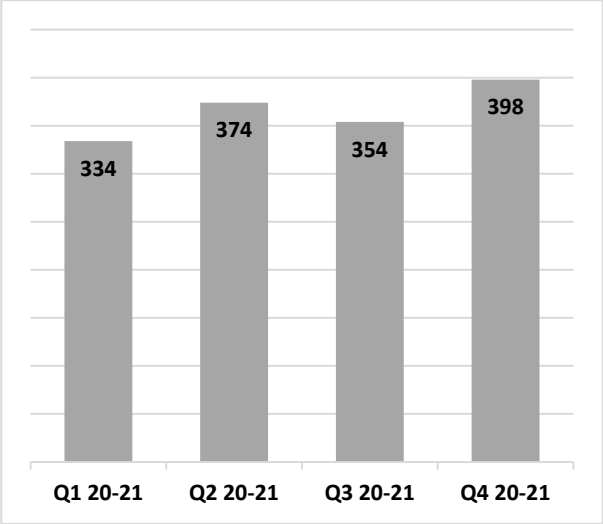


National Target – 0
Local Target – 0

10.2.1. Performance - There were 8x 136 breaches in Q4 2020/21, this is a significant reduction from Q3 2020/21.

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

Number of Section 136 Detentions in Q4 2020/21

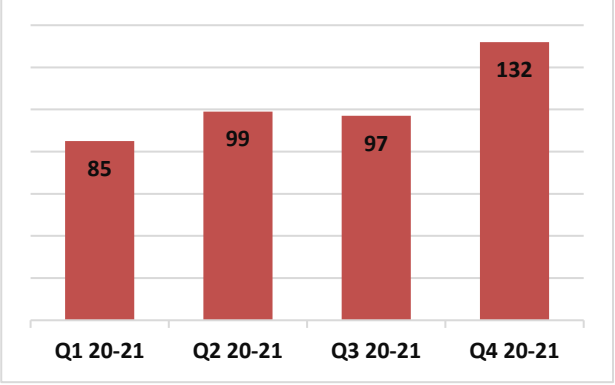


National Target – N/A
Local Target – N/A

10.2.3. Performance - There were 398 Section 136 detentions in Q4 2020/21 which is an increase from Q3 2020/21. Work is continuing to take place with the Police regarding appropriate Section 136 detentions.

10.2.4. Quality - Continued focus on flow and discharges from LSCFT and contract beds to ensure timely placement for patients in 136 suites requiring a bed. Each week breaches of patients in 136 suites are reviewed by a small working group from LSCFT, Police and Local Authorities for the AMHP services to undertake root cause analysis and action plan for improved performance.

Number of Detentions under the Mental Health Act in Q4 2020/21

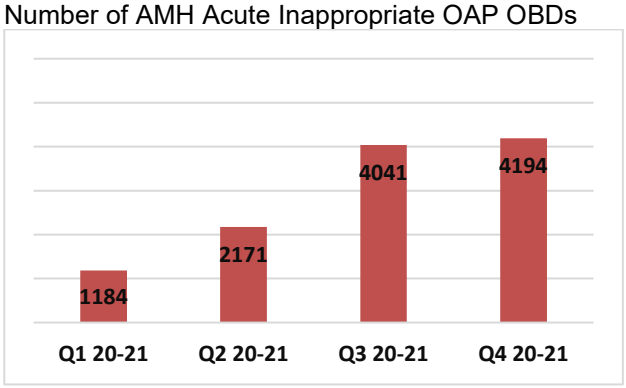


National Target – N/A
Local Target – N/A

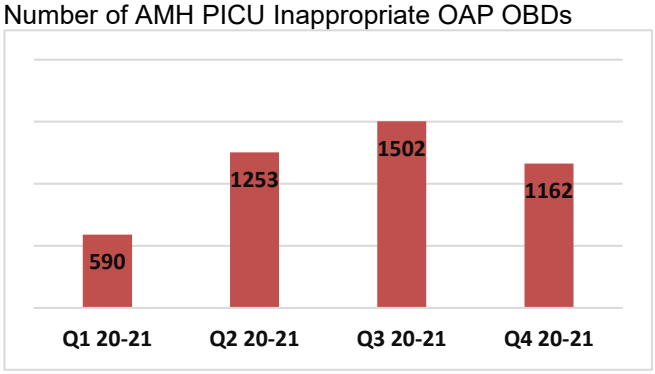
10.2.5. Performance - The number of detentions under the mental health act in Q4 2020/21 were 132 this is a 36% increase from Q3 2020/21.

10.3. Out of Area Placements

Number of AMH Acute Inappropriate OAP OBDs



Number of AMH PICU Inappropriate OAP OBDs



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

10.3.1. Performance - LSCFT have remained reliant on independent sector beds (reported as OAPs to meet acute mental health bed demand, through a mix of long-term capacity gap and shorter-term bed closures to facilitate COVID-safe wards. NICHE Consultancy identified that, in order to meet demand, the Trust requires an additional 27 Older Adult beds and 10 PICU beds. Furthermore, 37 acute functional and PICU beds across adult and older adult wards have been closed to enable COVID-secure Wards and enable ward refurbishment. This sum of a 64 bed deficit is commensurate with the number of Inappropriate OAPs in the latter half of 2020/21.

10.3.2. LSCFT have contracted an additional 67 beds from independent sector providers, which meet the NHSE Principle of Continuity. While outside of the borders of Lancashire, these hospitals are as accessible as L&SC bedstock and will provide continuity of care and governance. The Principle of Continuity means that these beds will not be reported as inappropriate OAPs from April 2021 onwards, and will be a part of the planned L&SC bedstock.

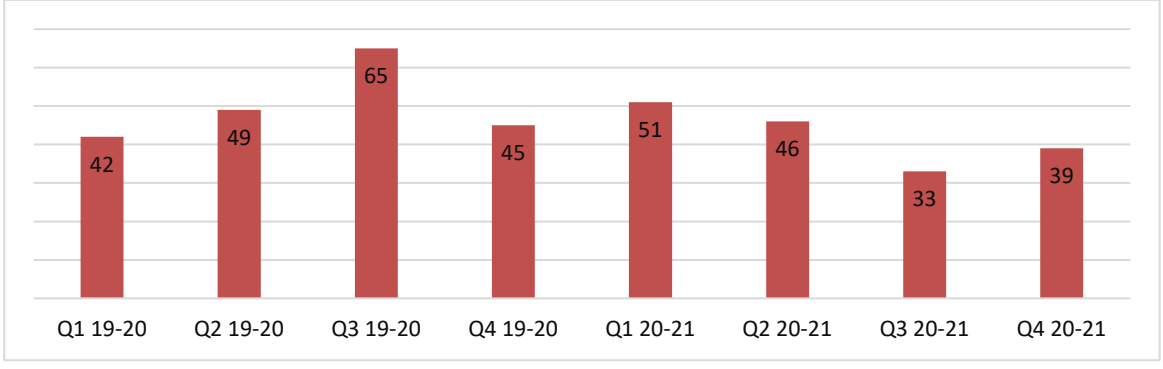
10.3.3. Quality - Acuity of patients was noted in Q4 2020/21 through regular flow calls each day with significant high numbers of PICU requests in March 2021.

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

10.4. Suicide Prevention

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

Annual View of Suspected Suicides by Q4 2020/21

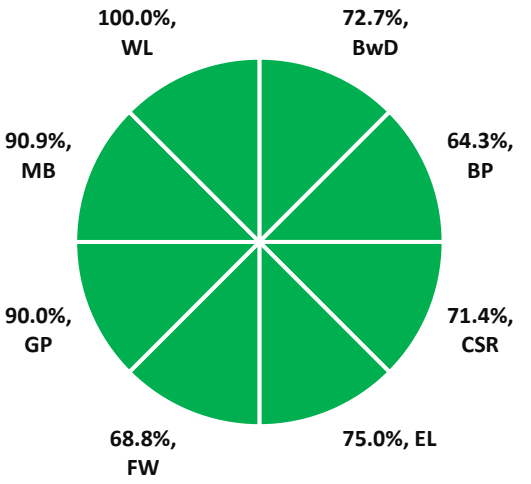


10.4.1. Performance - There is early indication of a reduction in suspected suicides in Q1 2021/22.

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

10.5. Early Intervention to Psychosis

% with a first episode of psychosis who start treatment in early intervention in psychosis services within two weeks of referral Q4 2020/21 - All ages



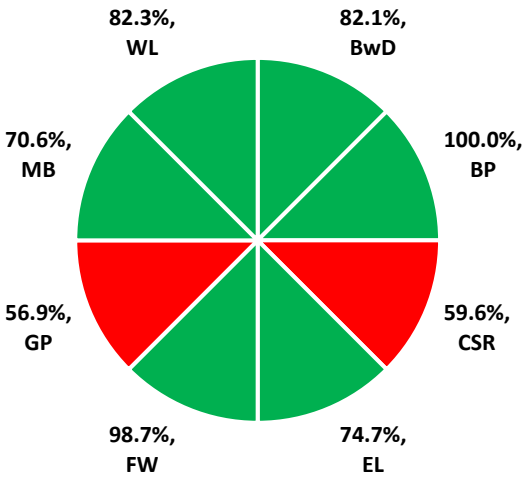
National Target – 60% (20-21)
Local Target – 56% (19-20)

10.5.1. Performance - The EIP target was met by all CCG areas in Q4 2020/21. There have been some concerns about staffing in the EIP teams however that is being addressed and all CCG areas are working to further improve performance against the 2 week referral target. LSCFT's local data Month 12 2020/21 EIP report provided below. LSCFT have achieved the 60%; there was underperformance in month for Blackpool CCG (3x fails) and East Lancashire CCG (3x fails). Across the 8x CCGs there were 10x fails in total. On analysis of these fails 5x were attributed to referral delays (where referrals are received after 14 days). Work is ongoing between Teams in order to reduce these delays. The IPS team is fully integrated with the EIP team and is exceeding employment targets, Further funding is in place for the IPS teams.

10.5.2. Quality – The team has a robust complaints process with no issues to report in Q4 2020/21. The teams are liaising with patients and families to improve areas of the service where appropriate. No harm has been reported as a result of delays and there have been 0x serious incidents reported for EIP.

10.6. Older Adult (MAS)

Memory Assessment Services Seen within 6-weeks Q4 2020/21



National Target – N/A
Local Target – 70%

10.6.1. Performance - Service remains impacted by acute trust suspension of diagnostic testing. Recovery trajectories developed but Network looking to develop detail to a greater degree. Further social restrictions have impacted in Q4. 77.3% of people were seen within the 6-week time frame across Lancashire in Q4 2020/21 overall which is a decrease from 80.7% in Q3 2020/21. The service did not achieve the target in month 10 (67.3%) but achieved the target of 70% in months 11 and 12 with 82.8% and 82.0%. The average wait across Lancashire increased to 4.3 weeks in March 2021, from 4.1 weeks in February 2021.

10.6.2. Quality – The position for service users being seen within 6 week's has been impacted in Greater Preston and Chorley South Ribble by staffing pressures whereby the Team was reduced by 2x Band 6, with 1x on Secondment (staff member returned in June 2021) and 1x staff member required to cover titration clinics, due to annual leave. The longest wait has remained static at 16 weeks. Initial assessments are now prioritised as clinic appointments, with Attend Anywhere utilised as a second option due to increased DNA. There is clinic availability in satellite clinics at Fulwood, Euxton, Penwortham and Longridge Hospital. In addition, the service is now seeing patients back in Charnley Fold as medic face-to-face OPA to assist with the diagnostic waiting times. The service is also re-starting its One Stop Clinics on Friday mornings from 2nd July 2021. A high number of referrals across the service were returned to GPs as incomplete or inappropriate (21.67% - April 2021), which impacts negatively on patient pathways. At point of triage the rejection data is now being captured to allow focussed discussions with referrers; once this has been collated for themes this will be fed back to commissioners.

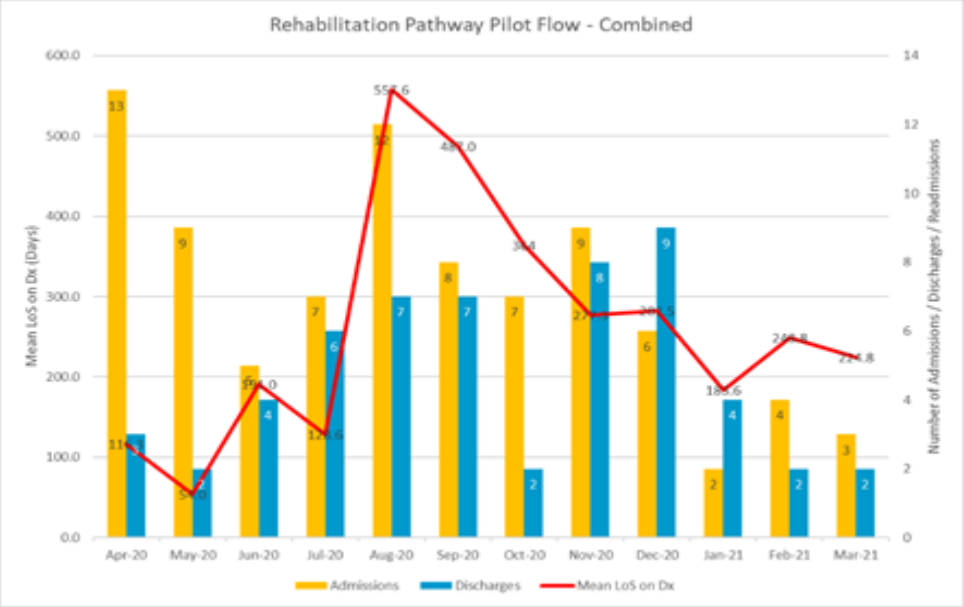
10.6.3. There has also been a slight increase in Attend Anywhere DNA's from care homes resulting in assessments having to be re-arranged.

10.6.4. Action - A Recovery plan is in place which includes the return of the WTE band 6. In addition, the Covid environment risk assessment for Charnley Fold was updated on 26th May 2021 and clinics are now re-commencing incrementally which is having a positive impact on the diagnostic waiting list.

10.6.5. Patient safety is being maintained for longer waiters with a follow-up call and duty staff reviewing waiting lists along with the manager on a regular basis. There is also management of a short-notice list of patients who are willing to accept cancellation appointments.

10.7. Rehab

Rehabilitation Pathway Pilot Flow – Combined



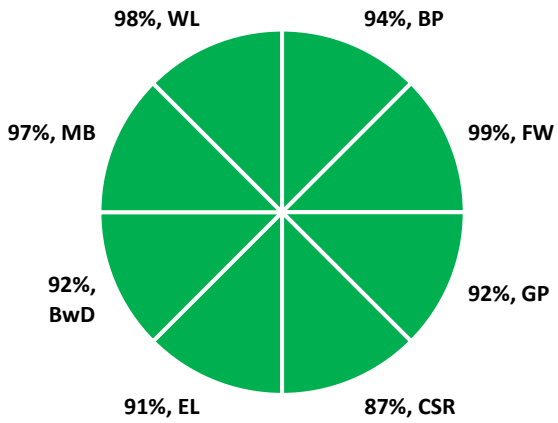
10.7.1. Performance – Admissions and discharges have reduced across Q4 2020/21. Unusually high numbers of admissions and discharges were seen in the first half of 2020/21 as the new independent sector beds came into use (see April/May 2020) and the Skylark Unit opened (see July/August 2020). As regular patient reviews commenced, the newly established LSCFT Rehab Flow Team was also able to discharge a number of long length of stay cases between August and October 2020, which can be seen in the spike in the mean length of

stay on discharge on the chart (left), also temporarily supporting flow through the rehab beds. It is therefore understood that the reduction in Q4 2020/21 is likely to be a reflection of flow returning to expected levels. It is also possible that the Winter 2020/21 Discharge Schemes, such as additional Discharge to Assess capacity, may have also had an impact by diverting some referrals from the Rehab Pilot Pathway.

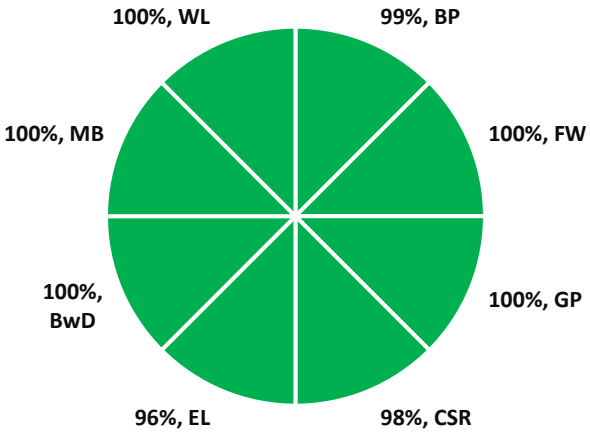
10.7.2. Quality – Routine quarterly quality monitoring is overseen by LSCFT as part of the lead contractor arrangements. A Quality Assurance summary report is shared with stakeholders on a quarterly basis.

10.8. IAPT

% of people receiving a first appointment within 6 weeks of referral Q4 2020/21



% of people receiving a first appointment within 18 weeks of referral Q4 2020/21



Performance – 6-week RTT achieved consistently at 95.2% in Q4 2020/21 18-week RTT achieved consistently at 99.7% in Q4 2020/21.

10.8.1. The overall waiting list size was 6,063 at the end of March 2021 compared to 5,452 end of February 2021. 165 people equating to 2.8% were stepped-up to step 3, having already received therapy at step 2. Now at 99% of 5-year seasonal average. There were 0 people waiting over 26 weeks for their therapy appointment. The outliers continued to be Fylde & Wyre and Lancaster & Morecambe which have longer waits at Step 3, these are continuing to be addressed with waiting list initiatives including CBT Sub-contract with Dr Julian & Birchwood Counselling

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

10.8.3. Action - Prevalence levels were only met by West Lancashire CCG in April 2021, with all other CCGs under target. There continues to be a shortfall in the number of referrals required to meet target. The Trust have a communications and social media plan which includes

increasing GP communication via CCG Communications Teams; social media output and targeting underrepresented groups. This aims to raise awareness of the service and allow better access for self-referral for vulnerable groups. Targeted work is also taking place for LTCs and there has been a greater number of referrals received for this cohort of patients as at M01.

10.9. Resilience Hub

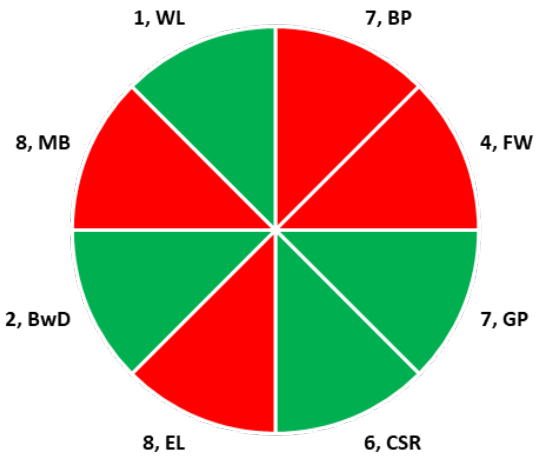
10.9.1. Background - The L&SC Resilience Hub is intended as a support resource for all public sector workers and volunteers who have worked through the COVID-19 pandemic and their families. This includes everyone from those who work in the NHS, local authorities and councils, ambulance service staff, care home workers, those working in social care and community workers. We are hoping that the Hub will eventually be able to operate as a resource for everyone who has felt the psychological strain of COVID-19.

10.9.2. Performance - There is ongoing work to ensure that the system dashboard data fully represents the work of the Hub (clinical, team-based and system level work). April 2021 data will be reported to NHSE/I on their template. Activity to date (23rd April 2021) includes 34 contacts for clinical assessment for the Hub between 1st - 23rd April 2021; 25 people were moved onto the waiting list for Hub interventions during this time period. There is a median wait of 7 calendar days between contact and first assessment. Total number of active clients on caseload was 140. Around 2/3 of the workload is focusing on High Intensity Interventions.

11. Learning Disabilities and Autism

11.1. Non-Secure Inpatient

Number of Patients Against Trajectory - Q4 2020/21



National Target – N/A
Local Target – Q4 20-21 end trajectory of 37

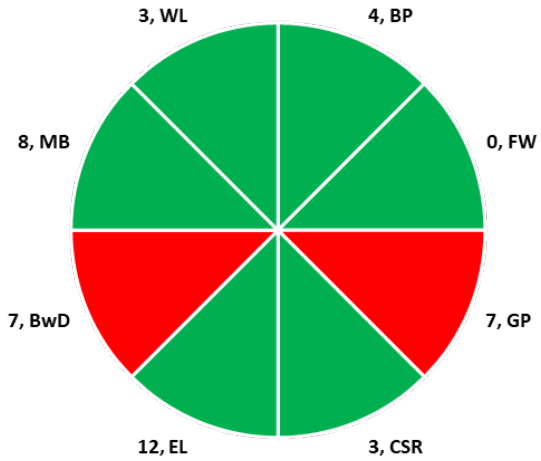
11.1.1. Performance

Position as at 17/06/2021 is 51 against our Q1 2021/22 trajectory of 50 (+1). All CCG in-patients have been reviewed as part of a deep dive by the regional team during April to understand the barriers to discharge. An aligned Health and Social Care Discharge team has been established across L&SC and both a health and social care professional identified to co-ordinate the discharges into the community.

11.1.2. During Q1 2021/22 there has been 12 admissions. 3 of these admissions are people who have stepped down from secure services as part of the discharge pathway; 6 readmissions. 10 discharges have taken place into a community setting. There are currently 3 people on S17 leave in the community.

11.2. Secure Inpatient

Number of Patients Against Trajectory - Q4 2020/21
Position at the end of Q4 was 44 which was met.



National Target – N/A
Local Target – Q4 < 47

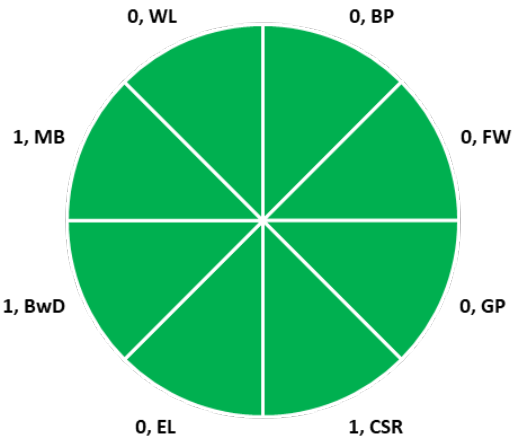
11.2.1. Performance

Position as at 17/06/2021 is 39 against our Q1 2021/22 trajectory of 42 (-3). All secure in-patients are being reviewed as part of a deep dive by the regional team during June 2021 to understand the barriers to discharge. An aligned Health and Social Care Discharge team has been established across L&SC and both a health and social care professional identified to co-ordinate the discharges into the community

11.2.2. During Q1 2021/22 there hasn't been any admissions, but 6 discharges have taken place: 3 people have stepped down into a CCG bed and 3 people discharged into the community. We currently have 1 person on S17 leave in the community.

11.3. Children and Young People Tier 4 Beds

Number of Patients Against Trajectory - Q4 2020/21



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

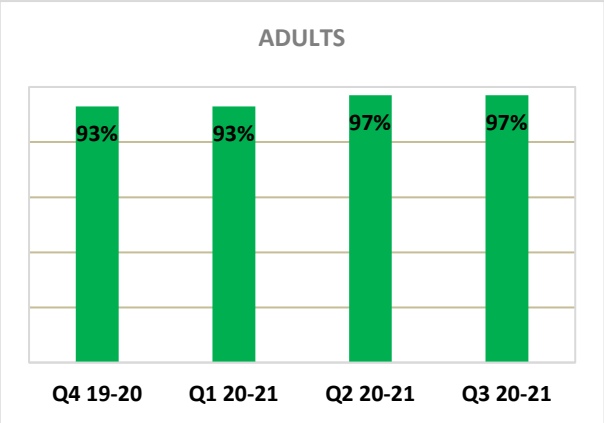
11.3.1. Performance

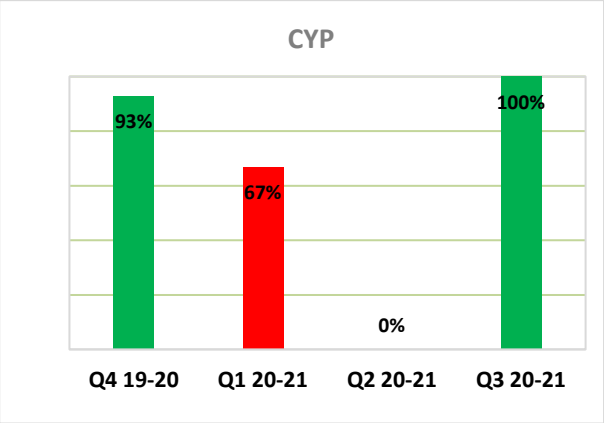
Position at 17/06/2021 is 2 children and young people in a hospital bed against our trajectory at the end of Q1 2021/22 as 5 (-3). During Q1 2021/22 there has been 1 admission and 2 discharges.

11.4. Care (Education) and Treatment Reviews

Performance

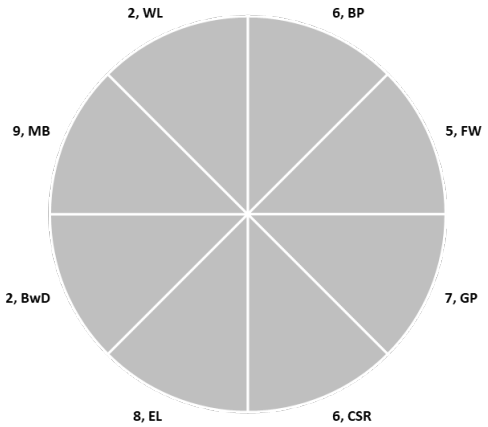
Trajectory is 75%. 100% compliance for both adults and CYP both for pre-admission and post admission reviews; 92% and 97% for non-secure and secure repeat reviews during Q4 2020/21.





11.5. Quality Oversight Visits

8-week Quality Oversight Visits for all CCG Inpatients:



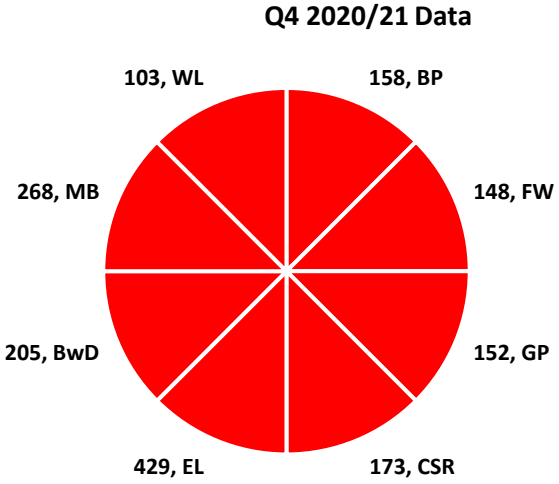
Performance

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

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

11.6. Annual Health Checks

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



National Target – 75%
Local Target – 75%

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

Definitions:

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

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

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

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

This data shows an increase in performance against 19-20. Work underway with BI to provide a monthly position to each CCG Primary Care Commissioner.

11.7. LeDeR

11.7.1. KPI requirements:

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

11.7.2. Review and Refresh of the LeDeR programme

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

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

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

12. Recommendation

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

Roger Parr
Deputy Chief Officer / CFO from Pennine Lancashire CCGs

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

Glossary

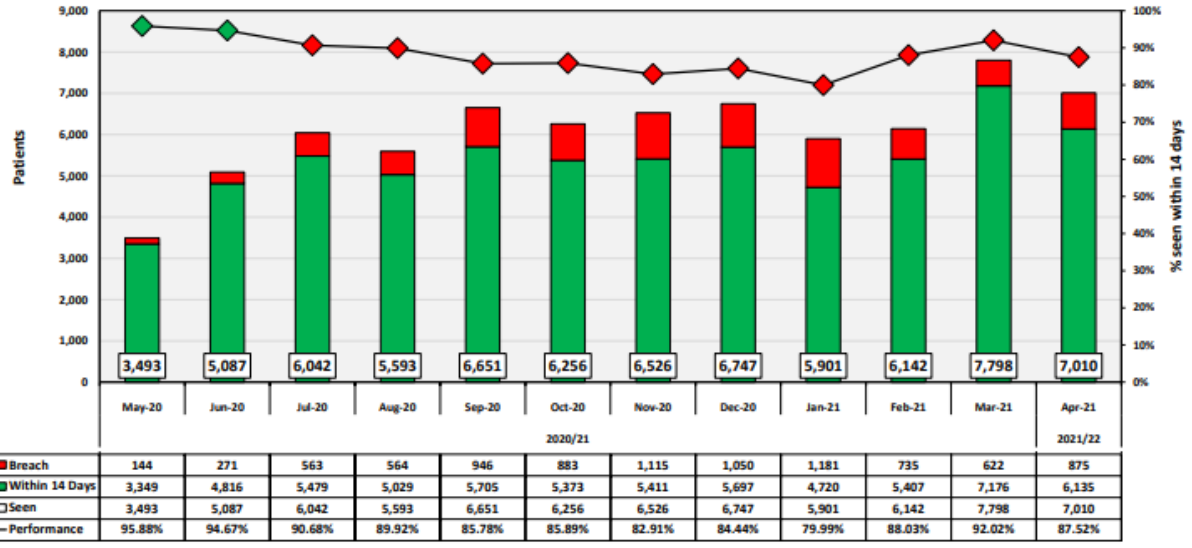
A&E	Accident & Emergency	LSCFT	Lancashire South Cumbria Foundation Trust
AHP	Allied Health Professional	LTC	Long Term Condition
AMHP	Approved Mental Health Professional	LTHT	Lancashire Teaching Hospital Trust
ASD	Autism Spectrum Disorder	MAS	Memory Assessment Service
BGH	Burnley General Hospital	MDT	Multidisciplinary Team
BI	Business Intelligence	MH	Mental Health
BTHT	Blackpool Teaching Hospitals Trust	MHLT	Mental Health Liaison Team
BVH	Blackpool Victoria Hospital	MLCSU	Midlands and Lancashire Commissioning Support Unit
BwD	Blackburn with Darwen	MRI	Magnetic Resonance Imaging
CASHER	Child and adolescent support and help enhanced response team	MRSA	Methicillin-resistant Staphylococcus aureus
CAMHS	Children and Adolescent Mental Health Service	MSA	Mixed Sex Accommodation
CBT	Cognitive Behavioural Therapy	MSK	Musculoskeletal
CC	Complications and Comorbidities	NEC	Not Elsewhere Classified
CCG	Clinical Commissioning Group	NELSD	Non-elective same day
CHC	Continuing Health Care	NELST	Non-elective short stay
CI	Consultant Initiated	NHSE	National Health Service England
CPA	Care Programme Approach	NHSI	National Health Service Improvement
CPN	Contract Performance Notice	NICE	National Institute for Health and Care Excellence
CQUIN	Commissioning for Quality and Innovation	NWAS	North West Ambulance Service
CSR	Chorley and South Ribble	OAP	Out of Area Placement
CT	Computerized Tomography scan	OPEL	Operational Pressures Escalation Levels
CTR	Care and Treatment Review	OPFA	Outpatient First Attendances
CYP	Children and Young People	OPFUP	Outpatient Follow Up
DC	Day Case	OPPROC	Outpatients Procedures
DES	Direct Enhanced Services	PCN	Primary Care Network
DH&SC	Department of Health and Social Care	PCR	Polymerase chain reaction
DNA	Did not attend	PDSA	Plan Do Study Act
DPH	Director of Public Health	PHE	Public Health England
DToC	Delayed transfer of care	PICU	Psychiatric Intensive Care Unit
ECDS	Emergency Care Dataset	PLCV	Procedures of Limited Clinical Value
ECRG	Elective Care Recovery Group	PPE	Personal Protective Equipment
ED	Emergency Department	Q&P	Quality and Performance

EDi	Eating Disorders	QI	Quality Improvement
EIP	Early Intervention Psychosis	QIPP	Quality for Innovation, Productivity and Prevention
EL	East Lancashire	QOF	Quality Outcomes Framework
ELCAS	East Lancashire Child and Adolescent Services	RAP	Recovery Action Plan
ELHT	East Lancashire Hospitals Trust	RAT	Rapid Assessment and Treatment
EMS+	Escalation Management System Plus	RBH	Royal Blackburn Hospital
EMSA	Eliminate Mixed Sex Accommodation	RCA	Root Cause Analysis
ENT	Ear Nose Throat	REAP	Resource Escalation Action Plan
F&W	Fylde and Wyre	RESTORE2	Recognising Early Soft Signs, Take Observations, Respond, Escalate
FDS	Faster Diagnostic Standard – is a new policy in which patients should have cancer ruled out or diagnosed within 28 days of referral	RLI	Royal Lancaster Hospital
FFT	Friends and Family Test	RPH	Royal Preston Hospital
FGH	Furness General Hospital	RTT	Referral to Treatment
FOI	Freedom of Information	S136	Section 136
G&A	General and Acute	SAGE	Scientific Advisory Group for Emergencies
GP	Greater Preston	SBAR	System Background Assessment and Recommendation
HCAI - CDIFF	Health Care Associated Infections - Clostridium Difficile	SCC	Strategic Commissioning Committee
HFC	Harm Free Care	SLAM	Service Level Agreement Monitoring
HSMR	Hospital Standardised Mortality rate	StEIS	Strategic Executive Information System
IAPT	Improving Access to Psychological Therapies	STF	Sustainability and Transformation Fund
ICP	Integrated Care Partnership	SUI	Serious Untoward Incident
ICS	Integrated Care System	SUS	Secondary Uses Service
IPA	Individual Patient Activity	TARN	Trauma Audit & Research Network
IPC	Infection Prevention and Control	TCI	To Come In
IPS	Individual Placement and Support	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.
IUCS	Integrated Urgent Care Service	UCC	Urgent Care Centre
IV	Intravenous	UHMB	University Hospitals of Morecambe Bay
L&SC	Lancashire and South Cumbria	US	Ultrasound
LA	Local Authority	VCFSE	Voluntary, Community, Faith and Social Enterprise Sector
LAC	Looked After Children	VSA	Value Stream Analysis
LAMP	Loop-mediated Isothermal Amplification	WL	West Lancashire
LCC	Lancashire County Council	WLIs	Waiting List Initiatives
LeDeR	Learning Disabilities Mortality Review	YTD	Year to date
LPS	Liberty Protection Safeguards		
LSABs	Local Safeguarding Adults Boards		

% 2 Weeks Cancer – Urgent GP Referral – Apr 21

2 Week Wait Referrals (93% Standard)

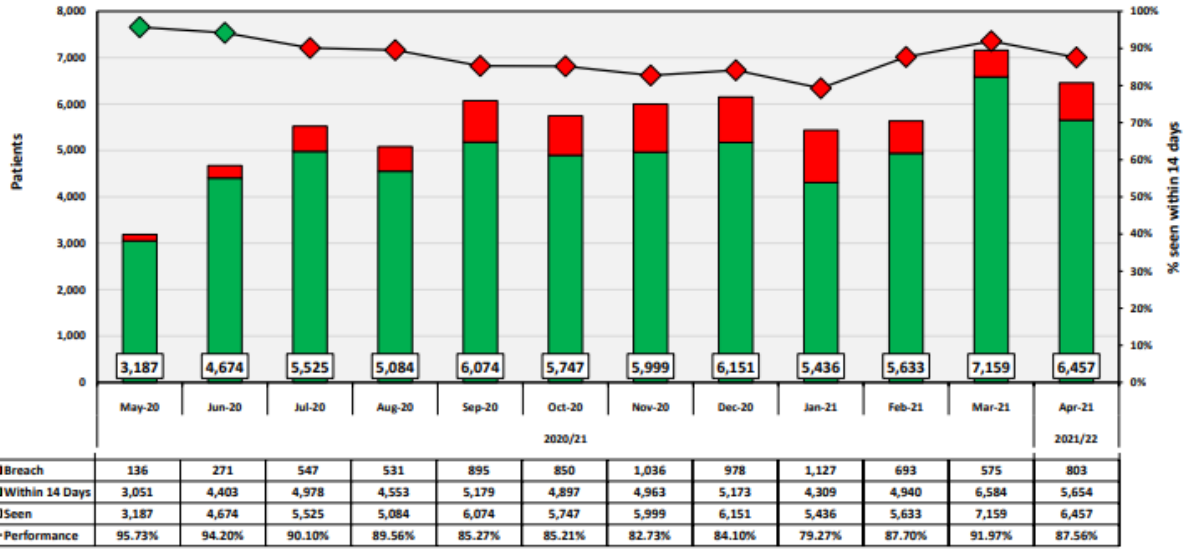
Cancer Alliance CCGs (May-20 to Apr-21)



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	144	271	563	564	946	883	1,115	1,050	1,181	735	622	875
Within 14 Days	3,349	4,816	5,479	5,029	5,705	5,373	5,411	5,697	4,720	5,407	7,176	6,135
Seen	3,493	5,087	6,042	5,593	6,651	6,256	6,526	6,747	5,901	6,142	7,798	7,010
Performance	95.88%	94.67%	90.68%	89.92%	85.78%	85.89%	82.91%	84.44%	79.99%	88.03%	92.02%	87.52%

CCG	Apr-21			May-20 to Apr-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	518	58	88.80%	5,287	329	93.78%
BCCG	653	110	83.15%	6,899	361	94.77%
CSRCCG	764	62	91.88%	7,972	971	87.82%
ELCCG	1,288	141	89.05%	13,742	840	93.89%
FWCCG	976	125	87.19%	9,667	672	93.05%
GPCCG	975	76	92.21%	9,872	1,205	87.79%
MBCCG	1,329	243	81.72%	14,156	4,007	71.69%
WLCCG	507	60	88.17%	5,651	564	90.02%
CA CCGs	7,010	875	87.52%	73,246	8,949	87.78%

Cancer Alliance Providers (May-20 to Apr-21)



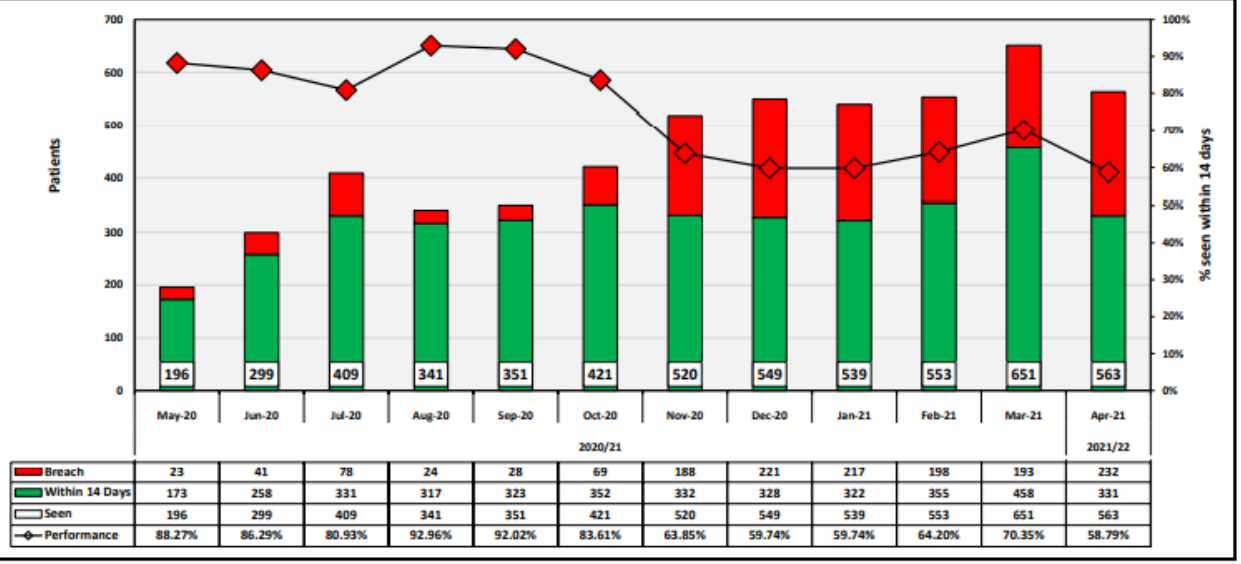
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	136	271	547	531	895	850	1,036	978	1,127	693	575	803
Within 14 Days	3,051	4,403	4,978	4,553	5,179	4,897	4,963	5,173	4,309	4,940	6,584	5,654
Seen	3,187	4,674	5,525	5,084	6,074	5,747	5,999	6,151	5,436	5,633	7,159	6,457
Performance	95.73%	94.20%	90.10%	89.56%	85.27%	85.21%	82.73%	84.10%	79.27%	87.70%	91.97%	87.56%

Provider	Apr-21			May-20 to Apr-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	1,478	220	85.12%	14,843	694	95.32%
ELHT	1,709	184	89.23%	17,994	1,066	94.08%
LTH	1,860	144	92.26%	19,224	2,385	87.59%
UHMB	1,410	255	81.91%	15,065	4,297	71.48%
CA Providers	6,457	803	87.56%	67,126	8,442	87.42%

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

2 Week Wait Breast Symptomatic Referrals (93% Standard)

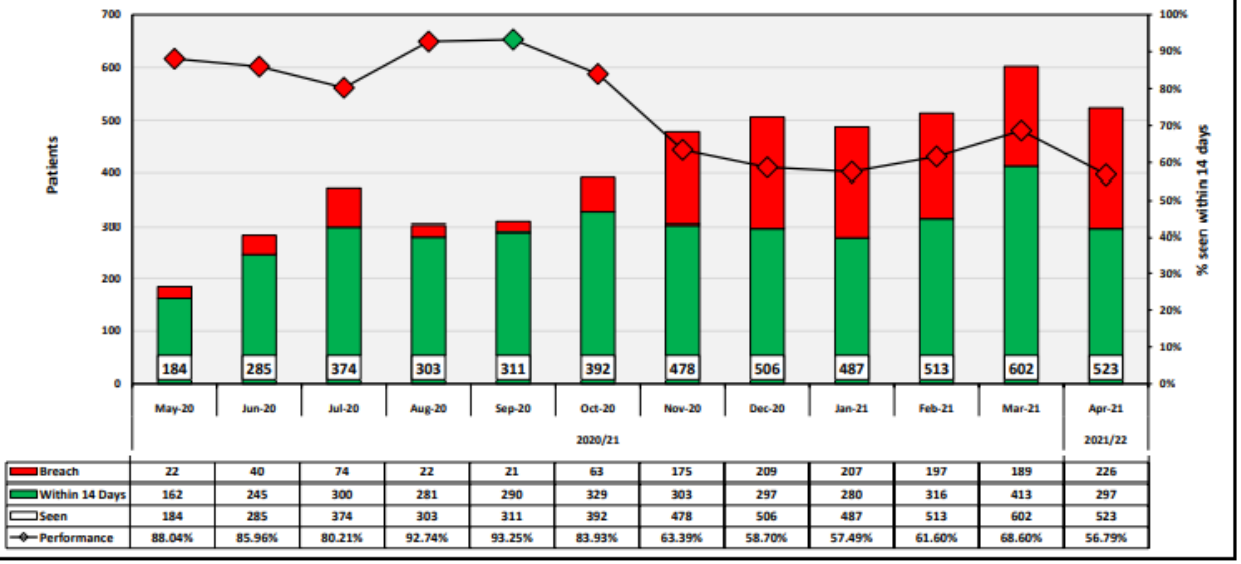
Cancer Alliance CCGs (May-20 to Apr-21)



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	23	41	78	24	28	69	188	221	217	198	193	232
Within 14 Days	173	258	331	317	323	352	332	328	322	355	458	331
Seen	196	299	409	341	351	421	520	549	539	553	651	563
Performance	88.27%	86.29%	80.93%	92.96%	92.02%	83.61%	63.85%	59.74%	59.74%	64.20%	70.35%	58.79%

CCG	Apr-21			May-20 to Apr-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BwDCCG	60	13	78.33%	638	50	92.16%
BCCG	70	41	41.43%	662	101	84.74%
CSRCCG	57	23	59.65%	624	309	50.48%
ELCCG	124	21	83.06%	1,399	93	93.35%
FWCCG	50	31	38.00%	553	122	77.94%
GPCCG	100	43	57.00%	694	362	47.84%
MBCCG	75	60	20.00%	499	424	15.03%
WLCCG	27	0	100.00%	323	51	84.21%
CA CCGs	563	232	58.79%	5,392	1,512	71.96%

Cancer Alliance Providers (May-20 to Apr-21)



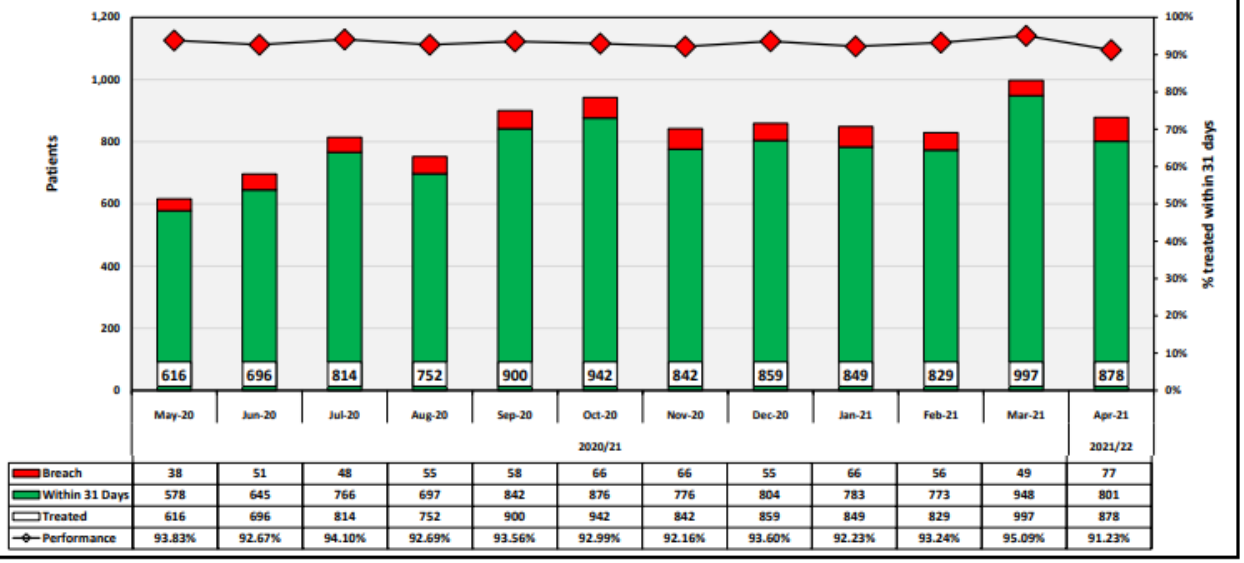
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	22	40	74	22	21	63	175	209	207	197	189	226
Within 14 Days	162	245	300	281	290	329	303	297	280	316	413	297
Seen	184	285	374	303	311	392	478	506	487	513	602	523
Performance	88.04%	85.96%	80.21%	92.74%	93.25%	83.93%	63.39%	58.70%	57.49%	61.60%	68.60%	56.79%

Provider	Apr-21			May-20 to Apr-21		
	Seen	Breach	Performance	Seen	Breach	Performance
BTH	111	66	40.54%	1,145	167	85.41%
ELHT	169	27	84.02%	1,927	109	94.34%
LTH	164	70	57.32%	1,356	704	48.08%
UHMB	79	63	20.25%	530	465	12.26%
CA Providers	523	226	56.79%	4,958	1,445	70.86%

% 31 Day Cancer – Definitive Treatment – Apr 21

31 Day First Treatment (96% Standard)

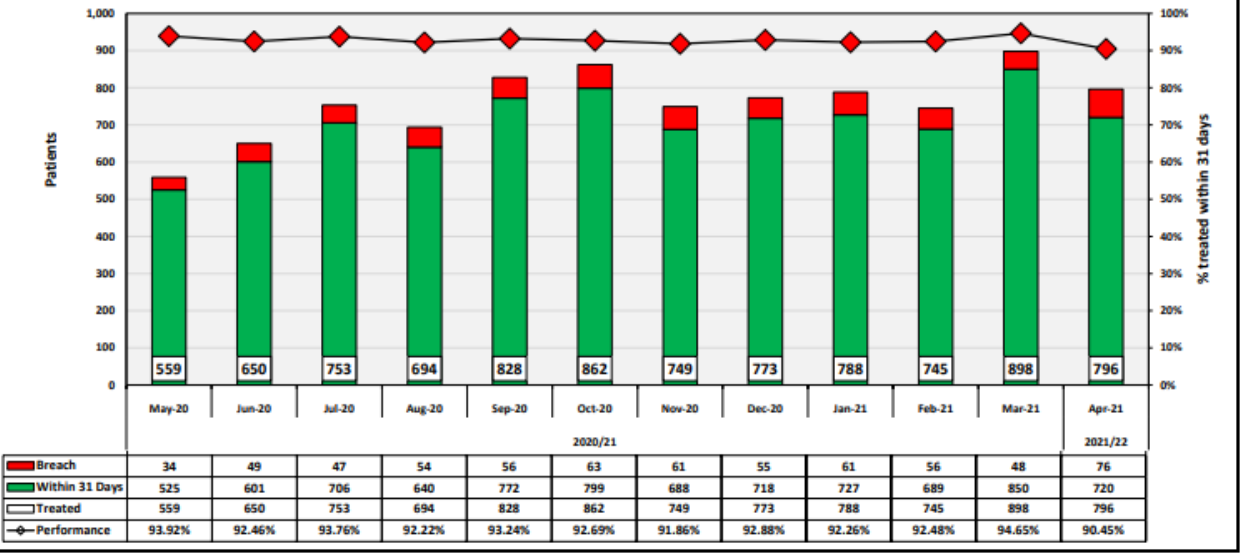
Cancer Alliance CCGs (May-20 to Apr-21)



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	38	51	48	55	58	66	66	55	66	56	49	77
Within 31 Days	578	645	766	697	842	876	776	804	783	773	948	801
Treated	616	696	814	752	900	942	842	859	849	829	997	878
Performance	93.83%	92.67%	94.10%	92.69%	93.56%	92.99%	92.16%	93.60%	92.23%	93.24%	95.09%	91.23%

CCG	Apr-21			May-20 to Apr-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	80	8	90.00%	745	41	94.50%
BCCG	105	5	95.24%	1,109	65	94.14%
CSRCCG	99	7	92.93%	1,069	92	91.39%
ELCCG	152	12	92.11%	1,923	122	93.66%
FWCCG	107	7	93.46%	1,376	83	93.97%
GPCCG	75	8	89.33%	948	79	91.67%
MBCCG	193	28	85.49%	2,150	183	91.49%
WLCCG	67	2	97.01%	654	20	96.94%
CA CCGs	878	77	91.23%	9,974	685	93.13%

Cancer Alliance Providers (May-20 to Apr-21)



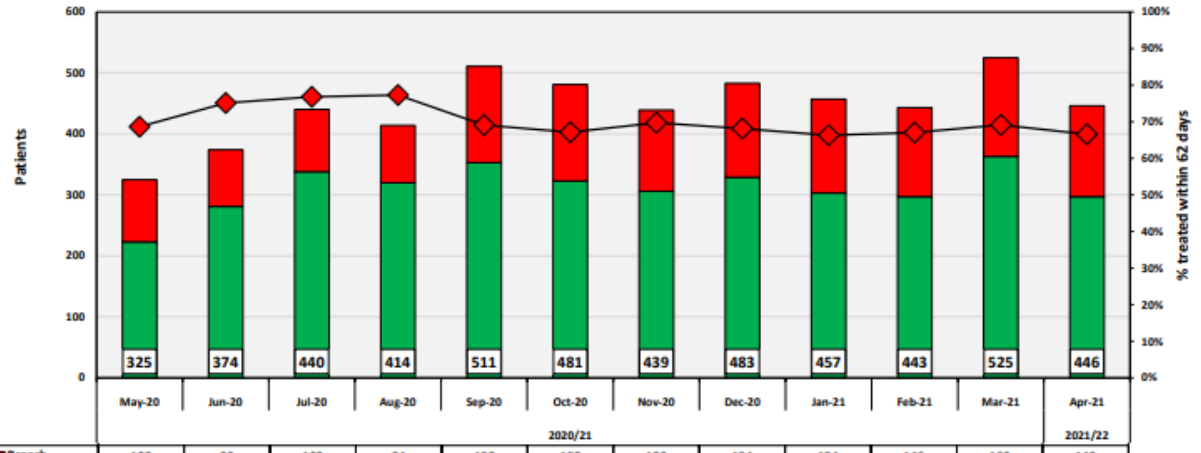
	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	34	49	47	54	56	63	61	55	61	56	48	76
Within 31 Days	525	601	706	640	772	799	688	718	727	689	850	720
Treated	559	650	753	694	828	862	749	773	788	745	898	796
Performance	93.92%	92.46%	93.76%	92.22%	93.24%	92.69%	91.86%	92.88%	92.26%	92.48%	94.65%	90.45%

Provider	Apr-21			May-20 to Apr-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	185	3	98.38%	2,080	57	97.26%
ELHT	187	20	89.30%	2,267	132	94.18%
LTH	269	39	85.50%	2,984	347	88.37%
UHMB	155	14	90.97%	1,764	124	92.97%
CA Providers	796	76	90.45%	9,095	660	92.74%

% 62 Day Cancer – Apr 21

62 Day Classic Performance (85% Standard)

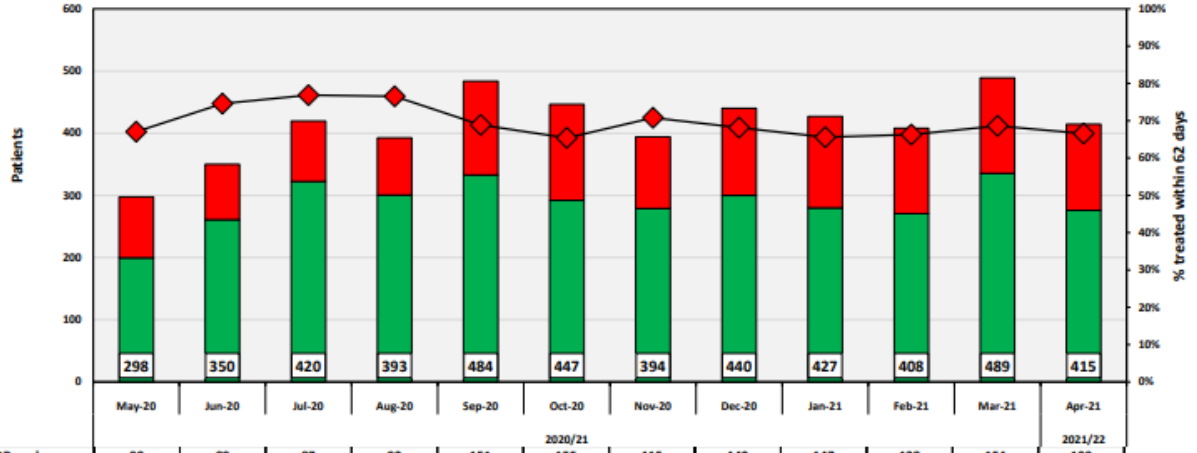
Cancer Alliance CCGs (May-20 to Apr-21)



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	102	93	102	94	158	158	133	154	154	146	162	149
Within 62 Days	223	281	338	320	353	323	306	329	303	297	363	297
Treated	325	374	440	414	511	481	439	483	457	443	525	446
Performance	68.62%	75.13%	76.82%	77.29%	69.08%	67.15%	69.70%	68.12%	66.30%	67.04%	69.14%	66.59%

CCG	Apr-21			May-20 to Apr-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BwDCCG	32.0	13.0	59.38%	367.0	92.0	74.93%
BCCG	45.0	10.0	77.78%	554.0	145.0	73.83%
CSRCCG	61.0	19.0	68.85%	596.0	192.0	67.79%
ELCCG	77.0	17.0	77.92%	1,020.0	268.0	73.73%
FWCCG	57.0	15.0	73.68%	771.0	193.0	74.97%
GPCCG	48.0	17.0	64.58%	531.0	189.0	64.41%
MBCCG	98.0	47.0	52.04%	1,160.0	436.0	62.41%
WLCCG	28.0	11.0	60.71%	339.0	90.0	73.45%
CA CCGs	446.0	149.0	66.59%	5,338.0	1,605.0	69.93%

Cancer Alliance Providers (May-20 to Apr-21)



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
Breach	98	89	97	92	151	155	115	140	147	138	154	139
Within 62 Days	200	261	323	301	333	292	279	300	280	271	336	276
Treated	298	350	420	393	484	447	394	440	427	408	489	415
Performance	67.06%	74.57%	76.88%	76.56%	68.87%	65.40%	70.81%	68.18%	65.57%	66.30%	68.61%	66.59%

Provider	Apr-21			May-20 to Apr-21		
	Treated	Breach	Performance	Treated	Breach	Performance
BTH	89.0	17.5	80.34%	1,184.0	278.0	76.52%
ELHT	102.0	30.0	70.59%	1,259.5	318.0	74.75%
LTH	136.0	52.5	61.40%	1,414.5	524.5	62.92%
UHMB	87.5	38.5	56.00%	1,104.0	392.0	64.49%
CA Providers	414.5	138.5	66.59%	4,962.0	1,512.5	69.52%

% Incomplete 18 weeks RTT – Apr 21

ICS Level: Lancashire & South Cumbria

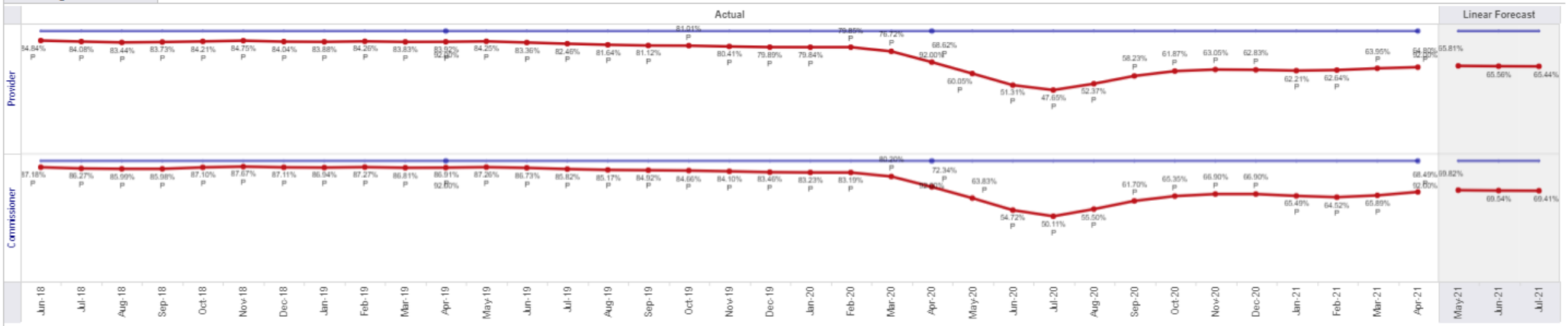
% of all Incomplete RTT (Referral to Treatment) pathways within 18 weeks

	Provider		YTD
Value	Apr-21	64.80%	64.80%
Target	Apr-21	92.00%	92.00%
Forecast	May-21	65.81%	64.80%

	Commissioner		YTD
Value	Apr-21	68.49%	69.49%
Target	Apr-21	92.00%	92.00%
Forecast	May-21	69.82%	69.49%

% Incomplete 18 Wks RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

Total number of Incompletes RTT – Apr 21

ICS Level: Lancashire & South Cumbria

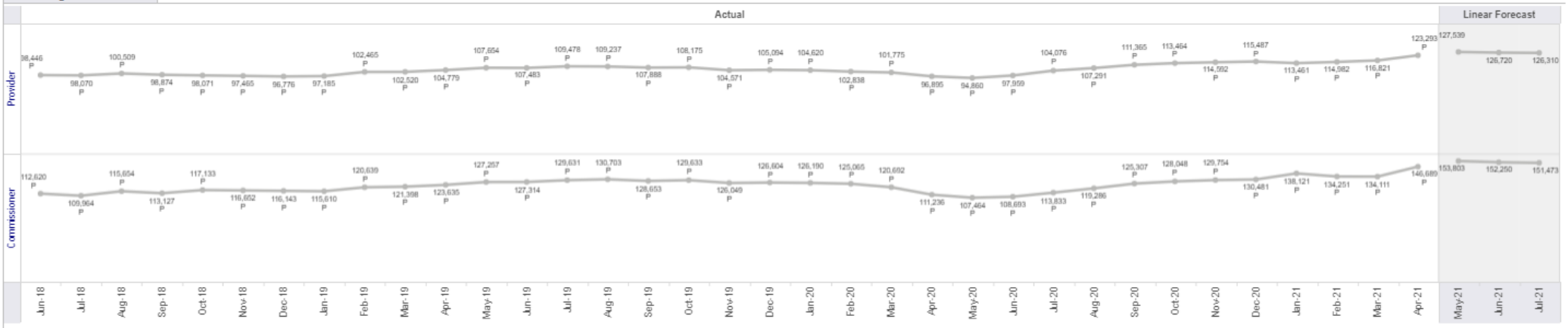
Total Number of Incompletes under and above 18 weeks RTT

	Provider	
Value	Apr-21	123,293
Target	Apr-21	
Forecast	May-21	127,539

	Commissioner	
Value	Apr-21	146,689
Target	Apr-21	
Forecast	May-21	153,803

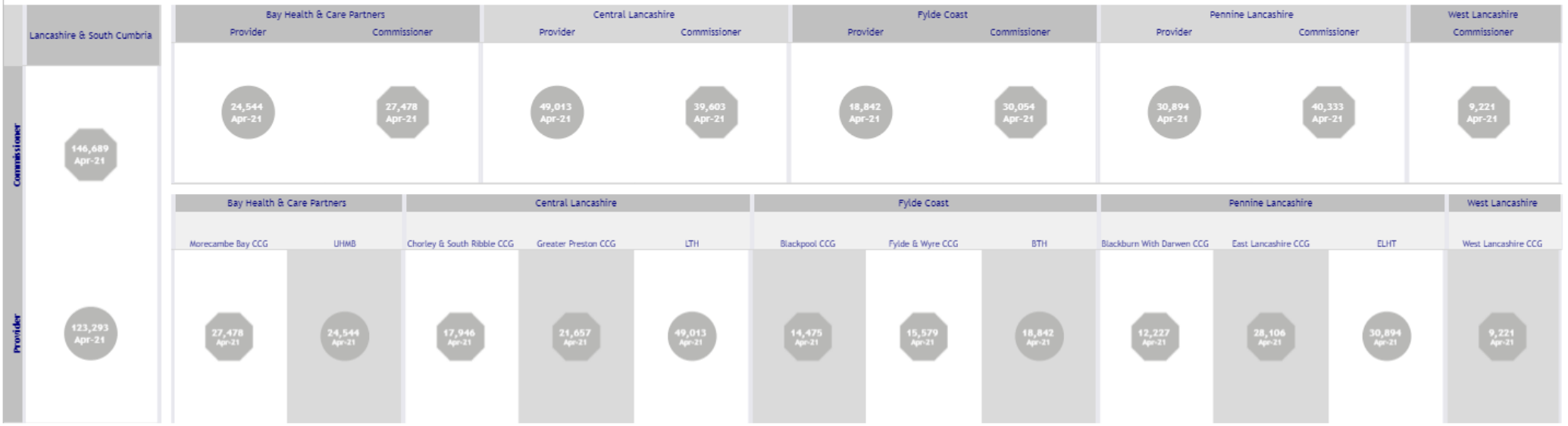
Total no. of Incompletes RTT

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations



Over 52 week waiters – Apr 21

Aristotle

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

NHS
Midlands and Lancashire
Commissioning Support Unit

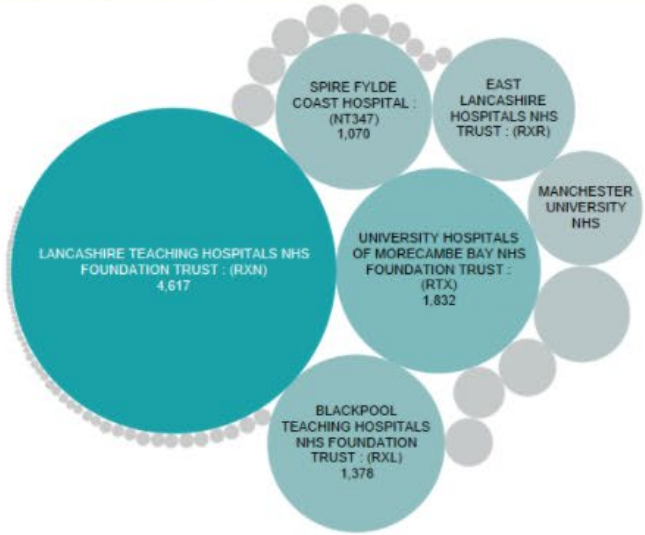
** Areas shaded blue can be used as filters by selecting them.

Referral to Treatment : 2) Incomplete pathways for all patients (unadjusted);
CCG Name : *;
Fiscal Year : 2021-22; Fiscal Month : April 2021
Provider: All; Treatment Function: All

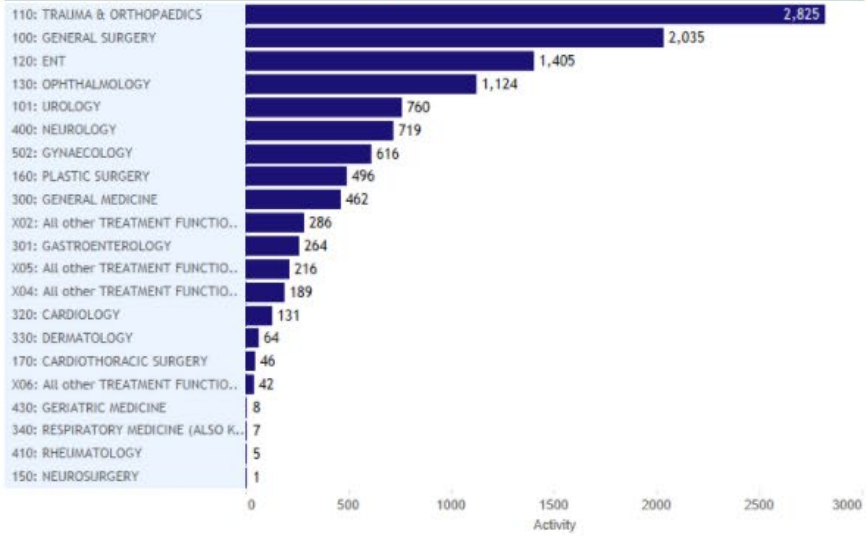
Select Referral To Treatment Pathway: 2) Incomplete pathways for all patients (unadjusted)

Fiscal Year	Select Month	Select Measure
2021-22	April 2021	Over 52 Weeks

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



Actuals by Treatment Function - Over 52 Weeks **



Ambulance Handover 30 min Delays

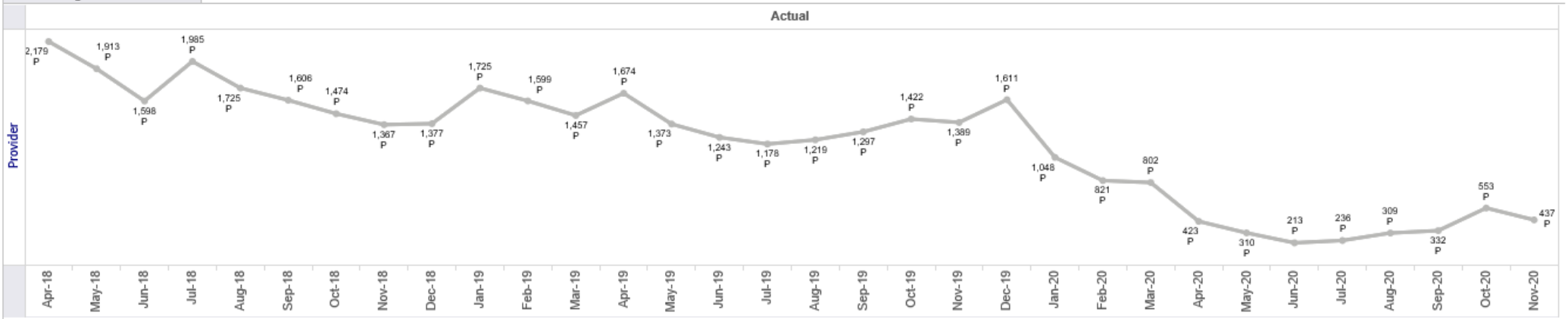
ICS Level: Lancashire & South Cumbria

Amb: 30 Min Handover Delays

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

Amb: 30 Min Handover Delays

Organisation



ICS

Integrated Care Partnerships \ Integrated Care Organisations

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

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

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

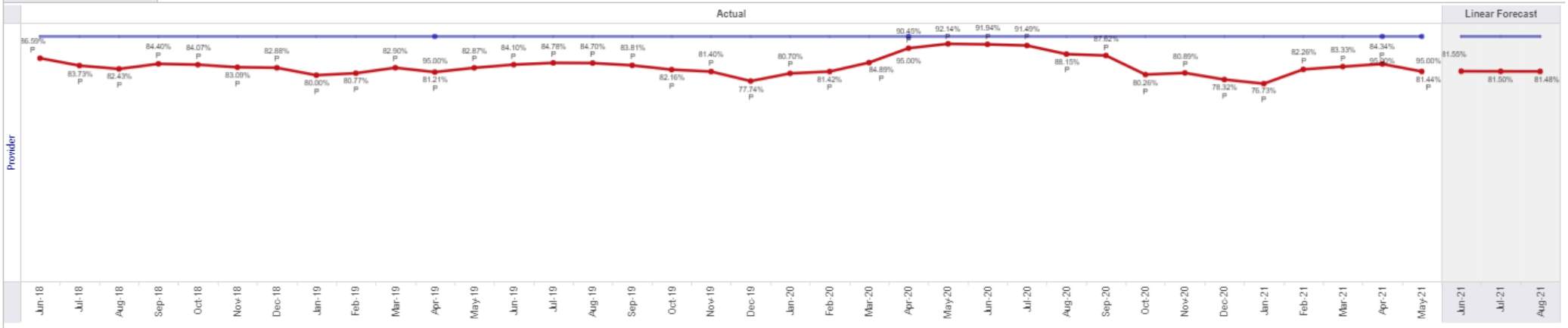
ICS Level: Lancashire & South Cumbria

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

	Provider		YTD
Value	May-21	81.44%	82.83%
Target	May-21	95.00%	95.00%
Forecast	Jun-21	81.55%	82.83%

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

Organisation



ICS	Integrated Care Partnerships \ Integrated Care Organisations			
Lancashire & South Cumbria	Bay Health & Care Partners Provider	Central Lancashire Provider	Fylde Coast Provider	Pennine Lancashire Provider
Provider: 81.44% May-21	80.03% May-21	81.90% May-21	83.84% May-21	79.66% May-21
	Bay Health & Care Partners UHMB	Central Lancashire LTH	Fylde Coast BTH	Pennine Lancashire ELHT
	80.03% May-21	81.90% May-21	83.84% May-21	79.66% May-21

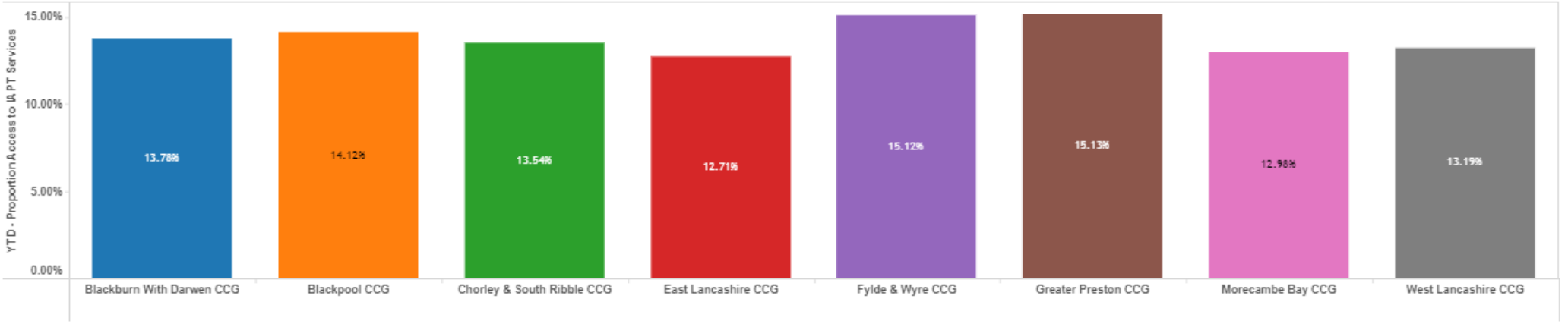
IAPT Access – Mar 21

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

Midlands and Lancashire Commissioning Support Unit

Area	Financial Year	Select data by
Lancashire	2020-21	Proportion Access to IAPT services %

Selected Area: Lancashire
Financial Year: 2020-21
The graph shows year to date figures for Proportion Access to IAPT services %. To filter for a particular month, click on the month name in the table below.



Data from NHS Digital Monthly Extracts

CCG Name	April	May	June	July	August	Septem..	October	Novemb..	Decemb..	January	February	March
Blackburn With Darwen CCG	0.76	0.69	1.12	1.09	1.42	1.22	1.58	0.86	1.25	1.37	1.30	1.12
Blackpool CCG	1.09	0.93	1.23	1.34	1.18	1.53	1.39	1.00	1.07	1.00	1.03	1.32
Chorley & South Ribble CCG	1.12	0.63	0.90	1.12	1.19	1.21	1.41	1.26	1.12	1.16	0.92	1.50
East Lancashire CCG	0.94	0.54	0.91	1.14	1.16	1.08	1.01	0.82	1.10	1.41	1.32	1.27
Fylde & Wyre CCG	1.36	1.00	0.75	1.39	1.42	1.52	1.24	1.26	0.90	1.83	1.03	1.42
Greater Preston CCG	1.08	0.69	0.94	1.20	1.08	1.42	1.61	1.61	1.28	1.26	1.38	1.59
Morecambe Bay CCG	0.87	0.59	0.90	1.12	1.01	1.17	1.25	1.28	1.06	1.28	1.14	1.32
West Lancashire CCG	0.61	0.50	0.93	0.97	1.08	1.51	1.29	1.29	1.01	1.15	1.15	1.69

Data from NHS Digital Quarterly Extracts

CCG Name	Q1	Q3	Q4
Blackburn With Darwen CCG	2.57	3.66	3.79
Blackpool CCG	3.28	3.46	3.33
Chorley & South Ribble CCG	2.65	3.79	3.59
East Lancashire CCG	2.38	3.45	4.00
Fylde & Wyre CCG	3.12	3.37	4.30
Greater Preston CCG	2.71	4.50	4.21
Morecambe Bay CCG	2.38	3.59	3.74
West Lancashire CCG	2.09	3.60	3.95

Strategic Commissioning Committee

Date of meeting	**15/07/2021**
Title of paper	**Elective Care Services Update**
Presented by	**Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs**
Author	**Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs**
Agenda item	**8**
Confidential	**No**

Purpose of the paper
For information
Executive summary
At the SCC, 15th April 2021, there was a request for future reports to feature a more in-depth analysis of performance and quality. This month, July 2021, the focus area relates to Elective Care.
Recommendations
The Strategic Commissioning Committee is requested to: 1. Note the contents of the report

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

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Implications

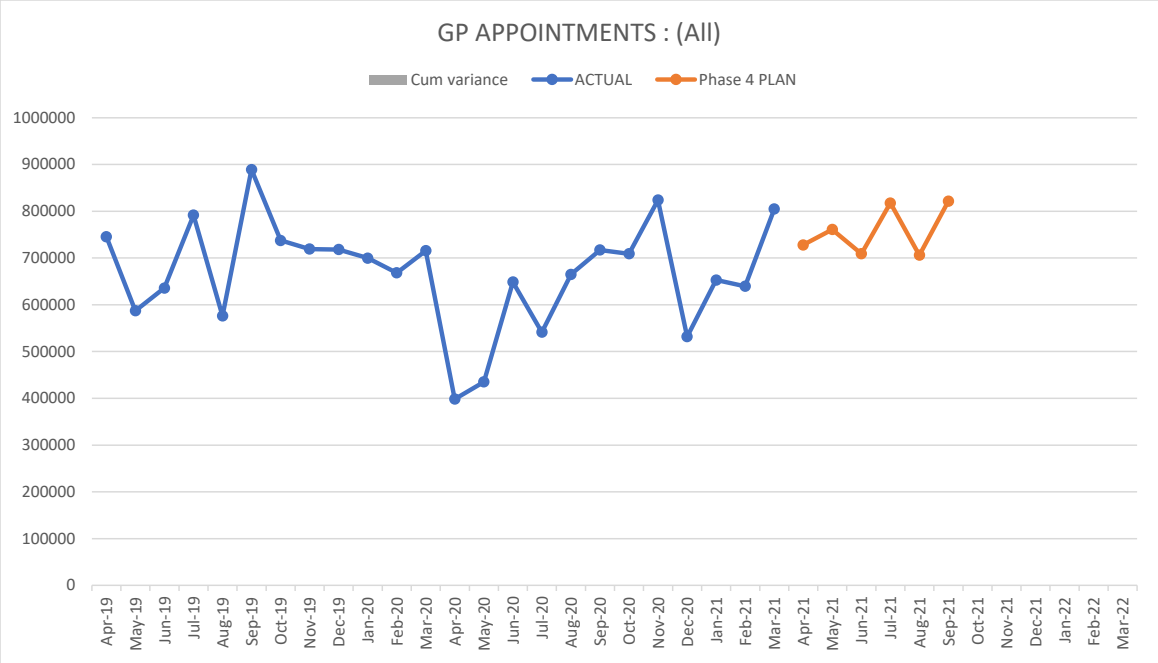
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Privacy impact assessment completed		✓		
Financial impact assessment completed			✓	
Associated risks				
Are associated risks detailed on the ICS Risk Register?			✓	
Report authorised by:				

ELECTIVE CARE SERVICES UPDATE FOR THE STRATEGIC COMMISSIONING COMMITTEE

1. Demand

1.1. Appointment demand and activity within GP practices has returned to pre-COVID levels (Chart 1). This is anticipated to be maintained and increase as patient confidence grows with the steady removal of restrictions. To this end, the ICS has submitted a monthly plan for Apr-Sep 2021 within the phase 4 planning submission that is 7.5% higher than the Apr-Sep 2019 position.

Chart 1 – GP Appointment trends and 2021 H1 plan

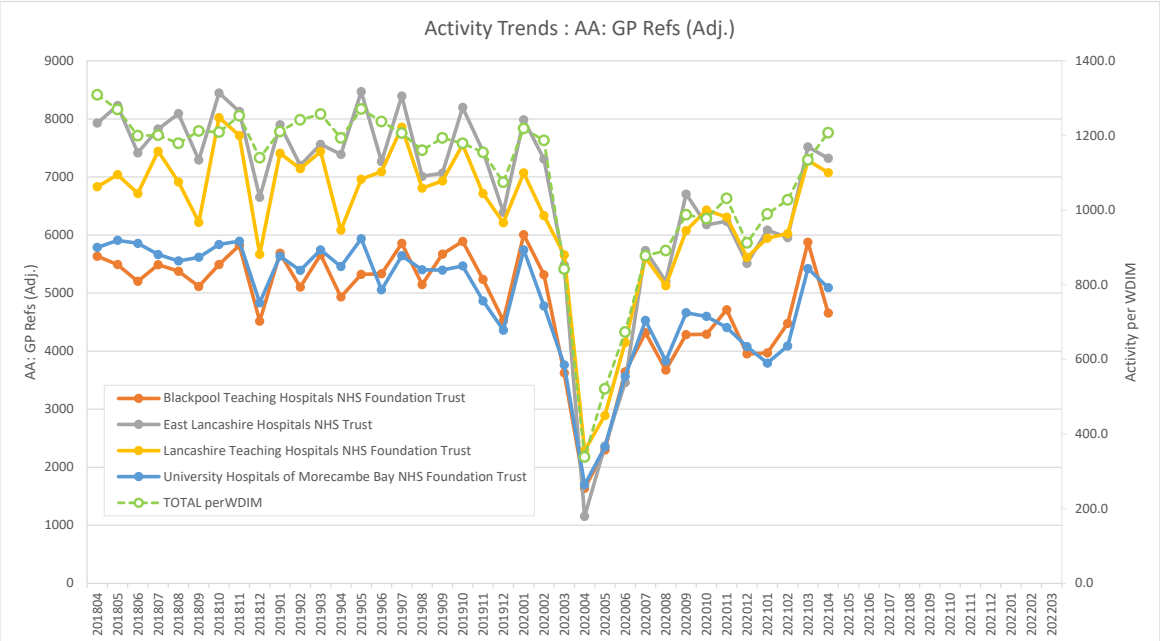


1.2. Although total appointments have moved back to pre-COVID levels the 'type' of appointment has changed with reductions in face-to-face appointments and increases in telephone and video appointments.

Period	% Face to Face Appointments	% Telephone Appointments
March 2019	85.9%	11.3%
March 2021	54.1%	44.4%

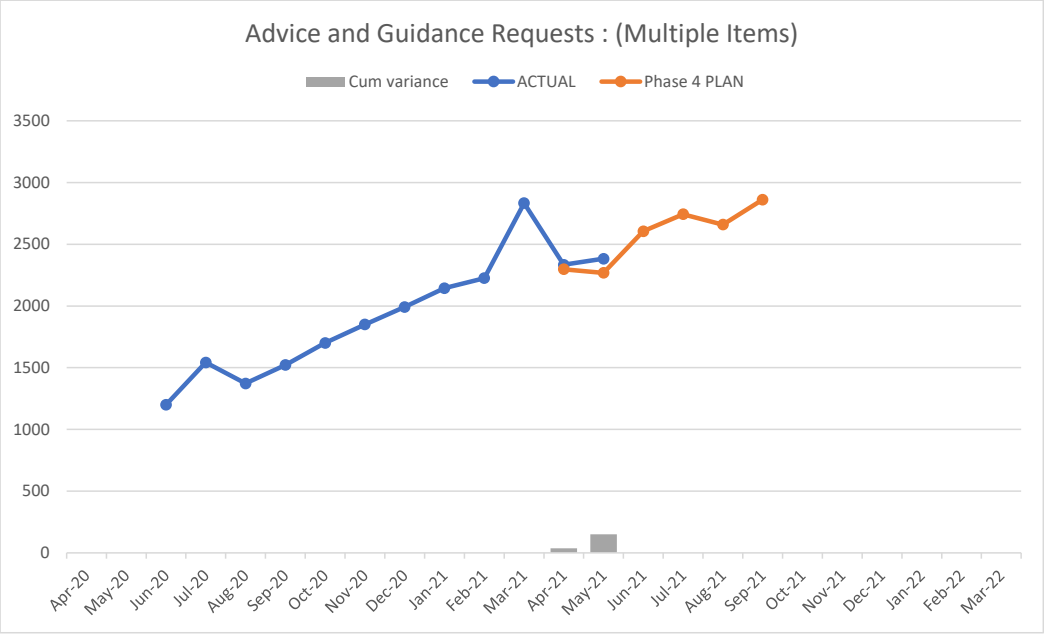
1.3. As noted in previous reports, the patterns of demand to our elective services changed significantly as result of COVID-19. Chart 2 below shows GP referrals to the four main ICS acute hospitals, this illustrates the decline and recovery of referrals. GP referrals have continued to increase through March and April 2021 (adjusted for working days in the month). April 21 activity across the 4 x L&SC providers was 96% of the activity volumes they reported in April 2019.

Chart 2 – GP referrals into the 4 main acute hospitals across Lancashire and South Cumbria



1.4. One approach being utilised across L&SC to support management of demand into the acute system has been the implementation of Advice and Guidance (based on the Morecambe Bay system [Except West Lancs which uses consultant connect]). The use of this system has been steadily increasing, and the final phase 4 plans are anticipating that this will continue [see Chart 3 – NB May 2021 data may not be fully complete].

Chart 3 – Advice and Guidance requests and Final Phase 4 Plan



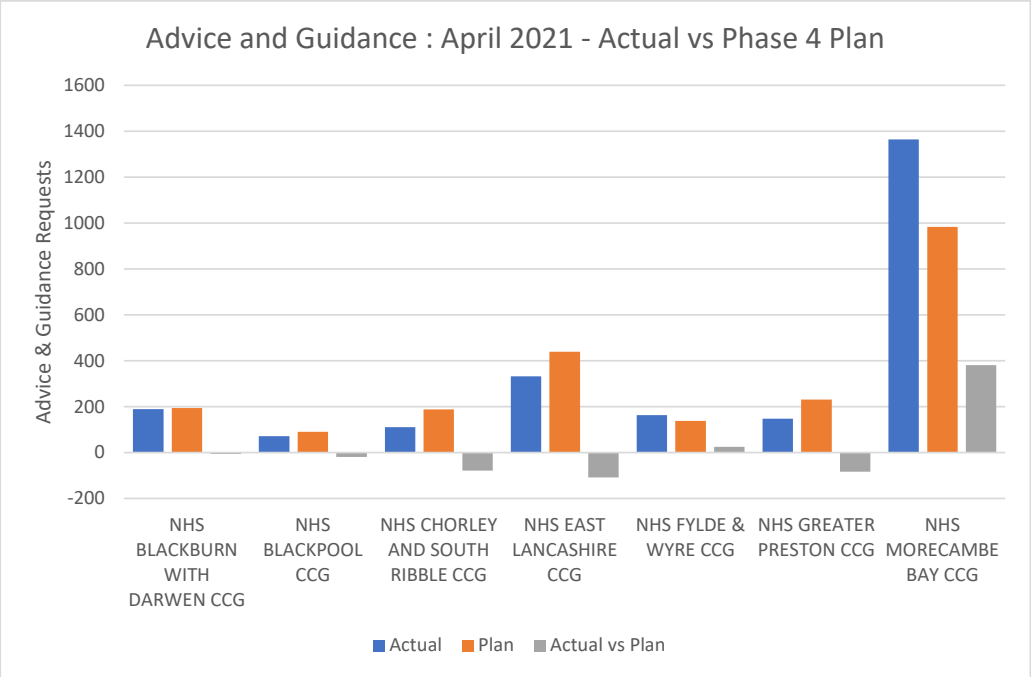
1.5. 92.2% of all Advice and Guidance requests in May 2021 were responded to within 2 days while referrals to outpatients were effectively halved (Table 1)

Table 1 – Pre and Post- Advice and Guidance outcomes

Treatment Plan [May 21]	BEFORE	AFTER A&G	MOVEMENT	% SHIFT
(blank)	728	689	-39	-5.4%
Admit	174	160	-14	-8.0%
Carry out further investigations	96	177	81	84.4%
Forced Closure		39	39	
Manage patient's care myself	108	561	453	419.4%
Other	147	204	57	38.8%
Radiology test sanctioned by radiologist		88	88	
Refer to outpatients	808	407	-401	-49.6%
Seek advice from another source	321	57	-264	-82.2%
TOTAL	**2382**	**2382**	**0**	**0.0%**

1.6. Encouragingly, the volume of advice and guidance requests reported in April and May 2021 are above the recently submitted plan levels (updated in the final phase 4 submission). However, there are variations in volumes and patterns of utilisation across CCGs. Morecambe Bay CCG (early adopter) accounts for over half of all advice and guidance requests and is also over plan.

Chart 4 – Advice and Guidance requests by CCG: May 2021



1.7. 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.

2. Activity

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

are available via the Elective Recovery Fund (ERF) for performance at 'Core +' (100% of historic levels) and 'Accelerator' (120% of historic)

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

	TOTAL ELECTIVE [4 x L&SC Providers]					
	April	May	June	July	August	September
2019-20 [Adjusted]	18803	18530	21068	20473	19063	20597
2021-22	17122	17146	19791	24571	22879	24721
% of 'baseline'	**91.1%**	**92.5%**	**93.9%**	**120.0%**	**120.0%**	**120.0%**

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

2.3. Activity trends based on the national dataset for CCGs (across all providers) highlight that the position in April 2021 was

Activity Type	April 2019 (Activity per WDIM)	April 2021 (Activity per WDIM)	April 21 Indicative Recovery %
Total Elective (EL+DC)	1124.6	989.7	88.0%
First Outpatients	2394.9	2202.2	92.0%
Follow-Up Outpatients	4756.2	4641.8	97.6%

Chart – Total Elective Activity Trends – L&SC CCGs

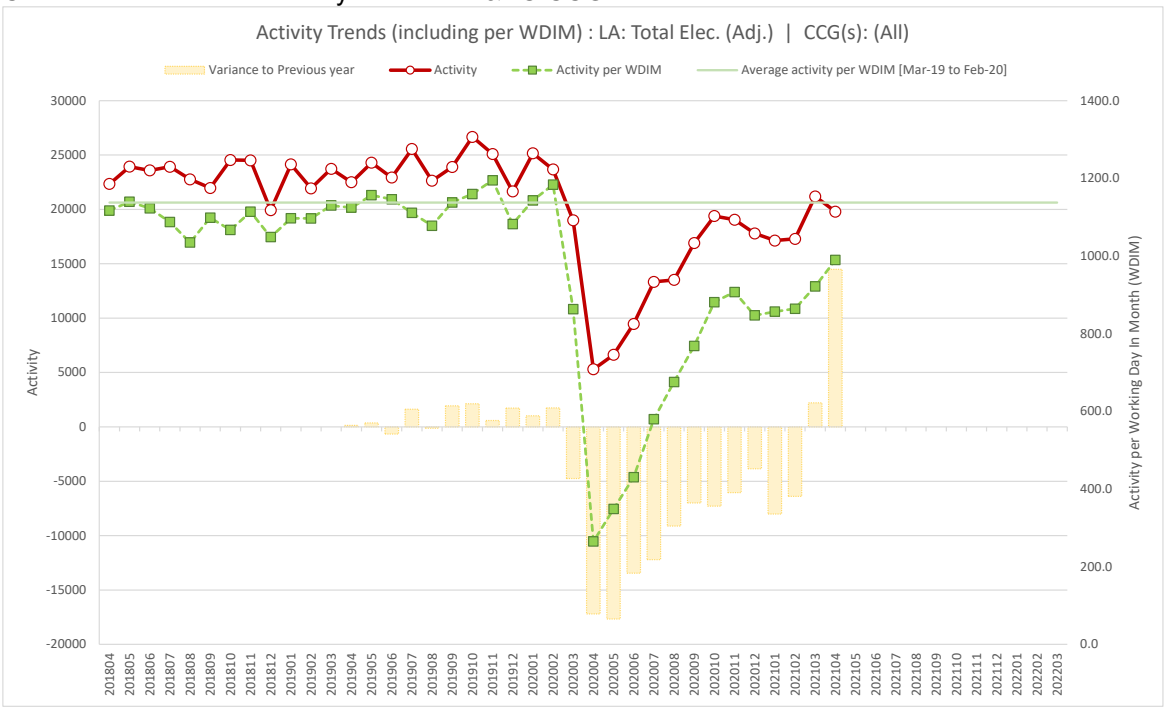


Chart – Total First Outpatient Activity Trends – L&SC CCGs

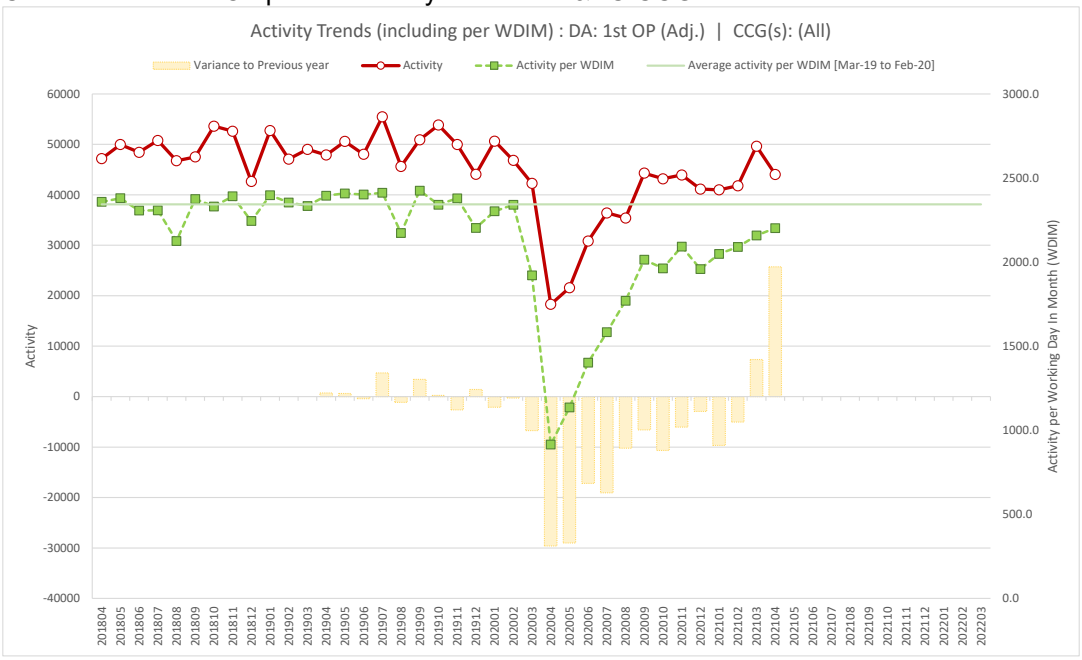
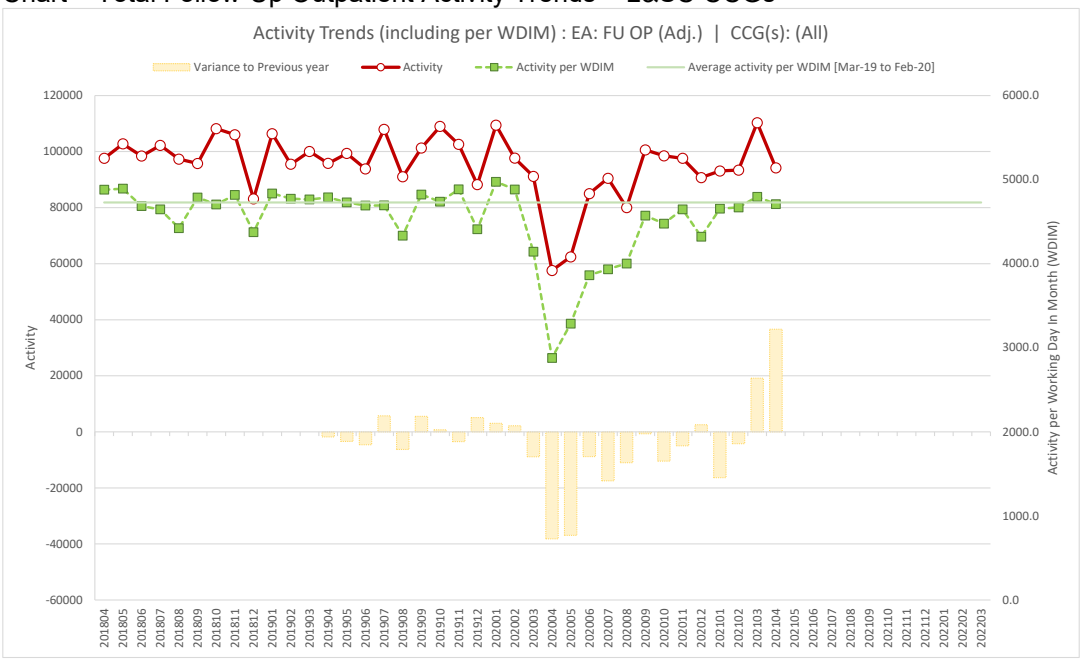


Chart – Total Follow-Up Outpatient Activity Trends – L&SC CCGs



2.4. Early indication weekly activity has been used by the ECRG to highlight the position in May 2021 against the Core, Core+ and Accelerator targets. The pace of restoration is different between the individual providers within the ICS as shown in the tables below for both April 2021 and May 2021.

	April Activity (SUS Flex)									
	Acute			Provider				IS		
	Actual	Target Core	% Diff	BTH	ELHT	LTH	UHMB	Actual	Target Core	% Diff
OEL	99%	82%	17%	83%	119%	92%	92%	93%	100%	-7%
DC	89%	82%	7%	89%	92%	84%	90%	59%	100%	-41%
OPFA	80%	89%	-9%	71%	81%	90%	74%	90%	100%	-10%
OPFUP	71%	92%	-21%	66%	60%	100%	52%	94%	100%	-6%

	May													
	Weekly Activity Return (excludes CCG IS)													
Point of Delivery	LSC Rolling 4 wk av.				Restoration Target			% Diff vs Latest 4 wk av. 30/05			Provider Rolling 4wk av. 30/05			
	09-May	16-May	23-May	30-May	Core	Core+	Accel	Core	Core+	Accel	BTH	ELHT	LTH	UHMB
OEL	100%	98%	91%	94%	88%	100%	100%	6%	-6%	-6%	82%	109%	86%	93%
DC	93%	89%	87%	93%	84%	91%	91%	9%	2%	2%	101%	93%	84%	93%
OPFA	105%	100%	96%	103%	92%	98%	98%	11%	5%	5%	121%	97%	102%	96%
OPFUP	109%	103%	99%	107%	95%	99%	99%	12%	8%	8%	119%	101%	106%	100%

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

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

2.6. All providers have identified schemes for deployment to support the accelerated recovery programme. The LSC PMO is working with Trusts to develop a consistent balance scorecard of scheme delivery, ensuring that strategic, cross-cutting issues, which may impact on the required activity trajectory growth can be captured and escalated to ECRG as appropriate

BTH	ELHT
Schemes across the following specialties and portfolios: cardiology, gastroenterology, gynaecology, trauma and orthopaedics, oral surgery, and MRI. Activities associated with the specific 68 accelerator schemes include: • Enhanced clinical validation of waiting lists. • Enablers to facilitate additional sessional activity. • Delivering colposcopy and hysteroscopy in an ambulatory setting. • Maintaining effective outsourcing arrangements to maximise the use and efficiency of internal capacity. A significant number of other schemes are in earlier planning stages and are subject to a structured delivery approach from the Trust's planning and delivery PMO	ELHT have commissioned significant enabling activity to: • Drive efficiency and performance in endoscopy, pain management, general surgery, trauma and orthopaedics, urology and oral surgery/maxillofacial. • Their activities particularly focus on the enabling activities which are necessary to bring on stretch and reserve capacity and to develop effective waiting list initiative activities. Some 70 separate schemes have been identified by the Trust

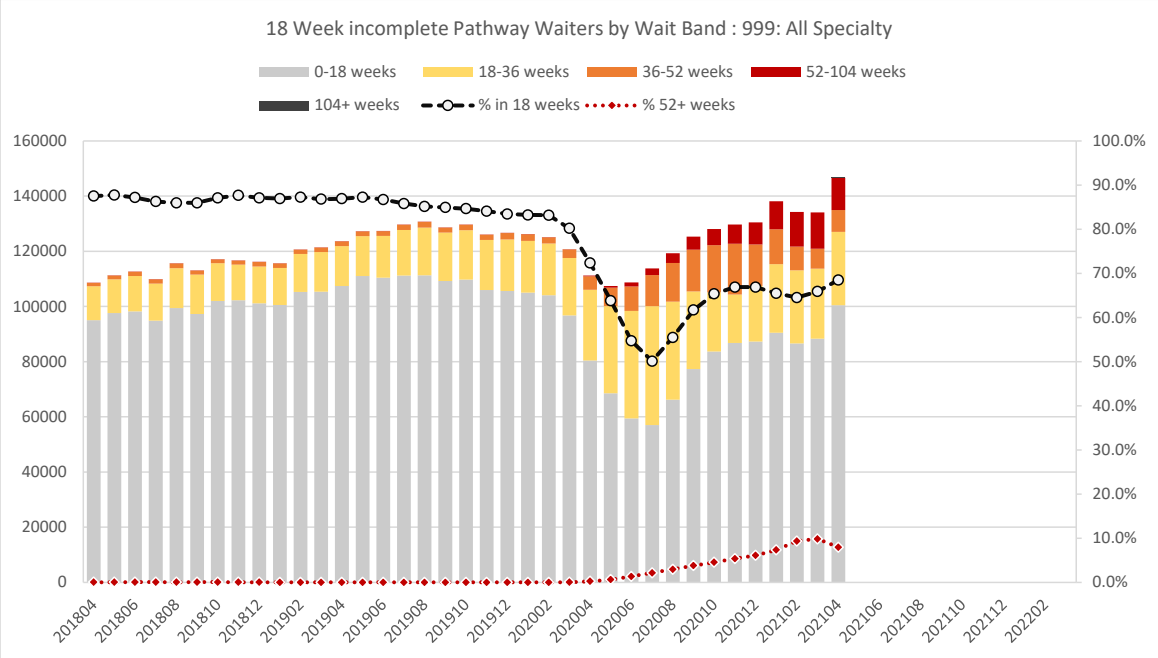
LTH	UHMB
LTH have further made significant progress with bringing online additional capacity for outpatient, day case and elective activities. Highlight schemes from their longlist of 121 distinct proposals include: • Extension of robotic surgery in general surgery. • Developing airflow units which will enable additional cardiology and respiratory outpatient activity to take place. • Procuring additional spinal kit to support productivity.	Schemes linked to accelerator: • Increased use of pre-operative assessment, to drive efficiency and increased utilisation of elective theatre capacity. • Extended use of inpatient escalation capacity, including enabling works. • Digital risk stratification, via Data Robot. This scheme is supporting clinical prioritisation and resource planning to assist with restoration trajectories and gateways. • Enhanced HSDU, Swab Hub and WLO capacity to enable activity growth. A further five schemes are in development. All schemes have been planned to deliver enhanced capacity and resilience across H1 with a view to sustainability, taking in to account seasonal factors and onward capacity planning. Specialty areas have focussed on those with opportunity to achieve backlog clearance, harmonising clinical prioritisation factors with additional elective activity.

3. 18 Weeks Referral to Treatment Target / Incomplete Pathways / 52+ Week Waiters

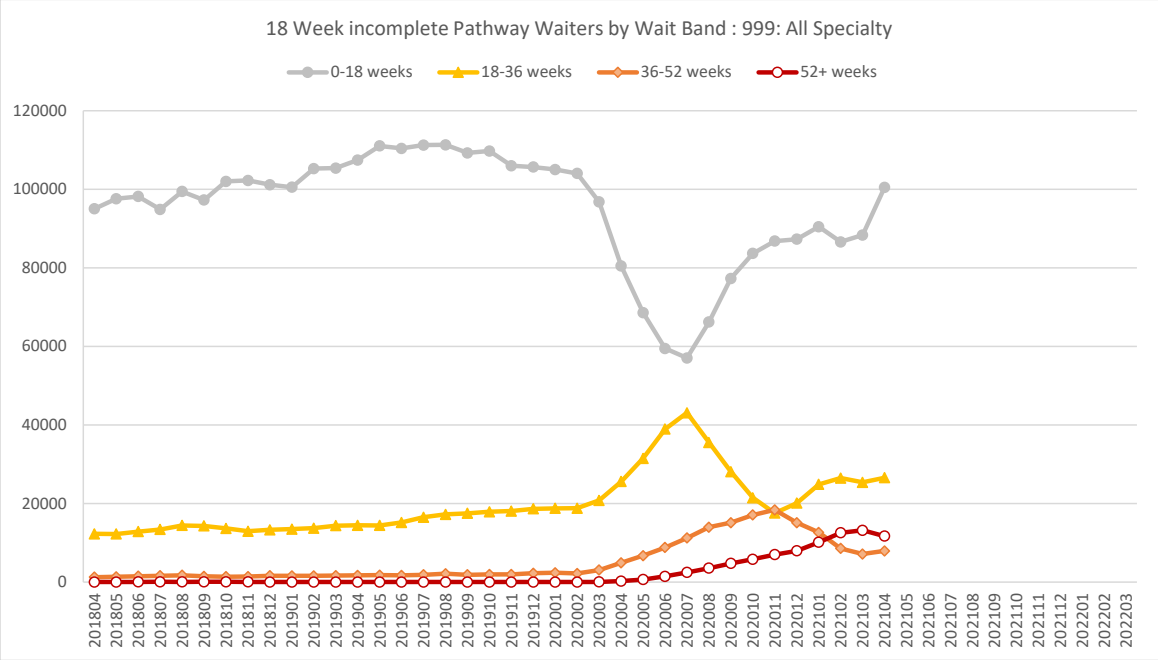
3.1. There are 3 key measures associated with referral to treatment times:

- 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%)

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.



3.3. 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 April 2021 the total number of patients waiting to start treatment has increased to 146,689, performance against the 18-week standard was 68.5%, and there were 11,701 over 52-week waiters (8.0%) of which 65 had been waiting in excess of 104 days.



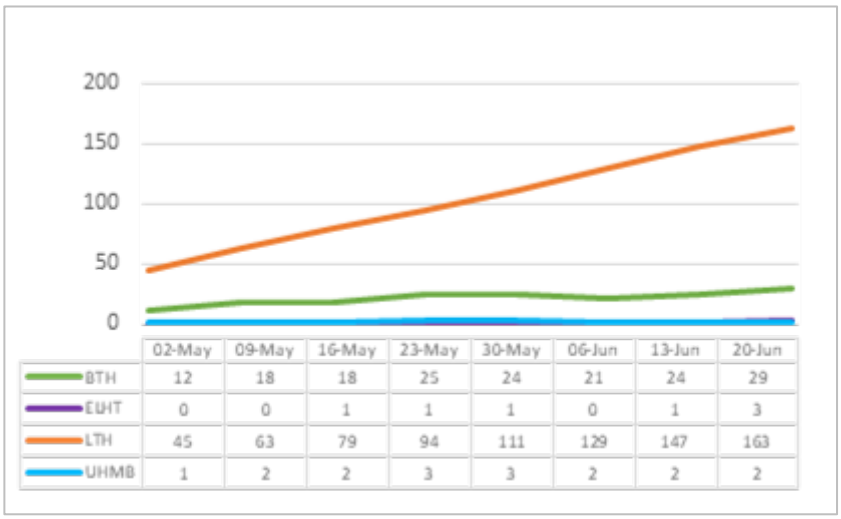
3.4. The number of over 52 week waiters has decreased in April 2021 for the first time over the past 13 months and indications are that this reduction has continued through May and into June. However, one of the drivers of this reduction is likely to be the reduced referrals into systems during April and May 2020 which are now tripping over the 52 week threshold. All other waiting time bands have increased in April 2021, especially the 0-18 band which is indicative of the recovery of referral demand referenced earlier in the report.

3.5. National 18 week returns have now been extended to include data beyond just the 52+ week category in recognition of the lengthening waiting lists across the country. Within the April 2021 return, 65 patients across Lancashire and South Cumbria had been waiting in excess of 104 weeks (2 years).

Table – 104+ week waiters by provider and specialty (April 2021)

Specialty	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	SPIRE FYLDE COAST HOSPITAL	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	PENNINE ACUTE HOSPITALS NHS TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	BARTS HEALTH NHS TRUST	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	BOLTON NHS FOUNDATION TRUST	SALFORD ROYAL NHS FOUNDATION TRUST	TOTAL	% TOTAL
General Surgery	10	7	1	1	2	0	0	0	0	1	**22**	**33.8%**
Trauma and Orthopaedic	2	5	6	0	0	0	0	0	0	0	**13**	**20.0%**
Plastic Surgery	11	0		0	0	0	0	0	1	0	**12**	**18.5%**
Gynaecology Service	0	0	5	1	0	0	0	1	0	0	**7**	**10.8%**
Ear Nose and Throat	3	0	0	2	0	0	0	0	0	0	**5**	**7.7%**
Urology	3	0	0	0	0	0	0	0	0	0	**3**	**4.6%**
Other - Paediatric	0	0		0	0	0	1	0	0	0	**1**	**1.5%**
Other - Surgical		0	0	0	0	1	0	0	0	0	**1**	**1.5%**
Ophthalmology	0	0	0	0	0	1	0	0	0	0	**1**	**1.5%**
TOTAL	**29**	**12**	**12**	**4**	**2**	**2**	**1**	**1**	**1**	**1**	**65**	**100.0%**
% TOTAL	**44.6%**	**18.5%**	**18.5%**	**6.2%**	**3.1%**	**3.1%**	**1.5%**	**1.5%**	**1.5%**	**1.5%**	**100.0%**	

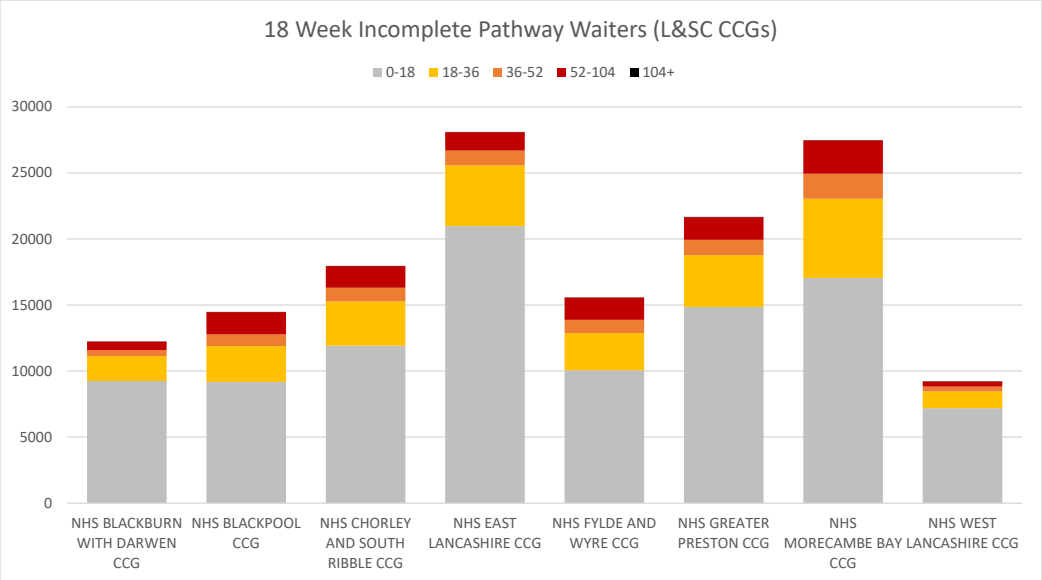
3.6. Local data shared through the ECRG covers a more timely view of the weekly position at provider level and this is reported to have 197 patients wating over 104 weeks as at 20th June 2021, with 163 (82.7%) of these reported at LTHT



	02-May	09-May	16-May	23-May	30-May	06-Jun	13-Jun	20-Jun
BTH	12	18	18	25	24	21	24	29
EUHT	0	0	1	1	1	0	1	3
LTH	45	63	79	94	111	129	147	163
UHMB	1	2	2	3	3	2	2	2

3.7. The following table shows the variation in numbers of patients waiting to start treatment and the % waiting 18 weeks and 52+ weeks at the end of April 2021. There is significant variation between CCGs which will be linked to differences in the position of the main providers and specialties. In terms of the volumes of longer waiter patients then there appears to be the greatest pressure in the Fylde Coast where over 10% of patients are waiting 52+ weeks.

CCG	0-18	18-36	36-52	52-104	104+	TOTAL	% in 18 weeks	% 52+ weeks
NHS BLACKBURN WITH DARWEN CCG	9241	1889	468	627	2	12227	75.6%	5.1%
NHS BLACKPOOL CCG	9180	2707	894	1675	19	14475	63.4%	11.7%
NHS CHORLEY AND SOUTH RIBBLE CCG	11922	3360	1033	1625	6	17946	66.4%	9.1%
NHS EAST LANCASHIRE CCG	20974	4610	1115	1400	7	28106	74.6%	5.0%
NHS FYLDE AND WYRE CCG	10061	2819	1005	1678	16	15579	64.6%	10.9%
NHS GREATER PRESTON CCG	14857	3918	1162	1714	6	21657	68.6%	7.9%
NHS MORECAMBE BAY CCG	17054	5995	1902	2519	8	27478	62.1%	9.2%
NHS WEST LANCASHIRE CCG	7182	1273	367	398	1	9221	77.9%	4.3%
TOTAL	**100471**	**26571**	**7946**	**11636**	**65**	**146689**	**68.5%**	**8.0%**



3.8. 74.5% of all over 52-week waiters for the CCGs are at the four main providers in the ICS, with 39.5% at LTHT (See Appendix 1). Four specialties account for 63.1% of all long waiters (as at the end of April 2021):

Specialty	April 2021	% Total 52+ week waiters
Trauma & Orthopaedics	2,825	24.1%
General Surgery	2,035	17.4%
ENT	1,405	12.0%
Ophthalmology	1,124	9.6%
Top 4	**7,389**	**63.1%**

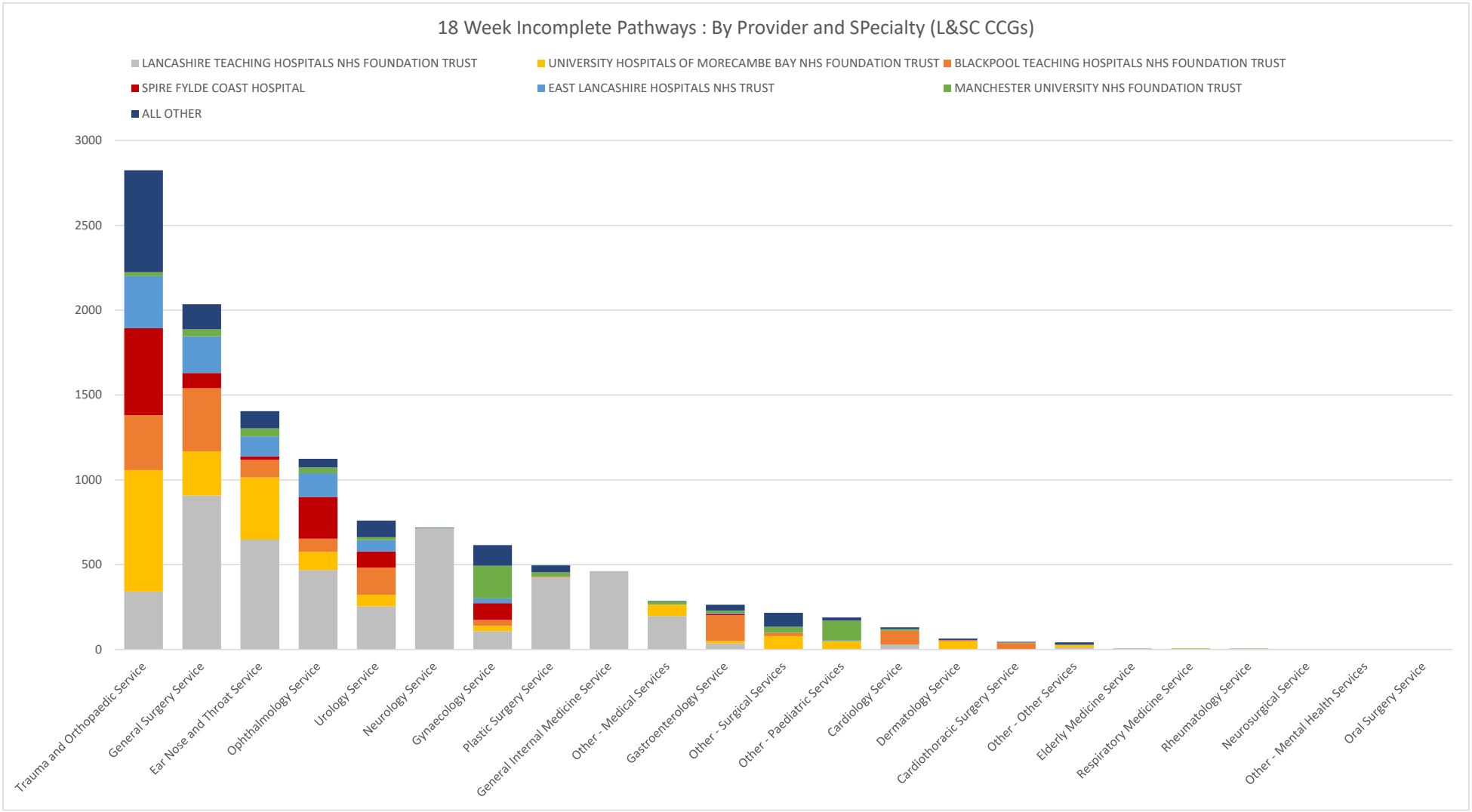
3.9. Spire Fylde Coast Hospital now has more over 52 week waiters than ELHT.

3.10. When a provider view is taken across the 4 x L&SC providers (Appendix 2) then Oral Surgery is reported to have the greatest number of 52+ week waiters (2,381) with almost 80% of these waiting at LTHT. Oral surgery is commissioned by NHSE and as such these waiters appear in provider totals, but not CCG figures.

Appendix 2: Over 52 week waiters for L&SC CCGs split by Specialty and Provider - April 2021

Specialty	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	SPIRE FYLDE COAST HOSPITAL	EAST LANCASHIRE HOSPITALS NHS TRUST	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	ALL OTHER	TOTAL	% TOTAL
Trauma and Orthopaedic Service	342	716	324	512	307	23	601	2825	24.1%
General Surgery Service	908	261	371	90	216	41	148	2035	17.4%
Ear Nose and Throat Service	648	366	104	21	117	48	101	1405	12.0%
Ophthalmology Service	469	107	78	245	141	34	50	1124	9.6%
Urology Service	254	69	159	96	67	17	98	760	6.5%
Neurology Service	716	0	0	0	0	0	3	719	6.1%
Gynaecology Service	108	31	35	99	29	192	122	616	5.3%
Plastic Surgery Service	426	1	4	0	0	24	41	496	4.2%
General Internal Medicine Service	462	0	0	0	0	0	0	462	3.9%
Other - Medical Services	197	68	0	0	1	17	3	286	2.4%
Gastroenterology Service	36	15	152	7	7	13	34	264	2.3%
Other - Surgical Services	0	79	20	0	0	35	82	216	1.8%
Other - Paediatric Services	0	47	3	0	3	117	19	189	1.6%
Cardiology Service	30	0	80	0	1	9	11	131	1.1%
Dermatology Service	1	48	7	0	0	0	8	64	0.5%
Cardiothoracic Surgery Service	0	0	38	0	0	3	5	46	0.4%
Other - Other Services	12	15	1	0	0	1	13	42	0.4%
Elderly Medicine Service	8	0	0	0	0	0	0	8	0.1%
Respiratory Medicine Service	0	5	2	0	0	0	0	7	0.1%
Rheumatology Service	0	4	0	0	0	0	1	5	0.0%
Neurosurgical Service	0	0	0	0	0	0	1	1	0.0%
Other - Mental Health Services	0	0	0	0	0	0	0	0	0.0%
Oral Surgery Service	0	0	0	0	0	0	0	0	0.0%
TOTAL	**4617**	**1832**	**1378**	**1070**	**889**	**574**	**1341**	**11701**	
% TOTAL	**39%**	**16%**	**12%**	**9%**	**8%**	**5%**	**11%**		

April 2021


18 Week Incomplete Pathways : By Provider and SPecialty (L&SC CCGs)
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST
SPIRE FYLDE COAST HOSPITAL
EAST LANCASHIRE HOSPITALS NHS TRUST
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST
ALL OTHER
3000
2500
2000
1500
1000
500
0
Trauma and Orthopaedic Service
General Surgery Service
Ear Nose and Throat Service
Ophthalmology Service
Urology Service
Neurology Service
Gynaecology Service
Plastic Surgery Service
General Internal Medicine Service
Other - Medical Services
Gastroenterology Service
Other - Surgical Services
Other - Paediatric Services
Cardiology Service
Dermatology Service
Cardiothoracic Surgery Service
Other - Other Services
Elderly Medicine Service
Respiratory Medicine Service
Rheumatology Service
Neurosurgical Service
Other - Mental Health Services
Oral Surgery Service

Lancashire and South Cumbria
Health and Care Partnership

Appendix 3: Over 52 week waiters for L&SC Providers split by Specialty - April 2021

Specialty	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	EAST LANCASHIRE HOSPITALS NHS TRUST	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	TOTAL	% TOTAL
Oral Surgery Service	68	312	1897	104	2381	20.0%
General Surgery Service	375	221	977	273	1846	15.5%
Trauma and Orthopaedic Service	328	312	381	748	1769	14.8%
Ear Nose and Throat Service	106	119	672	381	1278	10.7%
Ophthalmology Service	78	141	483	110	812	6.8%
Neurology Service			733		733	6.1%
Urology Service	163	68	273	74	578	4.8%
General Internal Medicine Service		0	483	0	483	4.1%
Plastic Surgery Service	4		454	1	459	3.8%
Neurosurgical Service			421		421	3.5%
Other - Medical Services	0	1	219	68	288	2.4%
Gynaecology Service	35	30	121	35	221	1.9%
Gastroenterology Service	153	7	39	15	214	1.8%
Cardiology Service	88	1	34	0	123	1.0%
Other - Surgical Services	21	0		97	118	1.0%
Dermatology Service	7	0	1	50	58	0.5%
Other - Paediatric Services	3	3	0	48	54	0.5%
Cardiothoracic Surgery Service	38	0		0	38	0.3%
Other - Other Services	1	0	12	15	28	0.2%
Respiratory Medicine Service	3	0		6	9	0.1%
Elderly Medicine Service	0	0	8	0	8	0.1%
Rheumatology Service	0	0		4	4	0.0%
Other - Mental Health Services	0				0	0.0%
TOTAL	**1471**	**1215**	**7208**	**2029**	**11923**	**100.0%**

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

Strategic Commissioning Committee

Date of meeting	**15/07/2021**
Title of paper	**Mental Health Update for the Strategic Commissioning Committee**
Presented by	**Roger Parr, Deputy Chief Officer / CFO from Pennine Lancashire CCGs**
Author	**Phil Horner, Head of Business Intelligence, LSCFT**
Agenda item	**8**
Confidential	**No**

Purpose of the paper
For information
Executive summary
This paper provides an update regarding performance against key nationally-monitored metrics, current key pressures within Lancashire & South Cumbria's mental health provision, the current mitigations for the pressures and plans for sustainable solutions to these issues.
Recommendations
The Strategic Commissioning Committee is requested to: 1. Note the contents of 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:	Andrew Bennett, Executive Lead Commissioning			

Lancashire and South Cumbria
Health and Care Partnership

MENTAL HEALTH UPDATE FOR THE STRATEGIC COMMISSIONING COMMITTEE

1. Introduction

1.1 This paper provides an update regarding performance against key nationally-monitored metrics, current key pressures within Lancashire & South Cumbria's mental health provision, the current mitigations for the pressures and plans for sustainable solutions to these issues.

1.2 The predicted impacts on mental health demand of the Covid-19 pandemic have been evident in the last 18 months, with suppression of non-urgent demand (e.g. lower referrals from primary care at times of social restrictions) and surges in demand being seen particularly in crisis pathways such as Home Treatment Teams, A&E and, ultimately, acute inpatient admissions.

1.3 Community mental health demand in Lancashire & South Cumbria has increased notably during the pandemic:

- 45% higher than 2019/20
- 40% above the current national average, the ninth highest rate in the country

1.4 Community services are absorbing much of this increased demand:

- Adult admission rates 19% above the national average up to March 2021
- Adult admission rates 4% above the national average in April 2021

1.5 A key factor driving suboptimal service responses for people needing urgent admission to hospital to support their mental health needs is that fact that recurrently commission bed capacity is 15% below modelled requirements and NHS Benchmark (this includes both LSCFT bed stock and subcontracted independent sector rehabilitation beds):

- Results in delays to admission & breaches of waiting time targets
- Results in a reliance on spot purchased independent sector beds which are classified as Inappropriate Out of Area Placements

1.6 A capital programme has been developed to provide Lancashire & South Cumbria with a bed base which is in line with both the recommendations of Niche Consultants (who conducted a review of the bed requirements for the next five years) and the NHS Benchmark number of beds for the population of the ICS. The reliance on Inappropriate OAPs has been mitigated through flow improvement initiatives which have increased discharge numbers by 30% without adversely impacting on readmission rates and reduced both median and mean Length of Stay to below the NHS Benchmark. Further flow improvement initiatives are currently being initiated. The gap between current and required beds has been further mitigated through increasing the number of contracted Independent Sector beds which meet the NHS England Principles of Continuity of Care.

2. Nationally-Reported Indicators

North West Region	IAPT Access Rate	IAPT Recovery Rate	IAPT waiting times - 6 weeks	IAPT waiting times - 18 weeks	EIP waiting times - MHSDS	Dementia diagnosis rate
	Rolling Quarter Feb-21	Rolling Quarter Feb-21	Monthly Feb-21	Monthly Feb-21	Rolling Quarter Feb-21	Snapshot Apr-21
CHESHIRE AND MERSEYSIDE STP	3.24%	49.12%	88.16%	95.26%	81.58%	62.1%
GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP (STP)	4.19%	47.03%	84.46%	98.21%	80.65%	68.2%
HEALTHIER LANCASHIRE AND SOUTH CUMBRIA	3.58%	51.35%	94.35%	99.19%	0.00%	67.3%
NORTH WEST	3.71%	48.64%	87.71%	97.47%	55.86%	65.6%
Other Regions						
NORTH EAST AND YORKSHIRE	4.06%	51.18%	93.73%	98.48%	76.00%	64.00%
EAST OF ENGLAND	4.72%	51.80%	93.19%	98.27%	77.94%	59.00%
MIDLANDS	4.59%	52.15%	93.15%	98.89%	74.16%	61.10%
LONDON	4.67%	51.37%	95.23%	99.49%	77.08%	65.90%
SOUTH EAST	4.64%	51.31%	91.31%	99.58%	74.29%	59.60%
SOUTH WEST	3.83%	45.12%	90.55%	98.51%	70.00%	57.70%
ENGLAND	4.34%	50.61%	92.30%	98.70%	71.46%	61.70%
Standard	6.25%	50.00%	75.00%	95.00%	60.00%	66.70%

North West Region	CYP Access Rate	CYP Eating Disorder Waiting time - Urgent	CYP Eating Disorder Waiting time - Routine	Out of area placement bed days (inappropriate)	Number of women in contact with specialist perinatal mental health services	Perinatal access (proportion of births)
	Latest 12mths Feb-21	Quarterly for Region, Rolling 12 months for STP Mar-21	Quarterly for Region, Rolling 12 months for STP Mar-21	Rolling Quarter Feb-21	Rolling 12mths Feb-21	Rolling 12mths Feb-21
CHESHIRE AND MERSEYSIDE STP	0.00%	96.49%	97.16%	725	1,045	3.80%
GREATER MANCHESTER HEALTH AND SOCIAL CARE PARTNERSHIP (STP)	0.00%	100.00%	93.33%	2,750	1,495	4.00%
HEALTHIER LANCASHIRE AND SOUTH CUMBRIA	0.00%	61.62%	93.93%	8,395	860	4.60%
NORTH WEST	42.18%	68.07%	89.23%	11,870	3,390	4.10%
Other Regions						
NORTH EAST AND YORKSHIRE	47.71%	61.25%	72.64%	9,375	4,135	4.30%
EAST OF ENGLAND	35.43%	70.59%	74.71%	5,635	4,510	5.90%
MIDLANDS	32.86%	71.94%	77.58%	11,410	6,230	5.10%
LONDON	35.59%	73.33%	67.54%	5,445	5,780	4.50%
SOUTH EAST	41.37%	82.35%	67.36%	10,950	4,315	4.40%
SOUTH WEST	33.70%	56.63%	59.63%	6,700	2,470	4.30%
ENGLAND	38.95%	70.51%	72.66%	63,075	30,900	4.70%
Standard	35.00%	95.00%	95.00%			7.10%

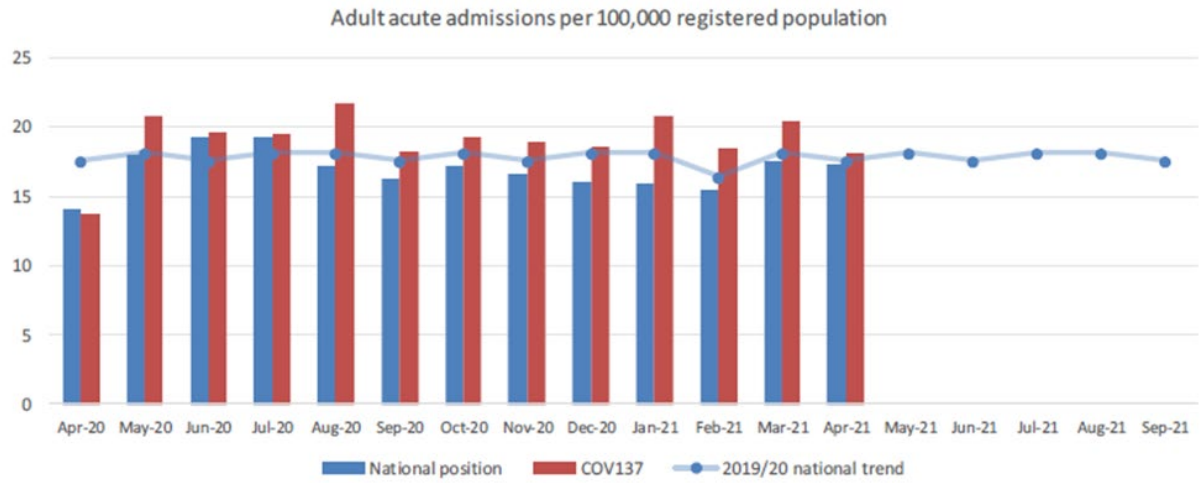
2.1 The above metrics are monitored by NHS England, with reporting lags within the national system. The current ICS position is as follows (with LSCFT IAPT indicative if ICS performance):

	NHSE Target	Feb 2021 National Report	May 2021 Performance
IAPT Access Rate (LSCFT, Cumulative) *(Note 1)*	3.03%	3.6%	2.5%
IAPT Recovery Rate (LSCFT)	50.0%	51.35%	54.70%
IAPT Waiting Times - 6 weeks (LSCFT)	75.0%	94.35%	94.10%
IAPT Waiting Times - 18 weeks (LSCFT)	95.0%	99.19%	100%
EIP Waiting Times: MHSDS	60.0%	0.0%	77.80%
Dementia Diagnosis Rate	66.7%	67.3%	72.6%
CYP Access Rate (target cumulative referrals)	3085	-	3598
CYP Eating Disorder Waiting Time (Urgent)	95.0%	61.6%	62.1%
CYP Eating Disorder Waiting Time (Routine)	95.0%	89.2%	20.0%
Out of Area Placements (Inappropriate) (Note 2)	1110	8395	830
Number of Women in Contact w/ Perinatal MH Services (Rolling 12 months)		860	935

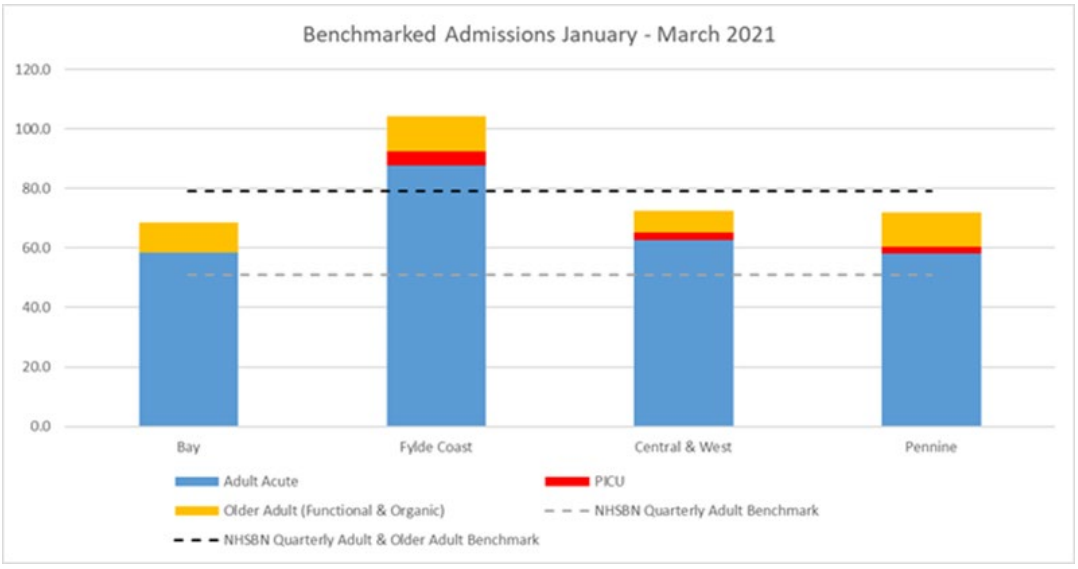
Notes:

1. IAPT services particularly impacted by lower numbers of mental health presentations in Primary Care. This is seen nationally
2. Internal LSCFT OAP target based on gap between commissioned beds and NHS Benchmark / Niche-modelled requirements

2.2 *Admission Demand*



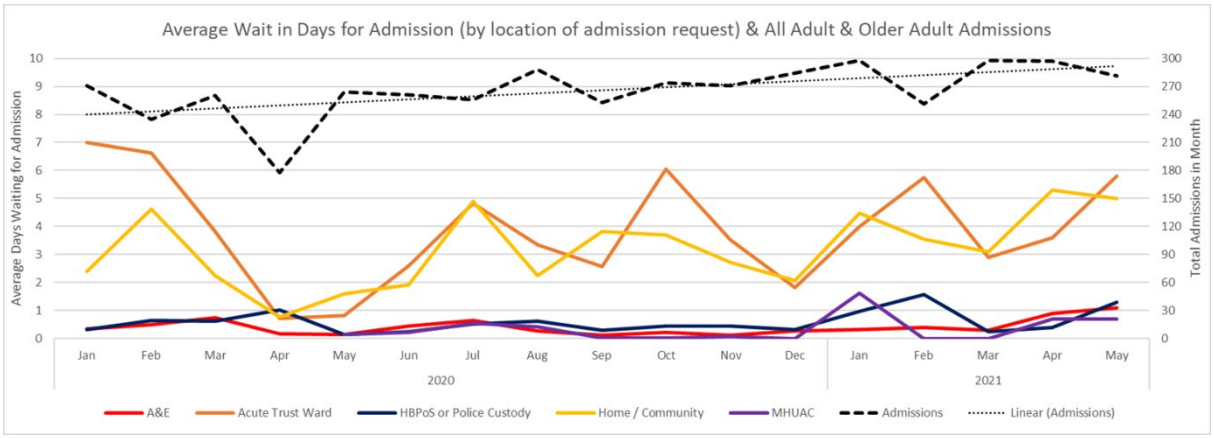
2.3 LSCFT admissions to Adult Acute wards have been above the national average during Covid, and above the 2019/20 Benchmark. This pressure on Adult Acute beds was particularly pronounced January-March 2021. It should be noted that LSCFT admissions to Adult Acute beds include the admissions of over 65s who do not meet criteria for admission Advanced Care Older Adult beds:



2.4 The total admissions to Adult and Older Adult beds in Q4 2021/22 were below the Benchmark in all localities with the exception of Fylde Coast.

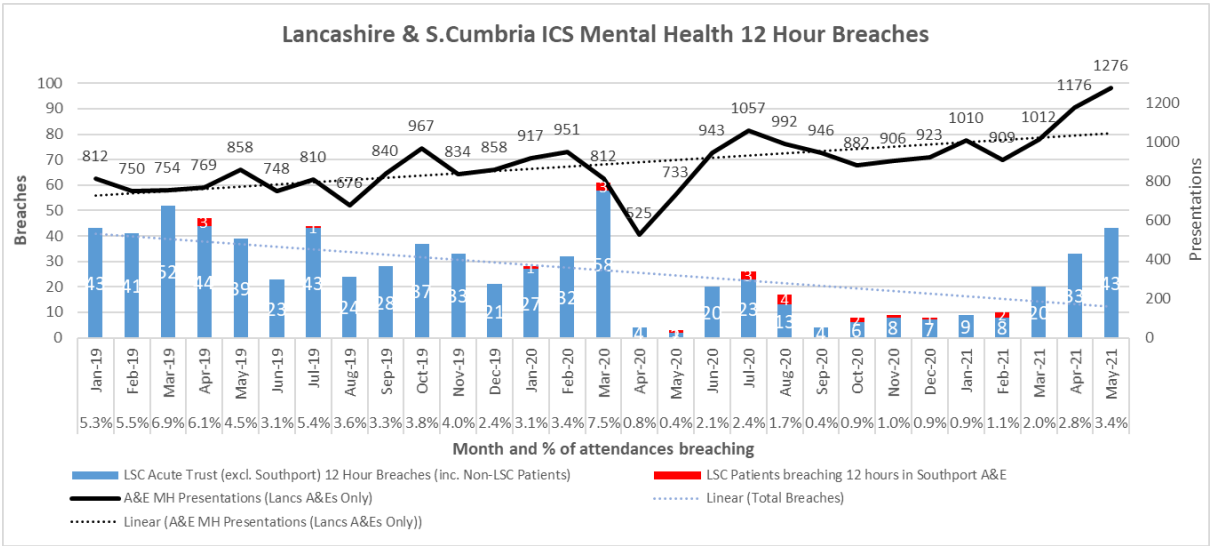
- The planned development of additional Older Adult capacity (along with Rehabilitation, PICU and Rehabilitation beds) will alleviate pressure on Adult Acute OAPs and admission delays, and accelerating this development will accelerate resolution of these pressures
- Home Treatment Team review and transformation, supported by Cumbria, Northumberland, Tyne & Wear NHS Trust, is underway and will further reduce avoidable admissions

2.5 While admission rates (combined Adult and Older Adult) are below the national average, they have increased, with Q1 2021 admissions 10.6% higher than Q1 2020 (pre-Covid), and high demand has continued into April and May. With bed occupancy of 100% (see below), the impact is delays in admission and 12 hour breaches where admissions are from A&E departments:



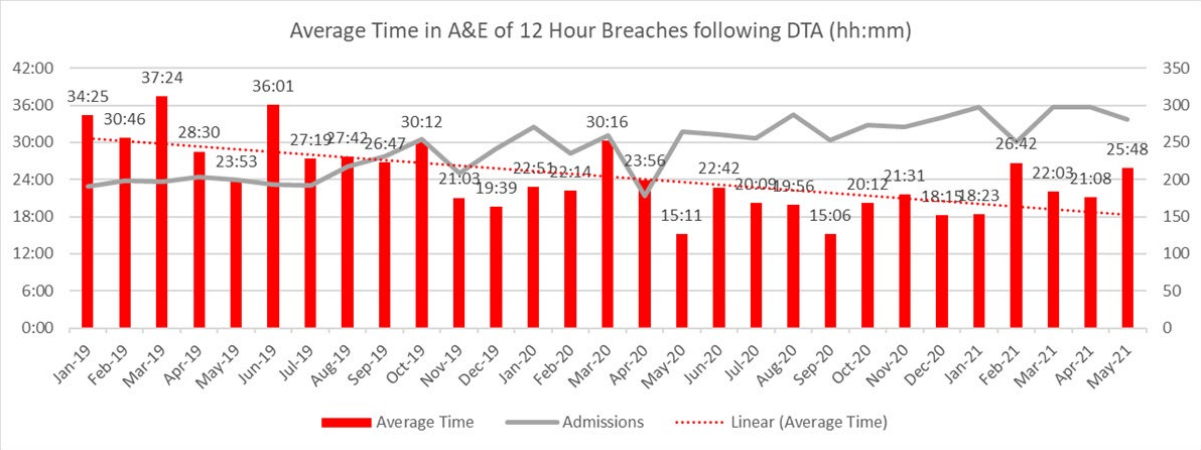
2.6 Clinical prioritisation of admissions is the paramount consideration, and Trust and Independent Sector bed availability is key constraint on admission, resulting in longer waits at times of no bed availability.

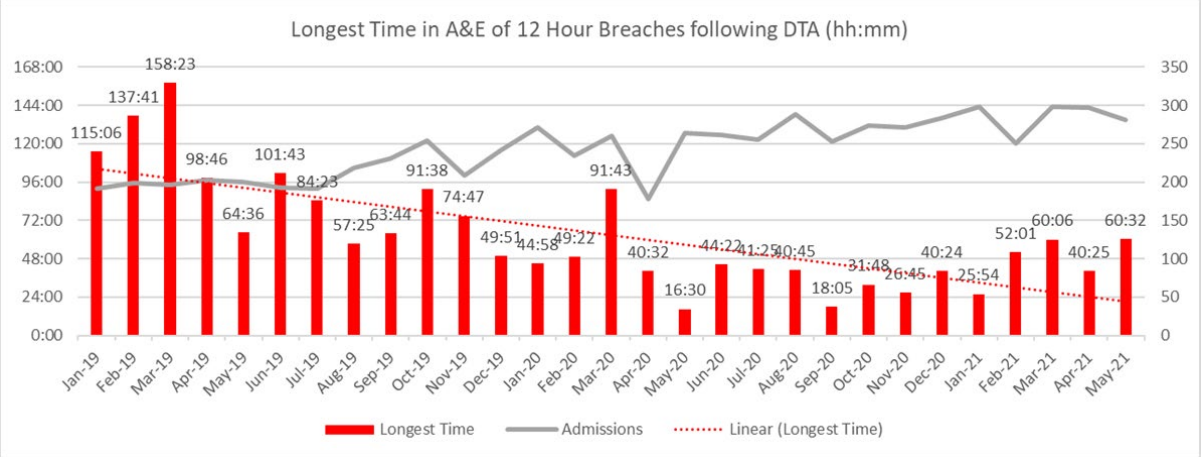
2.7 Trust actions are focussed on minimising the incidence and length of 12 hour A&E Breaches:



2.8 There was a clear dip in mental health presentations between March & May 2020 during Lockdown 1, with a post-Lockdown surge in June & July 2020. There was then sustained demand from July onwards: indicative of both higher acuity and, potentially, pathway issues into services (presenting in crisis, rather than via Primary Care).

2.9 Nonetheless, the monthly breach rate has reduced c.44% in spite of a 70% increase in demand via A&E. However, increased demand via A&E is reducing capacity to respond to referrals from Acute Trust Wards, reducing acute Trust flow, and a plan is being developed to invest in dedicated Acute Trust Ward Liaison capacity which will be finalized by September.

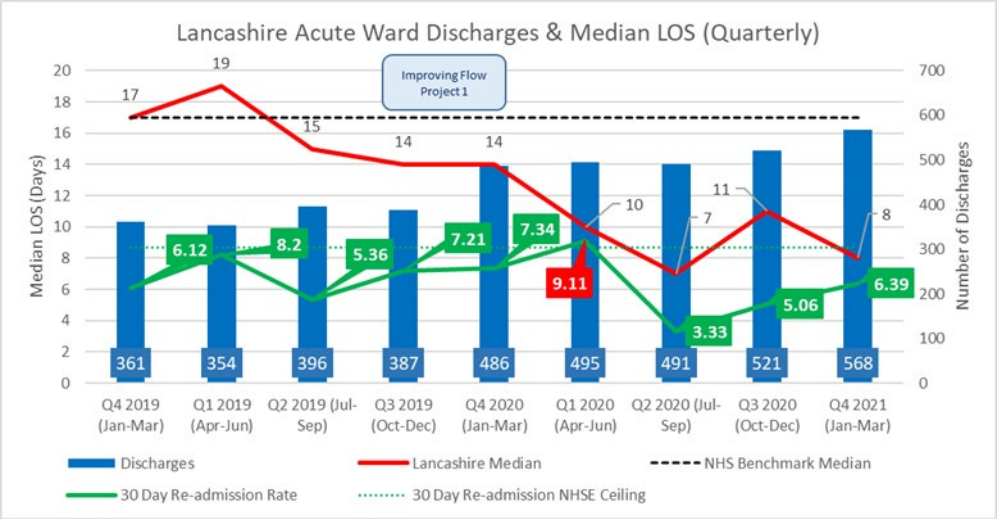


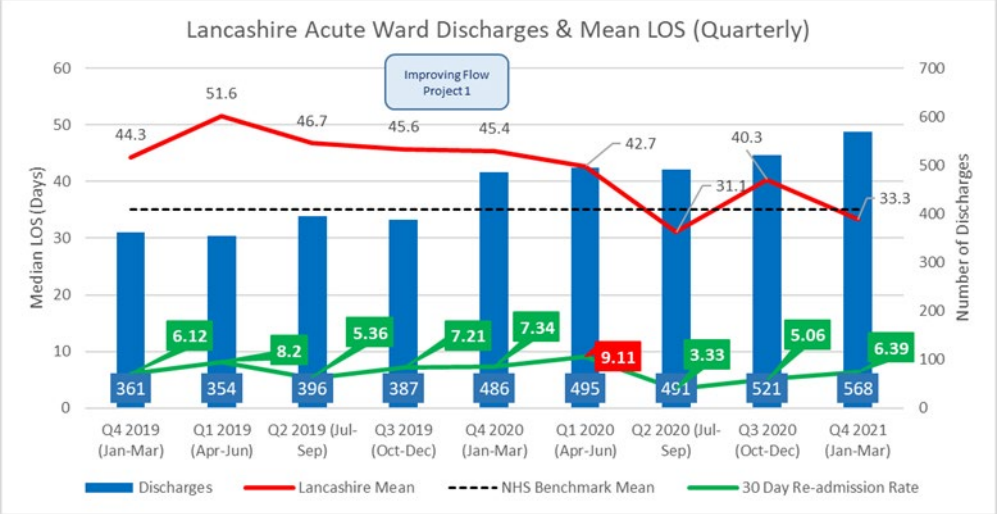


2.10 There has been sustained improvement in both average and longest 12 hr breach up to February 2021. Longer waits February-May 2021 correlate with a 19% increase admissions compared to preceding 18 months.

2.11 Analysis of the mental health breaches shows that these are all for complex patients that required a bed and cannot be cared for in the community. Patients waiting in ED are supported by the Mental Health Liaison Teams and offered regular refreshments and access to facilities. The main theme for the breaches continues to be bed availability, but there are some contributory factors around involvement on community mental health services on the day of ED presentation that are being explored to see whether there is further learning that can be identified or actioned; similarly, there are some issues relating to the Approved Mental Health Practitioner service. A piece of work is being arranged to review 4-hour breaches to ascertain any other contributory factors that can be explored to help reduce the number of 12-hour breaches. This will be compared with the known factors for 12-hour breaches prior to being escalated to the local Multi-Agency Group.

2.12 *Length of Stay*



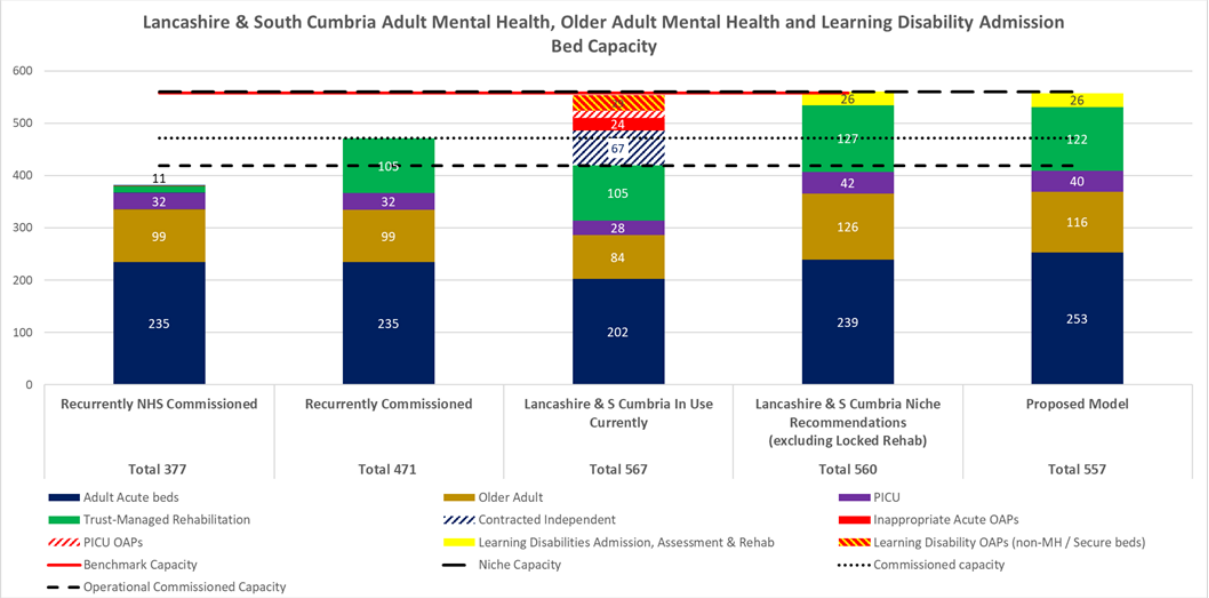


2.13 LSCFT delivered an initial Flow Improvement project using Listening into Action methodology in 2019/20, which increased the number of adult acute discharges by 30%, reducing both median and mean Length of Stay to below the NHS Benchmark average. Notably, there was no associated increase in readmission rates. LSCFT's May 2021 mean Length of Stay of 30.5 days was 8.4% lower than the national average for the month of 33.3 days.

2.14 Both Getting It Right First Time (GIRFT) and NHS England's OAP review positively noted the improvements and cited the improvements as examples of good practice. Using the GIRFT principles of segmentation of clinical cohorts to drive improvement, further improvement projects have been initiated:

- Perfect Week 21-25 June
  - 50% reduction in patients waiting for admission
  - Zero 12 hour A&E breaches to date
- Embedding Red to Green / SAFER implementation commenced 9th June
- MADE-style events have commenced 3 x weekly
- Implementing the Assessment Ward model within Fylde Coast

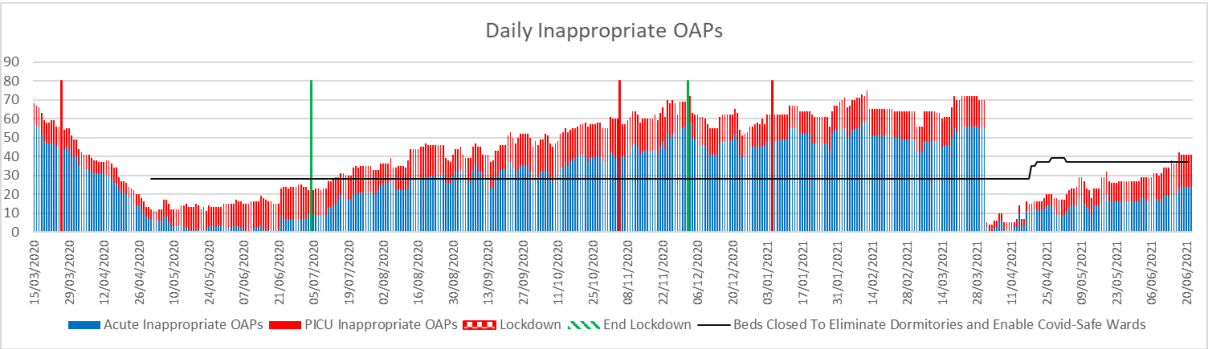
2.15 *Bed Capacity*



2.16 Low bed capacity is driving both admission breaches (both 12 hour A&E and 24hr s136) and reliance on Inappropriate Out of Area Placements. Niche Consultancy recommended that, based on current and likely future demand, 560 beds are required across Adult, Older Adult and Learning Disability provision (excluding very specialist Low Secure Rehabilitation provision and Secure LD provision). This is comparable to the NHS Benchmark capacity of 558 beds for a population size of Lancashire & South Cumbria.

2.17 Current recurrently commissioned capacity (including independent sector Long-Term Complex Care and High Dependency) is 471 beds. Covid-related IPC measures have reduced available commissioned bed capacity to 419. An accelerated capital programme will shorten timescale for elimination of OAPs and admission breaches.

2.18 *Out of Area Placements*



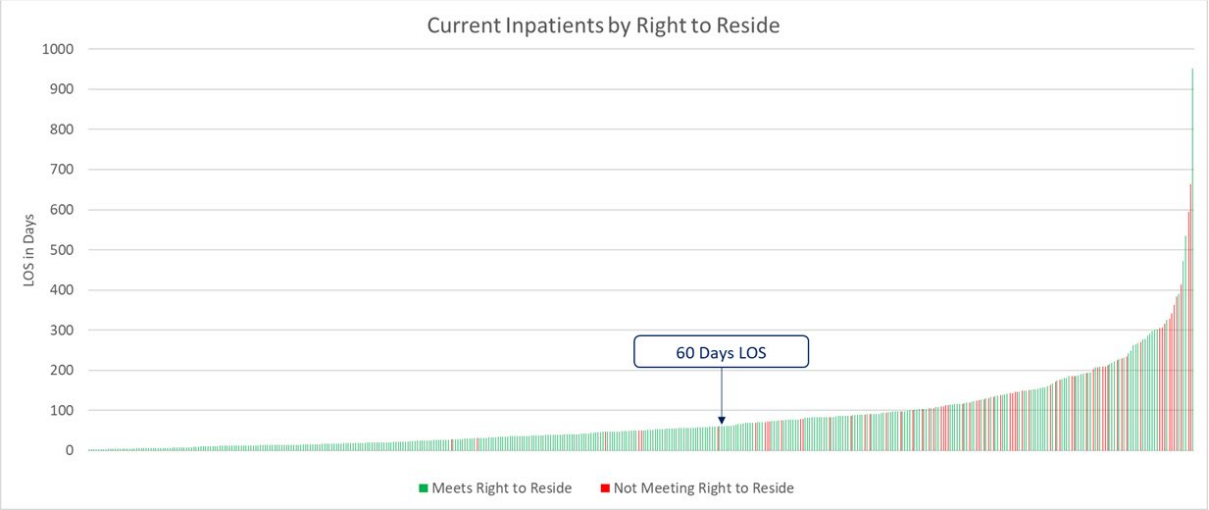
2.19 Until the delivery of the planned bed expansion programme, there will be a reliance on Independent Sector providers for bed capacity. LSCFT have contracted an additional 67 beds from independent sector providers, which meet the NHSE Principle of Continuity, reported as such from April 2021. While outside of the borders of Lancashire, these hospitals are as accessible as Lancashire and South Cumbria bed stock and will provide continuity of care and governance. The Principle of Continuity means that these beds

will not be reported as inappropriate OAPs from April 2021 onwards, and will be a part of the planned LSC bed stock.

2.20 The impact of 37 beds closed to facilitate socially-distanced wards and enable building works can be seen in the above graph, accounting for current Inappropriate OAPs use.

2.21 Right to Reside

2.22 While there is a need increase bed capacity to NHS Benchmark levels, there are flow issues which can be addressed immediately. Ensuring that patients are in the right care setting for their care needs would release immediate bed capacity within LSCFT. As in acute Trusts, Right to Reside criteria are being applied to all inpatients. The review of 456 patients on 21st June 2021 is presented below on page 11:

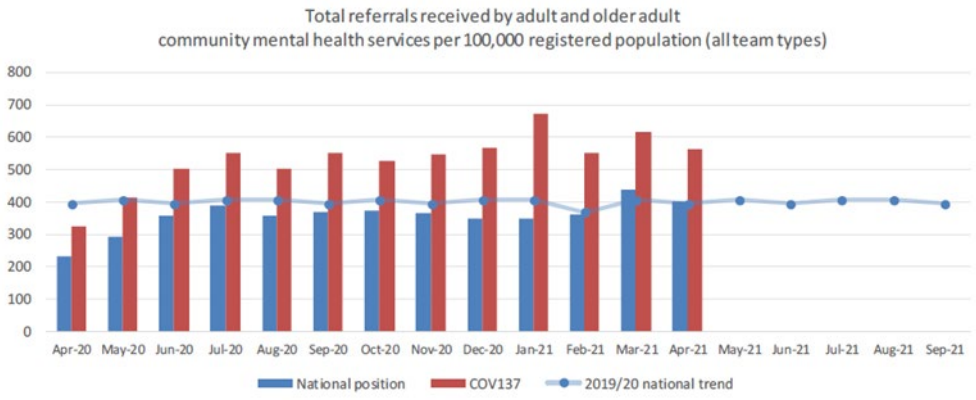


2.23 Of the 465 patients:

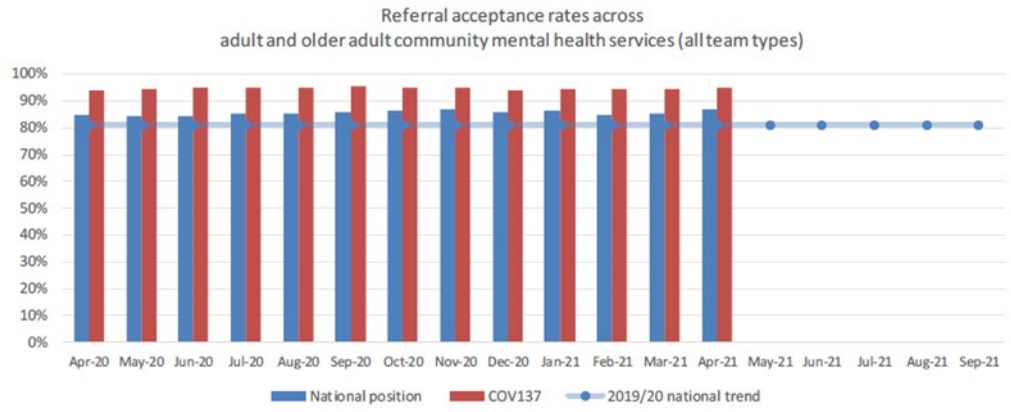
- 66 (14.1%) patients identified as not meeting Righting to Reside criteria
- Of 197 patients with LOS above 60 days, 60 (30.5%) identified as not meeting Righting to Reside criteria
- Of 93 patients with LOS above 120 days, 56 (60.2%) identified as not meeting Righting to Reside criteria

2.24 Multi-agency meetings (jointly chaired by ICS Director of Mental Health and LSCFT Deputy Chief Operating Officer) established three times per week.

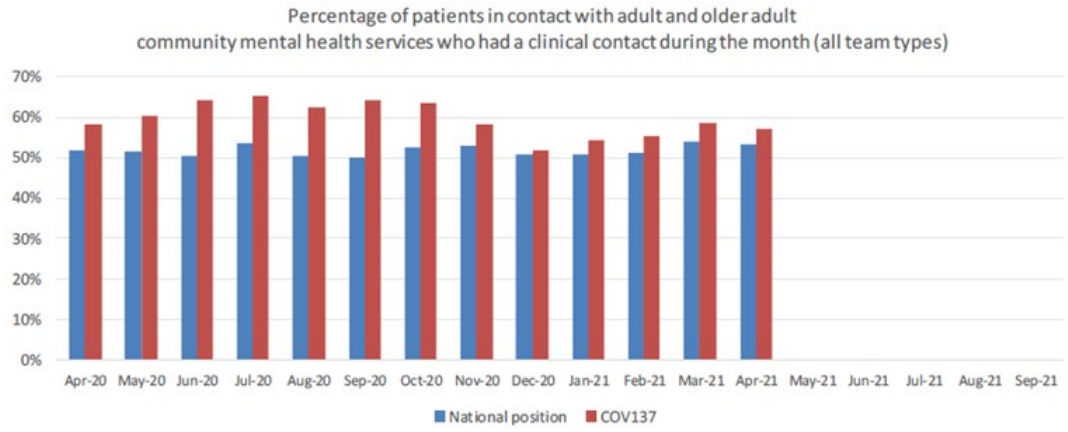
2.25 Community Mental Health Demand



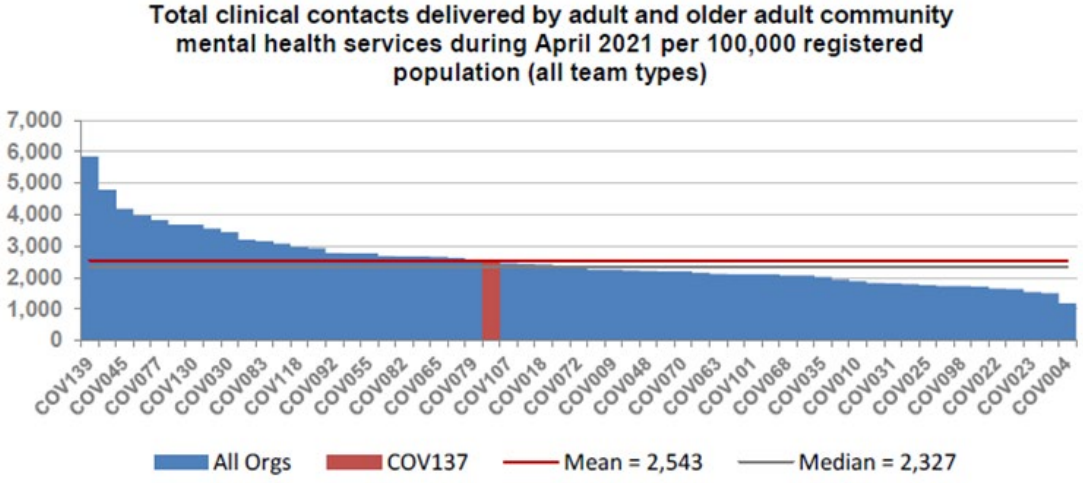
2.26 April referrals were 40% above the NHS Benchmark, the ninth highest rate nationally.



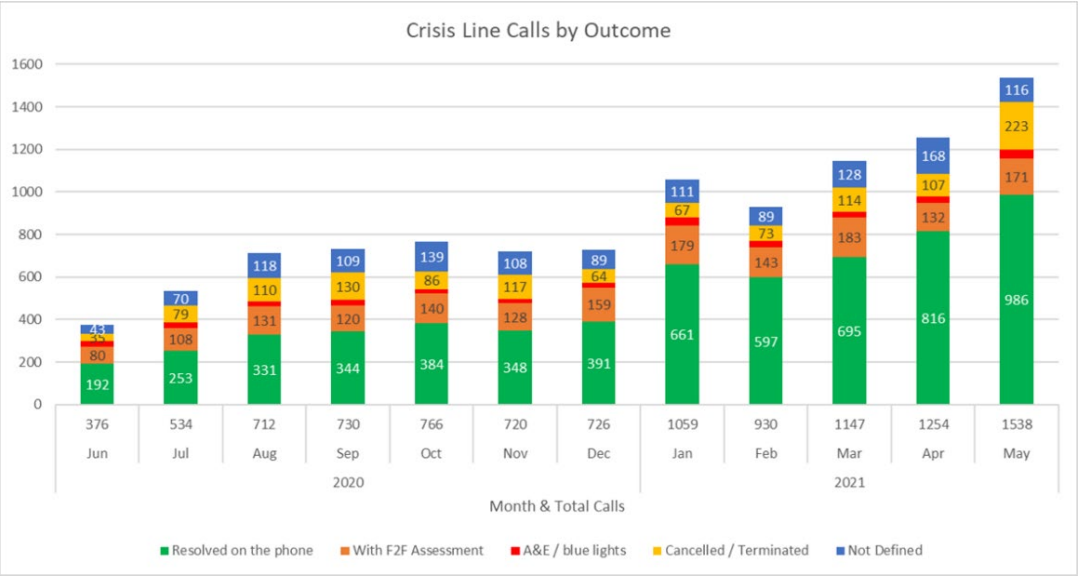
2.27 Acceptance rates are also above the NHS Benchmark, with 95% of Lancashire referrals accepted compared to the Benchmark 87%.



2.28 57% of caseload had a clinical contact in April, compared to a national average of 53%.



2.29 The contact rates are in line with the national Benchmark.



2.30 We are seeing increasing use of our Mental Health Urgent Referral Line ('Crisis Line'), which was established in June 2020 with the aim of providing quick access to mental health professionals in a crisis, and in doing so removing the need for people to present in mental health crisis at A&E.

2.31 The majority (64% in May) of calls to the Crisis Line are resolved during the call, and the increasing use of this helpline is evident.

2.32 A Community Mental Health Transformation programme is underway to support patients in the community and closer to home. This is a three year plan with investment.

2.33 Workforce / Staffing

2.34 Trust wide sickness in April 2021 decreased to 5.4% (down from 6.0% in March 2021). Covid-19 related sickness absence (recorded as Chest & Respiratory problems) decreased through April 2021 and accounted for 7.4% of all absences with an average of 15 staff off per day. Anxiety/stress/depression/other psychiatric illnesses absences prevalence continues to be the greatest reason for sickness, making up 37% of absence. A deep dive across Care Groups will be undertaken with HR support, which will link to Locality staff survey action plans. This will help to identify quick wins and a longer-term plan to support staff, starting with an initial assessment of each case recorded as stress related to ensure a welfare plan is in place for each staff member. Levels of sickness absence are highest within Access, Urgent Care and Inpatients, which correlates with a higher use of Bank and Agency Workforce in these areas. This has not been driven by any specific event or incident and the absence reasons vary. Return to work conversations are low and this will be an area of focus via People Group discussions and the staff survey action plan. Recovery trajectories are currently being developed by each Locality Network and will be submitted to Workforce and Education once finalised. The Trust continues to support staff through the Psychological Resilience Hub and the weekly newsletter includes wellbeing support and information on crisis support and the recovery college.

2.35 Serious Incidents

2.36 An increase in the number of incidents was reported on StEIS for March 2021 (22). Analysis indicated this coincided with national lockdown timescales. There has been a reduction in incident reported, with 10x in April 2021 and 8x in May 2021. Incident numbers will continue to be closely monitored.

The quality of the investigations and the subsequent reports continues to be of a better quality than in previous years, this follows extensive training delivered by LSCFT which considers CCG comments. Similar themes are still being seen in incidents; however the independent cluster review is focussed on these themes, and as such the outcome of this review will guide how these are addressed. The backlog of 72-hour reports has now been recovered. The Trust has established a weekly review to ensure that future reports are submitted within timescales.

2.37 Complaints

2.38 The PALS function has been enhanced, allowing the PALS Team to be visible in inpatient areas. PALS allow resolution of low-level issues as they arise and work to reduce concerns that would have previously progressed to a formal complaint. Issues raised with PALS have allowed understanding of service users' dietary requirements and have led to a greater range of activities being provided. The main theme arising from complaints and contacts with the PALS Team relate to communication and support is being provided around effective communication. A series of dashboards are being developed to help support services and managers to identify emerging issues which can then be triangulated with any themes and trends arising through incidents and soft intelligence.

2.38 Quality Improvement Collaboratives

2.39 The Trust has embarked on a number of quality improvement (QI) collaboratives to support teams to lead change and continuous improvement of care within the services they provide. The Trusts first large scale QI collaborative, sponsored by the Chief Nurse & Quality Officer, was launched in September 2020 and aims to Reduce Restrictive Practices by 30% across the Trust over 2 years. Significant progress has already been made by the ward teams involved in the first phase and there is great pride in owning and celebrating achievements. A Falls Improvement Collaborative and Care Planning Collaborative have also recently been launched to continuously improve practice in these areas.

To support improvement across the Trust, LSCFT have also created a quality improvement training programme that provides the right staff with the right skills to enable them to embark upon quality improvement initiatives locally. A dosing formula has been used to ensure all staff have the opportunity to attain these skills and support them with their implementation in practice. This will support the embedding of QI being a way of ensuring continuous improvement is led by staff at a local level.

3. Recommendations

3.1 The Strategic Commissioning Committee is requested to:

1. Note the contents of the report

Phil Horner, Head of Business Intelligence, LSCFT
June 2021

Strategic Commissioning Committee

Date of meeting	**15th July 2021**
Title of paper	**Lancashire and South Cumbria Medicines Management Group (LSCMMG) Commissioning Policy Positions – Mar-June 2021**
Presented by	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU
Author	Brent Horrell, Head of Medicines Commissioning, NHS Midlands and Lancashire CSU
Agenda item	**9**
Confidential	No

Purpose of the paper
For decision
Executive summary
The Lancashire and South Cumbria Medicines Management Group (LSCMMG) has developed recommendations for medicine reviews, medicine pathway, medicine policy and the implementation of NICE technology appraisals for adoption across Lancashire and South Cumbria.
Recommendations
That the SCC ratify the collaborative LSCMMG recommendations on the following: - *Insulin Lispro (Lyumjev) for the treatment of diabetes mellitus in adults* - *IV infusion ketamine for chronic non-cancer pain in adults* - *Metolazone for the treatment of patients with chronic heart failure with resistant volume overload* - *Zonisamide for migraine prophylaxis* - *NICE Technology Appraisals (February to May 2021).*
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:	Andrew Bennett

Lancashire and South Cumbria
Health and Care Partnership

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

Mar-June 2021

1. INTRODUCTION

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

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

2. DEVELOPMENT PROCESS

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

2.2 The review process includes the following key steps:

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

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

- *Insulin Lispro (Lyumjev) for the treatment of diabetes mellitus in adults*
  Lyumjev New Medicine Assessment SCC.docx

- *Ketamine IV infusions for chronic non-cancer pain*
  Ketamine Injection New Medicine Assessment SCC.docx
  Please note use of both oral and IV were discussed at the Lancashire and South Cumbria Medicines Management Group, to date recommendations have only been agreed for IV ketamine.

- *Metolazone for the treatment of patients with chronic heart failure with resistant volume overload*

No associated document

- *Zonisamide for migraine prophylaxis*
  Zonisamide New Medicine Assessment SCC.docx

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

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

Insulin Lispro (Lyumjev) for the treatment of diabetes mellitus in adults

3.1 Lyumjev was prioritised for review following a request from a clinician at Morecambe Bay CCG.

3.2 The LSCMMG agreed a "Green Restricted" RAG rating in adults who are suitable for Humalog® and their diabetes cannot be adequately managed with alternative formulary choices and at least one of the following applies:

- Where the prescriber believes a faster onset of action would be beneficial to the patient
- Where a patient requires 'tight' control of blood sugar levels
- Where a patient has rapid post-meal increase in blood sugar levels

NB. "Green restricted" allows prescribing in both primary and secondary care in accordance with the restrictions describes above.

3.3 As Lyumjev® is available at the same acquisition cost as Humalog®, no financial impact is expected. It is not anticipated that additional appointments will be required to initiate and review Lyumjev®.

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

IV infusion ketamine for chronic non-cancer pain in adults

4.1 The LSCMMG received a request from East Lancashire CCG to review the use of ketamine infusions for the management of fibromyalgia following identification of a small cohort of patients receiving repeated infusions from independent sector hospitals in their locality.

4.2 The LSCMMG agreed a "Black" RAG rating for IV infusion ketamine for chronic non-cancer pain in adults. IV ketamine infusions are therefore not recommended for use in Lancashire and South Cumbria.

4.3 It is anticipated that the historic use of ketamine IV infusions is limited and therefore existing patient numbers for the intervention are low. However, Lancashire and South Cumbria have a different commissioning position for IV ketamine relative to neighbouring health economies as IV ketamine is commissioned in both the Pan Mersey and Greater Manchester areas.

Metolazone for the treatment of patients with chronic heart failure with resistant volume overload

4.4 The LSCMMG was asked to review the RAG rating of metolazone by the lead cardiology pharmacist at Blackpool Teaching Hospitals NHS Foundation Trust, as GPs who were being asked to continue to prescribe Metolazone by the Trust were starting to query requests, despite previously having prescribed Metolazone for many years.

4.5 The LSCMMG agreed an "Amber0" RAG rating for metolazone for the treatment of patients with chronic heart failure with resistant fluid overload. The group agreed metolazone is suitable for continuation by primary care following specialist initiation provided that the patient has been stabilised by specialists and this has been clearly communicated to primary care clinicians.

4.6 Patient numbers and costs are expected to be low. Across Lancashire and South Cumbria over the last 12 months 2,357 x 2.5mg tablets and 1,356 x 5mg tablets have been dispensed, with a total cost of £14,625.

Zonisamide for migraine prophylaxis

4.7 Zonisamide (Zonegran®) for migraine prophylaxis was prioritised for review by the Lancashire and South Cumbria Medicines Management Group following a request by the Fylde Coast CCGs.

4.8 The LSCMMG agreed an "Amber0" RAG rating in patients when at least three prior prophylactic treatments have failed and erenumab, galcanezumab or fremanezumab are being considered.

4.9 It is estimated that approximately 6,200 patients have tried at least 3 preventative medicines for migraine in the Lancashire and South Cumbria health economy. If 5% (uptake aligned with uptake rate for erenumab in the costing template) of these patients (310) used zonisamide for migraine prophylaxis the total annual cost is estimated to be:
310 x £51 to £372 = £15, 810 to £115,320.

4.10 However, zonisamide may be cost saving in practice as it would be expected to be used prior to more expensive treatment with erenumab, galcanezumab or fremanezumab.

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

NICE Technology Appraisals (February 2021 to May 2021).

5.1 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.

5.2 Six CCG commissioned NICE TAs were identified: **Filgotinib** for treating moderate to severe rheumatoid arthritis (TA676); **Dapagliflozin** for treating

chronic heart failure with reduced ejection fraction (TA679); **Baricitinib** for treating moderate to severe atopic dermatitis (TA681); **Erenumab** for preventing migraine (TA682); **Bempedoic acid** with ezetimibe for treating primary hypercholesterolaemia or mixed dyslipidaemia (TA694); and **Andexanet alfa** for reversing anticoagulation from apixaban or rivaroxaban (TA697).

5.3 TA guidance recommendations for **dapagliflozin**, **baricitinib**, **erenumab and bempedoic acid** are not expected to create significant costs or capacity issues in the Lancashire and South Cumbria health economy.

5.3..1 NICE do not expect this TA guidance for **erenumab** to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population).

5.3..2 NICE estimate that commissioning of **dapagliflozin** for the treatment of chronic heart failure with reduced ejection fraction will be costing saving in Lancashire and South Cumbria in year 1 (£105,000) with costs rising to a maximum cost of £167,000 by year 5.

5.3..3 NICE estimate that commissioning **baricitinib** in Lancashire and South Cumbria will either be cost neutral or lead to a small cost burden (c.£1000).

5.3..4 NICE do not expect this TA guidance for **bempedoic acid** to have a significant impact on resources; that is, the resource impact of implementing the recommendations in England will be less than £5 million per year in England (or £9,000 per 100,000 population). This is because the technology is a further treatment option, and the overall cost of treatment will be similar.

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

5.5 The increased cost of **filgotinib** relates to widening its availability to patients with moderate severity rheumatoid arthritis (RA). It has been estimated using local data that uptake for moderate RA will be 24 per 100,000. Applying this to the adult population of Lancashire, this will result in a potential of 320 patients accessing **filgotinib** for moderate RA. This will result in a potential cost impact of £3.3million per annum to the Lancashire and South Cumbria health economy. However, there is a patient access scheme and the anticipated discount is expected to be significant.

5.6 NICE estimate that the cost of **andexanet alfa** (using the list price) at year 5 is £786,000.

5.7 The LSCMMG agreed that acute trusts will be responsible for producing guidance to ensure appropriate usage of **andexanet alfa.** The MLCSU will monitor usage and compare to the usage estimated by NICE. If discrepancies become apparent from the data, this will be raised to the LSCMMG followed by audit at identified providers.

6. CONCLUSION

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

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

Brent Horrell, Head of Medicines Commissioning,

NHS Midlands and Lancashire CSU

Strategic Commissioning Committee (SCC)

Date of meeting	15th July 2021
Title of paper	Development of Lancashire and South Cumbria (LSC) Clinical Commissioning Policies - **Policy for Management of Otis Media with Effusion (OME) using Grommets and Adenoidectomy.**
Presented by	Brent Horrell, Head of Medicines Commissioning, Midlands and Lancashire Commissioning Support Unit
Author	**Julie Hotchkiss FFPH**, Consultant in Public Health, Midlands and Lancashire Commissioning Support Unit
Agenda item	10
Confidential	No

Purpose of the paper

To present the revised policy (V1.2) for the Management of Otis Media with Effusion (OME) using Grommets and Adenoidectomy developed by the LSC Clinical Policy Development and Implementation Group (CPDIG) and to assure the SCC of the process taken.

Executive summary

- The existing policy (V1) was ratified by JCCG on 5 September 2019.
- The revised policy (V1.2) aligns criteria to those defined by Evidence Based Interventions (EBI) List 2.
- The EBI criteria included in the revised policy were accepted by the Clinical Lead for ENT at University Hospitals Morecombe Bay on 28 April 2021.

On 17 June 2021, the LSC CPDIG agreed that the revised policy should be presented to the SCC for ratification. Given the consultation undertaken in 2019, the small number of responses received at that time and the small number of changes required to bring the policy in line with EBI List 2, the CPDIG also agreed that further clinical or public consultation was not required.

Recommendations

That the SCC:

- Note the content of the revised policy.
- Approve the content of the revised policy.
- Approve the process taken to develop the policy.
- Agree that no further involvement is required in terms of wider engagement or consultation.

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

Meeting	Date	Outcomes
LSC CPDIG	15/04/2021 20/05/2021 17/06/2021	Clarifications and limited clinical consult requested. Clinical feedback presented. Agreed no further consultation required. Agreed that the revised policy should be presented

				to the next SCC for ratification.
Conflicts of interest identified				
None				
Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed	X			**Service Impact** It will free up clinic/theatre space and ENT surgeons for other priority work. **Innovation, Need and Equity:** Resources, particularly human resource, which could be better used elsewhere in the health system are being spent on these activities when the need for care is much greater elsewhere.
Equality impact assessment completed	X			The EIA completed in 2018 did not identify any issues. The revision has not impacted the policy in this respect
Privacy impact assessment completed			X	
Financial impact assessment completed	X			The equivalent of £62,000 could be utilised on other services if activity on this procedure comes into the lowest quartile of activity nationally.
Associated risks	X			The amendments support alignment to the policy implemented by the national EBI2 programme of work. As such, no legal issues have been identified as a result of the revisions recommended. Significant media/public interest is unlikely as engagement/consultation has already been undertaken by the national EBI2 programme.
Are associated risks detailed on the ICS Risk Register?			X	

Report authorised by:	Brent Horrell

The development of Lancashire and South Cumbria clinical commissioning policies:

Development of Lancashire and South Cumbria (LSC) Clinical Commissioning Policies - **Policy for Management of Otis Media with Effusion (OME) using Grommets and Adenoidectomy.**

A decision paper for the Strategic Commissioning Committee (SCC)

1. Situation

1.1 As part of the CPDIG work programme the group are reviewing existing policies alongside the NHS England/Improvement Evidence-Based Interventions (EBI) programme of work, to ensure due consideration is given to aligning the local policy with robust justification.

1.2 The EBI Policy 2E is Removal of adenoids for treatment of glue ear is incorporated within the LSC Policy for Management of Otitis Media with Effusion (OME) using Grommets.

1.3 Appendix 1, presents the revised draft of the local Policy for Management of Otitis Media with Effusion (OME) using Grommets following its review by the CPDIG completed in June 2021. The Policy incorporates the NHS England/Improvement Evidence-Based Interventions (EBI) Policy, 2D Removal of adenoids for treatment of glue ear into the existing local policy. As the existing policy uses degree of hearing loss as the sole determinant, amendments have been made to the policy giving due consideration to the phrasing of the revised criteria.

2. Assessment

2.1 The existing LSC policy uses "persistent and frequent upper respiratory tract symptoms" as a criterion for adjuvant adenoidectomy. The new EBI guidance gives greater clarity with criterion "… a persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)", and the CPDIG agreed this should be adopted.

2.2 However, also in the criteria for funding adjuvant adenoidectomy in the EBI policy are:

b. The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion

c. The child is undergoing grommet surgery for treatment of recurrent acute otitis media.

The existing Policy for Management of Otitis Media with Effusion (OME) using grommets, does not consider recurrent acute otitis media as an indication for surgery, as the policy is based on degree of hearing loss, therefore cross-reference was made to criterion c ensuring the pre-existing criteria relating to hearing loss were met.

2.3 Appendix 1 includes the proposed revisions (see red text) as approved by the CPDIG at their June 2021 meeting.

3. Clinical Engagement feedback

3.1 Upon preparing for engagement CPDIG noted that the existing policy was ratified by JCCCG on the 5th September 2019 and referred to the previous clinical engagement carried out in 2019, where it was noted that only one reference was made to adenoidectomy, which was in the original draft at that time.

3.2 The reference was made by the Clinical Lead for ENT at University Hospitals Morecambe Bay, who made the following comment:

"*Adenoidectomy is indicated for recurrent OME and this isn't clear in the document. Recurrent OME, that needs a second pair of grommets, is most of the time, carried out with adjuvant adenoidectomy*."

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3.3 Upon contacting the Clinical Lead to discuss the intention of this revised policy the Clinical Lead responded to agree the revisions proposed i.e. the EBI wording.

3.4 The CPDIG noted that Public Involvement carried out in 2019, resulted in only 8 people responding to the survey, notably none of the comments were relevant to the inclusion of adenoidectomy.

3.5 Subsequently members recommended further public involvement in addition to that undertaken by NHSE as part of the EBI programme of work, was not needed.

4. Recommendations

4.1 The SCC is asked to consider and ratify the policy.

Brent Horrell
Chair of the LSC Clinical Policy Development and Implementation Group
Head of Medicines Commissioning
Midlands and Lancashire Commissioning Support Unit
6 July 2021

APPENDIX 1

Lancashire and South Cumbria Clinical Commissioning Groups (CCGs)

Policies for the Commissioning of Healthcare

Otitis Media with Effusion (OME) management using Grommets and Adenoidectomy 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 commission the surgical management of OME using grommets when the following criteria are satisfied: a) The patient is under 12 years of age.
	AND
	b) Hearing loss has persisted over a period of at least three months.
	AND EITHER
	c) The patient has a hearing level in the better ear of 25-30dBHL or worse averaged at 0.5,1,2 and 4kHz
	OR
	d) Exceptionally, where there is well documented evidence that a hearing loss of less than 25-30 dBHL is having a significant impact on the child's developmental, social or educational status.
1.2	OME in children with Down's syndrome or a cleft palate is unlikely to improve without further management and hearing loss may exacerbate existing communication problems. Patients with Down's syndrome or cleft palate who are suspected of having OME should be referred for specialist assessment immediately by an MDT with expertise in assessing and treating these children[1,2,3]. Following referral, the management of OME in children with Down's syndrome or cleft palate should be carried out in line with the specific guidance in NICE CG60[1].
1.3	The CCG will not routinely commission adjuvant adenoidectomy unless one or more of the following criteria are met: a) The child has persistent and / or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)
	OR
	b) The child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion

	OR
	c) The child is undergoing grommet surgery for treatment of recurrent acute otitis media in line with criteria 1.1 above
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	The insertion of grommets is a surgical procedure where a small tube (a tympanostomy tube, also known as a grommet or myringotomy tube) is inserted into the eardrum in order to keep the middle ear aerated for a prolonged period of time, and to prevent the accumulation of fluid in the middle ear.
2.3	The scope of this policy includes requests for the management of OME using grommets.
2.4	The CCG recognises that a patient may have certain features, such as • having OME • wishing to have a service provided for their OME, • being advised that they are clinically suitable for the insertion of grommets, and • be distressed by their OME 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. The CCG note that the evidence demonstrates that if grommets are not inserted within 12-18 months of presentation there is no difference in hearing between treated and untreated patients.
2.5	For the purpose of this policy the CCG defines OME as the accumulation of fluid within the middle ear space resulting in hearing impairment.
2.6	National Institute for Health and Care Excellence (NICE) guidance on the management of OME in children under twelve exists.[1]
3	**Appropriate Healthcare**
3.1	The purpose of grommet insertion is normally to allow air to pass into the middle ear, preventing the accumulation of fluid and allowing hearing to return to normal.
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. For the avoidance of doubt 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 patient's specific circumstances before confirming a decision to provide funding.

4	**Effective Healthcare**
4.1	The following policy criteria rely on the principle of appropriateness: • The criterion relating to children and adults over 12 as the CCG considers the evidence of the greatest benefit is in those under the age of 12 years. • The criterion relating to the requirement for persistent hearing loss as the CCG considers that for patients who are not severely affected by OME any potential benefit from the intervention is outweighed by the morbidity associated with surgery.
5	**Cost Effectiveness**
5.1	The CCG does not call into question the cost-effectiveness of the surgical management of OME and therefore this policy does not rely on the Principle of Cost-Effectiveness. For the avoidance of doubt if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be Cost Effective in this patient before confirming a decision to provide funding.
6	**Ethics**
6.1	The CCG does not call into question the ethics of the surgical management of OME and therefore this policy does not rely on the Principle of Ethics. For the avoidance of doubt if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
7	**Affordability**
7.1	The CCG does not call into question the affordability of the surgical management of OME and therefore this policy does not rely on the Principle of Affordability. For the avoidance of doubt if a patient is considered exceptional in relation to the principles on which the policy does rely, the CCG may consider whether the treatment is likely to be affordable in this patient before confirming a decision to provide funding.
8	**Exceptions**
8.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
8.2	In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
9	**Force**

9.1	This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
9.2	In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then: • If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory. • If the new NICE guidance does not have mandatory status, then the CCG will aspire to review and update this policy accordingly. However, until the CCG adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this CCG are concerned.
10	**References**
	1. NICE Clinical Guidance (CG) 60, Otitis media with effusion in under 12s: surgery. Published February 2008 https://www.nice.org.uk/guidance/cg60 2. ~~NICE Clinical Knowledge Summaries (CKS) Otitis media with effusion Scenario: Management https://cks.nice.org.uk/otitis-media-with-effusion#!scenario~~ 3. ~~NHS Choices, Glue Ear https://www.nhs.uk/conditions/glue-ear/treatment/~~ 4. Evidence-Based Interventions List 2 Guidance, Academy of Medical Royal Colleges, Published November 2020. 5. Rosenfeld RM, Shin JJ, Schwartz SR, et al. Clinical practice guideline: Otitis media with effusion executive summary (update). Otolaryngol Head Neck Surg. 2016;154(2):201-214. https://doi.org/10.1177/0194599815624407. doi:10.1177/0194599815624407. 6. Schilder AG, Marom T, Bhutta MF, et al. Panel 7: Otitis media: Treatment and complications. Otolaryngol Head Neck Surg. 2017;156(4_suppl):S88-S105.doi: 10.1177/0194599816633697 [doi].

Appendix 1: Associated OPCS codes

The codes applicable to this policy are:

OPCS codes
D151, D289, E20.1, E20.4, E20.8, E20.9 Diagnosis Codes H652, H653, H661, H662, H663, H664, H669

Date of adoption *05.07.2021*
Date for review *05.10.2024*

Strategic Commissioning Committee

Date of meeting	**15th July 2021**
Title of paper	Strategic Commissioning Committee 21/22 Workplan (Final)
Presented by	**Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS**
Author	**Andrew Bennett** **Emily Kruger-Collier**
Contributors	ICS Programme Executive Sponsors and Leads Head of Acute and Transformation Specialised Commissioning
Agenda item	**11**

Purpose of the paper
For decision
Executive summary
The Strategic Commissioning Committee has a key role to make commissioning decisions on major programmes across Lancashire and South Cumbria. This report introduces a final copy of the proposed workplan for 2021/22, following the draft presented at the June meeting, setting out the areas for collective decision-making.
Recommendations
The SCC is asked to: • Agree the proposed workplan and schedule for delegated decision-making. Share the proposed workplan with each CCG's Governing Body.
Next Steps
The workplan will now be operationalised and incorporated into the SCC agendas during 21/22.

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Equality impact assessment completed			x	Equality Impact Assessments are completed by individual programmes as part of the SCC workplan. This paper does not require an equality impact assessment.
Patient and Public Engagement Completed			x	
Financial implications		x		
Risk Identified	x			If the proposed decisions for ICS Priority Programme are not agreed and delegated to the

				Strategic Commissioning Committee then these may experience significant delays to planned timelines to alternatively seek a decision via each CCG Governing Body.

Report authorised by:	Andrew Bennett

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Strategic Commissioning Committee 2021/22 Workplan

1. Introduction

1.1 The primary purpose of the Strategic Commissioning Committee (SCC) is to take collective commissioning decisions about services provided to the Lancashire and South Cumbria population.

1.2 Part of the role of the Strategic Commissioning Committee (SCC) is to make strategic commissioning decisions for all ICS Priority Programmes.

1.3 Executive Sponsors and Programme Leads have been asked to propose any decision requirements via the SCC during 2021/22 for members to agree and to ensure these are incorporated into the work plan for the SCC.

1.4 A draft of the work plan was shared with members at the informal June 2021 SCC meeting for appraisal. All feedback and additional items have been incorporated into the work plan and is presented within Section 2, which includes the proposed decisions required by the SCC and the associated products for the following areas;

- Committee administration
- Collaborative Policy developments
- ICS Priority Programmes

1.5 Section 3 has been added to provide a summary of the Specialised Services priorities.

1.6 Based upon current plans, section 4 provides an indicative quarterly schedule for the ICS Priority Programmes of when the proposed decisions will be required to enable the SCC to effectively plan future agendas over the remainder of 21/22.

2. 2021/22 Workplan

Committee Administration			
Service/ Subject	**Executive Sponsor**	**Description**	**Key Output**
Committee Administration	Andrew Bennett	Holding of Committee meetings Committee Agendas and papers Committee minutes Publication of notice of meetings Approval and publication of Committee Agendas and papers Approval of Committee minutes and ensure publication of minutes on each CCG website Approval of progress against Workplan and ensure publication within each CCG annual report of progress Approval of Quarterly and Annual Committee Reports to each CCG Governing Body Review of self-assessment. Review of progress against Annual Workplan Committee Self-assessment.	Delivery of the statutory role, responsibilities, and Accountabilities as set-out in the TOR's. Annual Committee report to CCG Governing Bodies
Committee Administration	Andrew Bennett	Review annual work plan and submit amendment recommendations for adoption to each CCG Governing Body / GP memberships Review Committee TOR and submit amendment recommendations for adoption to each CCG Governing Body / GP Memberships.	Annual Committee Work plan Committee TOR

Commissioning Policies And Standards			
Service/ Subject	**Executive Sponsor**	**Description**	**Products/ Output**
Commissioning Policies	Andrew Bennett	Agree updated commissioning policies developed collectively for all CCGs	Policy Documents
Medicines Management Policies	Andy Curran	Agree updated medicines management policies developed collectively for all CCGs	Commissioning Policies Commissioning Pathways Ratification of NICE Technology Appraisals
Commissioning Standards	Sponsors of specific workstreams recommending standards	Agree key clinical standards to be consistently met across Lancashire & South Cumbria, so that all people receive the highest possible care and best outcomes.	Standards Documentation

ICS Priority Programmes

Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
Population Health Management	Julie Higgins	• Development of PHM business case for £15m • Development of PHM programme • Delivery of health inequalities plan signed off by ICS • Delivery of health improvement programmes • Oversight process for above	Business plan PHM programme PID	Work on going in PHM cell
Digital	Gary Raphael	There are a number of ICS level digital bids and projects being undertaken during 21/22, some of which are supporting other ICS Priority Programmes and will be incorporated into the relevant business cases.		If SCC decision requirements for the Digital programme are identified for 21/22, a revision to the

Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
		Oversight will be provided to the SCC via programme updates but no specific decision requirements have been identified at this stage as the timescales are predominantly driven at a National level by NHSE-X.		workplan will be submitted at the earliest opportunity.
Vascular	Karen Partington	- Review and approve Pre-consultation Business Case. - Decide on requirement and readiness to consult with the public on options for operating model. - Review outcomes of public consultation (if required) - Approve full business case - Approve commissioning approach and delivery plan	Pre-Consultation Business Case Full Business Case Delivery Plan	The restart of the vascular service programme was agreed at the March 2021 Lancashire and South Cumbria Provider Collaborative Board.
Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN) programme	Aaron Cummins	Phased additional investment over 3 years to implement an enhanced model of acute stroke care (workforce and estates) to benefit the LSC population - save lives and reduce numbers with complex disability; reduce societal costs caused by stroke. • 3 Acute Stroke Centres. • Triage, treat and transfer operating model. • Improve equitable access to best practice acute stroke care across a mixed urban and semi-rural geography. • Clinical improvements to be measured by SSNAP.	Business case	The phased investment plan and associated workforce development plan has received guidance and assurance from the Stroke Patient and Carer Assurance Group; the ISNDN Board, the FAC and PCB in advance.

Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
		• Financial benefits to be measured by Local Authorities and NHS Finance.		System affordability issues and solutions to address will be presented. Integration with stroke prevention and stroke rehabilitation in the community will also be described.
New Hospitals Programme	Jerry Hawker	Capital Investment programme to build new hospitals to replace RLI and RPH (including investment at other sites)	PCBC Consultation Documentation DMBC	This is draft pending an agreed short list of options.san
Mental Health	Caroline Donovan	Responsibility for co-production of LSC all age Mental Health system strategy.	System Strategy	
Children's Mental Health	Caroline Donovan	Review and approve the National KLOE responses. Responsibility for co-production of LSC all age Mental Health system strategy. Mobilisation of the Clinical model for CYP Mental Health services across Lancashire and South Cumbria.	System Strategy	
	Caroline Donovan	To deliver our agreed co-produced learning disability and autism priorities for 2021/22 in line with the Long Term Plan and our Phase 4 Planning Submission.	System Strategy	

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Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
Learning Disability & Autism		Responsibility for co-production of LSC LD and Autism system strategy.		
		Business cases received from MCFT and LSCFT Recommendation to be made on the future provider of Community Forensic and Autism Only Services	Provider Confirmed	
		Review NHS Finance Framework Guidance High level project plan to be developed Learning Disability and Autism Joint Finance aligned budgets stages 1 and 2 to be progressed	Aligned Budgets	
Community Diagnostic Hubs	Kevin McGee	Implementation of Community Diagnostic Hubs to provide additional out of hospital elective diagnostic activity (in line with LTP	Business case (revenue and capital) for Year 1+ sites (to be operational by October 2021)	Expectation of allocation of national monies to support implementation of Yr 1 sites. Short timescales for business case development May-June 2021 with submission to NHSE NW Regional team by 28th June.
	Kevin McGee	Implementation of Community Diagnostic Hubs to provide additional out of hospital elective diagnostic activity	Business case (revenue and capital) for Year 2+ sites	Further guidance awaited re. Year 2+ process and whether national funding

Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
				allocations will be available. Systems may need to fund. Submission required to NHSE NW Regional team by 26th August. Operational in 2022/23.
CHC / IPA Transformation	Talib Yaseen	To transform the current fragmented CHC/IPA service across the L&SC NHS into an integrated service through the development of a Central Hub and place based embedded teams. (Business case approved at March 2020 JCCCG and respective CCG Governing Bodies 795K additional recurrent funding approved in March 2020 and confirmed now available to support service transformation first phase.) Funding to improve assessments is the immediate priority along with further development of the model for CYP to inform the new CHC model utilising 795k recurrent funding Further work on MH and LD needs to take place to support a full integrated service Backlog of assessments to be quantified and addressed.	CHC Funding Proposals CHC Operational Plan IPA transformation model	Funded Care Implementation Programme Board to take place on 26/05/2021 Strong LA commitment to joint working and membership Key risks- lack of dedicate program management resource, system reform, commitment to funding a strong delivery model

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Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
Intermediate Care	Louise Taylor	Design and implementation of new model for home-based and bed-based support and recovery (Intermediate Care), established as current ICS Transformation Programme of Works. The Programme currently has 32 identified outcomes which are managed as part of the programme. Further detail can be provided if required.	Governance changes as and when Business Case ICP Level Blueprint(s) Future Risk share agreements Potential Future Financing & Joint Commissioning proposals Initial tranche transformation projects	Current arrangement for Executive oversight sits with Health & Care Partnership Board & Out of Hospital Cell. A decision needs to be made and communicated if this structure is to change to the Strategic Commissioning Committee as the single assurance body for ICS Programmes, within which further programme outputs need to be signed off.
Palliative & End of Life Care	Talib Yaseen	Define the best practice pathway for end-of-life care for Lancashire & South Cumbria Health Care Partnership from the point of the patient being identified as being potentially within the last 12 months of life in general practice through to death and including bereavement support. The pathway will determine commissioning standards and clinical pathway outcomes	LSC End of Life Care Clinical Pathway for commissioning	

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Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
Cancer Alliance	Melanie Zeiderman	**Non-surgical oncology review:** Phase 1 of a capacity and demand study of non-surgical oncology, taking a workforce approach	May need approval for a phase 2 piece of work- to develop options appraisal of service models	
		Urology area network : There are outstanding issues in relation to GIRFT Urology review in 2018, and LSC is not compliant with the specialised services for urology cancer spec.	May need approval to act on findings and commission further service review/options appraisal for an operational model which is compliant with spec.	Also on PCB agenda
		Endoscopy : Cancer Alliance funds and owns the Endoscopy Transformation Programme. Currently focused on recovery but longer term aim to provide options for optimum delivery model. Linked strongly to Community Diagnostic Hubs work- we are linked to Diagnostics programme on the phase 1 submission		May need commissioning approval at a later date to consider expansion/ centralisation models of delivery
System Reform	Andrew Bennett	In preparation for the new statutory arrangements from April 2022, proposals are being developed to support effective deployment of resources during the 2021/22 transition year, in line with major system and place-based priorities.	Transitional operating models and functional allocation of resources for 2021/22 relating to: • Primary Care & Community Services • Population Health Management • Quality & Performance Improvement	These proposals will constitute the first stage of getting our resources into a future form and will allow us to use 2021/22 as a transition year to test and adjust these in the light of experience and in response to any

Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
System Reform			Communications & Engagement	national guidance that is received.
	Andrew Bennett	In preparation for the new statutory arrangements from April 2022, proposals are being developed to support the design of a future operating model for 'strategic commissioning' and other corporate functions of a new NHS organisation working across the L&SC footprint	Draft operating model for NHS LSC – functions, resource allocations at system / place Final operating model for NHS LSC – functions, resource allocations at system / place	
	Denis Gizzi	From April 2022, the functions of the 8 CCGs in Lancashire and South Cumbria will become the responsibility of the new statutory NHS Body for LSC. A detailed plan and project management arrangements are being developed to ensure the safe and effective closedown of the CCGs.	CCG Close down plan and project management arrangements Report on closedown of CCGs	National guidance is awaited any may result in the CCG Closedown plan being further developed or amended.
	Sarah Sheppard	Workforce – placeholder Linked to transfer of staff from 8 x CCGs to NHS LSC organisation.	TBC Likely to include management of change policies	Further products/ outputs from the workforce workstream critical path may be added to the SCC work

Programme	Executive Sponsor	Description	Products/ Outputs	Supplementary Notes
				programme once it has been agreed.
System Reform	Caroline Donovan	Mental Health, Learning Disability & Autism Provider Collaborative – placeholder Linked to lead provider model and implications for commissioning decisions within LSC and impact on patients	TBC	Further products/outputs from the MH, LD&A Provider Collaborative critical path may be added to the SCC work programme once it has been agreed
	Kevin McGee	Acute Provider Collaborative – placeholder Linked to provider collaborative model and implications for commissioning decisions within LSC and impact on patients	TBC	Further products/outputs from the Acute Provider Collaborative critical path may be added to the SCC work programme once it has been agreed

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3. Specialised Services 2021/22 Workplan

Specialised Services				
Programme	**Executive Sponsor**	**Description**	**Products/ Outputs**	**Supplementary Notes**
Women's and Children's Program	Nicola Adamson	• Sustainable paediatric surgery and paediatric critical care services. • Future provision of neonatal care to meet standards. • Introduce enhanced paediatric oncology shared care unit services and address sustainability issues in radiotherapy due to proton beam expansion.	Case for change by March 2022 / gateway 1	If approved at gateway 1 PCBC is planned by Mar 2023.
Adult Critical Care modernisation	TBC	• Review of adult critical care transport services. • Appropriate commissioning of adult critical care capacity and pathways.	Business case	Review to be undertaken alongside ICS Hospital Cell and ODN teams
Spinal Cord Injury	Nicola Adamson	Sustainable model of service for the future across the North West. The NW centre is currently located at Southport. A gap analysis of current service provision against new national service specifications and recommendations is required.	Equality Impact Assessment Case for Change	
Vascular		Covered in section 2		
Urology Cancer Services		Covered in Section 2		
CF Centre maturity	Nicola Adamson	Currently services for patients in Lancashire and South Cumbria are provided from Blackpool under network governance led by Manchester.	Change in commissioning designation	

assessment (Blackpool)		This work will assess whether Blackpool can be designated as a standalone centre. The national CF review will need to be taken into consideration which is looking at national standards, remote monitoring, data and clinical pathways.		
Local Care for Bone Marrow Transplantation	Nicola Adamson	There has not been a review of Allogeneic Bone Marrow Transplantation services for the population of Lancashire and South Cumbria. Currently patients are treated in Manchester. This project will consider if choice can be extended to the provision of a clinically safe service in Blackpool.	Feasibility assessment EIA Clinical case for change and commissioning options appraisal	
Confirm designation arrangements for PFO	Nicola Adamson	Currently Patent Foramen Ovale treatment is undertaken in Manchester or Liverpool. Work is required to assess if the Blackpool Cardiac Centre can meet the necessary standards to provide a local service.	EIA Business Case Commissioning decision in relation to service options	
Interventional Cardiology	Nicola Adamson	Review of interventional cardiology services across Lancashire and South Cumbria to ensure a safe networked model of care across all sites.	Service review and recommendations	

Mental Health and Learning Disabilities	Caroline Donovan	• Modernise the planning and delivery of Specialised Mental Health Services through the implementation of Lead Provider Collaboratives. • Achieve the objectives of 'Building the Right Support' in relation to the secure care needs of people with Learning Disabilities and Autistic Spectrum Conditions. • Ensuring that Specialised Mental Health services are delivering care to the Right Patient; in the Right Place; for the Right duration through effective case management approach. • Ensure best practice in relation to reducing the use of restrictive practices in inpatient MH services. • Closure and decant from Whalley Hospital.	Achieve 'go live' to plan and oversee via regular assurance meetings. TCP trajectories on track for individual transfers with plan for pathway fund developed locally. Review SSQD dashboards and providing scrutiny on any outliers. Work with the 2 other provider collaboratives in the NW via MoU to deliver this service change whilst overseeing the safe decommissioning and reprovision of the low secure services for the patient population.	
Prison Health	Andrew Bibby	• Secure high-quality healthcare in our institutions through commercial processes (contract management; and retender life expired contracts) • Recover Prison Health Services • Preparing or the new NHS landscape • Deliver on improvements to care for CYP in the criminal justice system • Mobilise Transfer of Commissioning responsibility for HMP Haverigg from CNE Team • Court Healthcare • Reconnect Rollout		

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4. ICS Priority Programme Decision Schedule

4.1. The table below presents an indicative schedule of products requiring decisions, scheduled across the remaining quarters of 21/22.

4.2. Due to the significant scope of the New Hospitals programme, it is recommended that the SCC may wish to hold exceptional meetings regarding decisions at critical points in the programme pathway to allow sufficient time for discussion and subsequent decision making.

Quarter (21/22)	Programme / Service	Product
Q2	**Population Health Management**	Business Plan
	Population Health Management	PHM programme PID
	Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN)	Business Case
	New Hospitals	PCBC
	Learning Disability & Autism	Provider Confirmation Update Aligned Budgets Update
	Community Diagnostics Hub	Year 1 Business Case Year 2+ Business Case
	Intermediate Care	Business Case
	Cancer	Non-surgical Oncology Review Report
	System Reform	CCG Close down plan and project
Q3	**New Hospitals**	Consultation Documentation
	Childrens Mental Health	Business Strategy
	Learning Disability & Autism	Business Strategy
	CHC / IPA Transformation	Second phase funding request Presentation of IPA transformation model
	Intermediate Care	ICP Level Blueprint(s) Risk Share Agreement
	Palliative & End-of-life care	LSC End of Life Care Clinical Pathway for commissioning
	System Reform	Transitional operating models and functional allocation of resources for 2021/22 relating to: • Primary Care & Community Services • Population Health Management • Quality & Performance Improvement • Communications & Engagement
	System Reform	Draft operating model for NHS LSC – functions, resource allocations at system / place Updated CCG closedown plan to reflect content of national guidance
Q4	**Intermediate Care**	Future Financing & Joint Commissioning proposals Initial Tranche Transformation Projects
	System Reform	Final operating model for NHS LSC – functions, resource allocations at system / place
	System Reform	Report on closedown of CCGs
Dates Not Yet Known	**Vascular**	Pre-Consultation Business Case Full Business Case Delivery Plan

	Cancer	Urology Area Network Deep Dive Outcome
	System Reform (likely Q3)	Management of Change Policies

5. Recommendations

The SCC is asked to:

- Agree the proposed workplan and schedule for delegated decision-making.
- Share the proposed workplan with each CCG's Governing Body.

Emily Kruger Collier
July 2021

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Cover sheet: Strategic Commissioning Committee

Date of meeting	**15th July 2021**
Title of paper	**Update Report from the CCG Transition Board**
Presented by	**Andrew Bennett, Executive Director of Commissioning, LSC ICS**
Author	**Dawn Haworth, Senior Programme Manager**
Agenda item	**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.

At the June meeting of the CCG Transition Board the agenda focussed on the following areas:

- SCC Sub Committees Expressions of Interest Update
- Commissioning Functions Update
- CCG Close down process
- HR and OD Workstream Update
- Communications & Engagement Update

The attached highlight report summarises the progress against these areas which was reported at the Transition Board.

There are no risks for escalation to the Strategic Commissioning Committee at this stage.

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			N/A	
Privacy impact assessment completed			N/A	
Financial impact assessment completed			N/A	
Associated risks			N/A	
Are associated risks detailed on the ICS Risk Register?			N/A	A Risk and Issues Log for the System Reform Programme has been established

L&SC ICS
Transition Board
Monthly Highlight Report

Healthier Lancashire & South Cumbria

ICS Transition Commissioning - Summary				
ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Programme Status	Current Status
C	*Plan and implement the transitional commissioning arrangements for 2021/22 and the transactional arrangements to close down eight CCGs by June 2022*	Chair = Roy Fisher	Programme On Track	
C01	**Define transitional Commissioning governance arrangements**	Andrew Bennett		Complete
C02	**Develop and agree transitional functional allocation of resources**	Andrew Bennett		In Progress but with minor issues/delays
C03	**Agree plan for transactional close-down of CCGs**	Denis Gizzi Helen Curtis		In Progress no issues/delays

Commissioning Reform - Objectives					
ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
C01	**Define transitional Commissioning governance arrangements**	Andrew Bennett	The Strategic Commissioning Committee has now been established, and all of its sub-committees are now established (Quality and Performance, Collaborative Commissioning, CCG Transition Board). An Expressions of Interest process has been completed to ensure an appropriate mix and sufficient numbers of lay oversight in the groups.	31/03/22	Complete
C02	**Develop and agree transitional functional allocation of resources**	Andrew Bennett	Three key pieces of work are underway: 1. Strategic commissioning functions 2. Corporate functions 3. 'Accelerator' areas - Primary/community services integration – Peter Tinson - Population health management – Julie Higgins, Dr Andy Knox - Quality and performance improvement – Helen Curtis, Kathryn Lord, Julie Higgins - Communications and engagement – Neil Greaves A check and challenge session across the various perspectives is planned for 15th July	30/06/22	In Progress but with minor issues/delays
C03	**Agree plan for transactional close-down of CCGs**	Denis Gizzi Helen Curtis	A lead Accountable Officer and lead Executive Director have been assigned, along with key individuals from specific functions (e.g. finance). Development of a detailed work plan is underway, currently based upon previous experience of the transition from Primary Care Trusts to CCGs and/or CCG mergers. These will be validated against national guidance once received.	30/06/22	In Progress no issues/delays

Communications & Engagement - Objectives					
ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
G01	**Strategic narrative documents and toolkits for use by senior leaders to set out language and messaging and to shape communica tio ns, engagement, involvement with all stakeholders**	Neil Greaves Hannah Brooks	Senior leadership toolkit completed and shared. Delivering Integrated Care Summary Document complete and shared. Terminology in ICP common narrative currently being updated ready to be shared in June.	31/03/22	In Progress no issues/delays
G02	**Co ordinating communications and engagement plans for all stakeholders at system and place levels, including those staff who are affected by the transition of activities associated with the closedown of CCGs**	Neil Greaves Hannah Brooks	Meeting scheduled on 15 June with ICP engagement leads and ICP programme directors to discuss communication and engagement plans to ensure consistent messaging and timing.	31/03/22	In Progress no issues/delays
G03	**Oversight, planning and direction to support communications and engagement of system reform across LSC and consistent key messages for staff, providers, partners and public**	Neil Greaves Hannah Brooks	Monthly staff briefings established (first one sent 14.05.21) for staff affected by transition of activities from closedown of CCGs and monthly wider stakeholder briefings established (first one sent 28.05.21). 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.	31/03/22	In Progress no issues/delays

Workforce - Objectives					
ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
E01	**Develop critical path and key deliverables**	Cath Owen	Key objectives for the programme have been developed with consideration to workstream leads, deadlines and EIRAs This will then be validated against national guidance when received	14/05/21	Complete
E02	**Development of overarching principles and guidance (local)**	Cath Owen	CCG Transition Board has approved people transition principles, system resource and recruitment protocol, and a set of people transition FAQs. These principles and protocol will be in use during the current transition period whilst we await national guidance	14/05/21	Complete
E03	**CCG closedown/disestablishment (inc. transfer of workforce and relevant HR systems)**	Cath Owen	Awaiting national HR technical guidance in respect of formal transfer of staff. Membership of CCG closedown group (managed by Helen Curtis) and have developed key actions that will be required, pending guidance (linked to critical path above)	31/03/22	Not Started
E04	**Recruitment into NHS LSC senior leadership team and associated governance arrangements**	Cath Owen	Awaiting National Guidance on appointments process. Not expected until after passing of legislation and no appointments expected to be made until such time as legislation passed.	31/03/22	Not Started
E05	**Organisational development**	Cath Owen	OD support programme offer made available by NHSEI for AOs and Senior Directors within CCG. OD support programme for all staff to be developed and made available from Q2	31/03/22	In Progress no issues/delays
E06	**Staff engagement and consultation**	Cath Owen	First staff bulletin issued on 21 May 2021 in conjunction with C&E colleagues. Monthly bulletin will be issued. Staff Side engaged and being regularly updated via established formal mechanisms.	31/03/22	In Progress no issues/delays

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	**15 July 2021**
Title of paper	**Collaborative Commissioning Advisory Group (CCAG) update**
Presented by	**Mike Bone, Chairman, CCAG**
Author	**Jill Truby Committee Secretary**
Agenda item	**13**
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 8th June 2021.
Executive summary
The CCAG met on 8th June 2021 and received the following reports: • Updated Terms of Reference and Membership • Minutes of Primary Care Programme Board • Draft Programme Work for Strategic Commissioning Committee • Mental Health, Learning Disability and Autism – draft Transition Plan
Recommendations
The SCC is asked to note the report.

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

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Implications

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

Lancashire and South Cumbria
Health and Care Partnership

Collaborative Commissioning Advisory Group (CCAG) update

1. Introduction

1.1 The CCAG met on 8th June 2021 and received the following reports:

- Updated Terms of Reference and Membership
- Minutes of Primary Care Programme Board
- Draft Programme Work for Strategic Commissioning Committee
- Mental Health, Learning Disability and Autism – draft Transition Plan

2. Reports

2.1 Updated Terms of Reference and Membership

The updated Terms of Reference for the Clinical Commissioning Advisory Group had been approved by the Strategic Commissioning Committee. It was acknowledged that these were subject to change following receipt of the White Paper. Discussion ensued on the mechanism for specialise commissioning items to be included for discussion in this group together with provision for alternative representation from an ICP area.
The CCAG accepted the Terms of Reference subject to possible change between now and the end of March 2022 following receipt of the White Paper.

2.2 Minutes of the Primary Care Programme Board

The minutes of the Primary Care Programme Board 4 May 2021 were presented for noting. It was considered that inclusion of these minutes in this meeting presented an opportunity to identify collaborative work, or accelerate work, by this group to add value to the work of other groups. Peter Tinson would be asked to attend the July meeting to explore opportunities in further detail.
The CCAG noted the minutes and agreed to invite Peter Tinson for a more detailed discussion at the July meeting.

2.3 Draft Programme Work for Strategic Commissioning Committee

The CCAG received a report that introduced a final draft of the proposed workplan for 2021/22 setting out the areas for collective decision-making.

It was agreed that a specialised services commissioning work plan could be integrated into this workplan in future. Nicola Adamson would undertake further work on this.

It was noted that the SCC will have key decisions to make regarding the New Hospital Programme.

CCAG provides assurance to the SCC that proposed programmes are monitored and managed effectively.

The CCAG noted the proposed workplan and schedule for delegated decision-making and noted that a final version will be presented to the next formal meeting of the SCC in July 2021.

2.4 Mental Health, Learning Disability and Autism – draft Transition Plan

The CCAG received a working document setting out an initial programme plan for the development of Mental, Learning Disability and Autism collaborative arrangements.

In line with the Long-Term Plan, the Lancashire & South Cumbria (L&SC) ICS has introduced a System Transition Board (May 2021) to oversee and support the continued development of provider collaboration for mental health, learning disability and autism services. There is also an expectation that the System Transition Board will enable the smooth transition of NHS commissioning activities across L&SC in line with the national desire to shift the landscape for the commissioning and provision of mental health, and learning disability and autism services. The NHS providers, that form part of the System Transition Board, will work collaboratively to plan the transformation of services and to manage system performance.

The group will support the planning of system delivery across L&SC, supporting systems strategies, aligning transformation activities, as well as defining and agreeing the scope of specific NHS-led provider collaboration activities, in particular commissioning programmes.

The CCAG will continue to receive further development updates. The CCAG noted the report.

3. Conclusion

3.1 This paper is a summary of the CCAG meeting held on 8th June 2021.

4. Recommendations

4.1 The SCC is requested to:

1. Note the contents of the report

Jill Truby
28 June 2021

Lancashire and South Cumbria
Health and Care Partnership

Strategic Commissioning Committee

Date of meeting	**15 July 2021**
Title of paper	**Report from the ICS Quality and Performance Sub-Committee**
Presented by	**Kathryn Lord, Director of Quality and Chief Nurse, Pennine Lancashire CCGs**
Author	**Caroline Marshall, Deputy Director of Quality and Deputy Chief Nurse, Pennine Lancashire CCGs**
Agenda item	**14**
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 8 July 2021 including risks which have been identified.

Executive summary

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

- CAMHS Services
- Adult Mental Health Services
- Learning Disabilities – Access to services
- Risk of unidentified harm due to long waits for treatment.

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:	Kathryn Lord, Director of Quality and Chief Nurse, Pennine Lancashire CCGs

Report from the ICS Quality and Performance Sub-Committee

1. CAMHS Services

1.1 Referrals to CAMHS Services are increasing and this is impacting on the number of Children and Young People (CYP) being admitted or needing to be seen.

1.2 There is an increase in the trend of foster placement breakdowns.

1.3 The rate of referrals from School Nurses of CYP with anxiety and stress has increased.

1.4 There has been an Increase of SEND CYP where commissioners are working with families and providers due to a breakdown in packages, sometimes as a result of Covid-19.

1.5 An increase is noted in anxiety, self-harm and those in crisis.

1.6 LSCFT are increasing appointments to support the increase in demand.

1.7 Cases of Eating Disorders in CYP is also significantly rising with more presenting to A&E.

1.8 Complaints relating to the Eating Disorders pathway are increasing.

1.9 There is a national shortage of Eating Disorders specialist beds which is being addressed nationally.

2. Adult Mental Health Services

2.1 12hr Mental Health breaches are increasing with bed availability and system pressures contributing to the delays. Work is underway to explore the care these patients are receiving.

2.3 Concern was expressed as to the impact a long delay in a busy ED would have on the patient's recovery and length of stay. LSCFT are currently looking into this.

2.5 Work continues at ICS looking at suicide trends and cases.

2.6 Concern was raised regarding the linkage between MH and physical health conditions which are interlinked with the 18 week RTT/long wait positions.

3. Learning Disabilities

3.1 Severe pressure in finding placements for LD was reported.

3.2 Concern was raised regarding access for people with LD to physical health services and pathways and this would need further consideration.

4. Identified Risks

4.1 The Sub- Committee agreed that there is a risk of unknown harm to patients due to long waits for treatment.

5. Conclusion

5.1 Members of the Quality and Performance Sub-Committee agreed that items 1 – 3 above should be brought to the attention of the SCC for acknowledgment and further discussion.

6 Recommendations

6.1 The SCC is requested to:

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

Caroline Marshall
08.07.21

Lancashire and South Cumbria
Health and Care Partnership

Item 15

Strategic Commissioning Committee - 13 May 2021

Questions received from members of the public

We invite members of the public to ask question relating to items on the Strategic Commissioning Committee agenda. The following questions were received ahead of the meeting on 13 May 2021 and responses have been provided below. These responses are correct at the time of publication on Thursday 8 July 2021.

Question: If the decisions to close hospitals, to close services, to move services "into the community" and to build a "super" hospital are locally led and based on the clinical need of the local population, how were the decisions to proceed with these actions taken before a clinical case was built, how is it that almost identical decisions are being taken in every one of the 42 ICS across England?

Response: At this early stage no decisions have been made regarding the New Hospitals Programme in Lancashire and South Cumbria. We don't yet know what our new hospital facilities will look like or where they will be located. Our proposals will be led by clinical opinion, experience and scientific data and the needs and views of our patients, staff and local people will be very important. There will be an update on the New Hospitals Programme which will be available for the public to observe at the Strategic Commissioning Committee on Thursday 15 July.

Question: How do you define "community" in these circumstances? Is it anywhere within the ICS footprint? or beyond?

Response: Health and care partners will frequently refer to different communities which may include groups of people who have a particular characteristic in common such as staff, clinical professions or partners from a specific sector. This most commonly includes describing citizens who live in local areas across Lancashire and South Cumbria which they would recognise as their community. Our partners continue to work with, engage and involve local people in changes and new ways of delivering services in neighbourhoods, in local partnerships and across Lancashire and South Cumbria.

Question: How will you assess whether moving services out of hospitals has improved access and patient care compared to when they were universal services provided publicly within hospital and NHS premises. I am particularly interested in the fact that services provided by small voluntary groups and other third sector groups are not universal, not all of the same standard, are difficult to access and are very limited by postcode and availability of volunteers in particular locations to run such services. Please explain how this situation can be an improvement on a national health service.

Response: There are a number of different threads in your question. Firstly, it is important to say that the majority of NHS care already takes place outside hospital premises in GP practices and a range of community services. Some of these operate from a universal model under national contracts, some are commissioned locally with a view that they respond to the needs of different communities. Voluntary, community and social enterprise organisations provide a range of services, sometimes locally, sometimes regionally which we would regard as additional to the statutory health and social care services in a particular area. At this early stage no decisions have been made to move services out of hospitals as part of the New Hospitals Programme. Any decisions made by partners across Lancashire and South Cumbria will be based on improving outcomes and improving health and care services for the population of Lancashire and South Cumbria.

Question: As CCGs are scrapped, please provide details of the debts of each of those CCGs.

Response: Any changes to CCGs will be based on changes to national legislation. These discussions are emerging as part of the Department of Health and Social Care white paper, Integration and innovation: working together to improve health and social care for all. CCGs will be publishing their annual reports in the coming weeks which will include their financial information. Once these have been published they will be available on their websites.

Question: Please provide details of the number of redundancies of staff in each CCG

Response: Any changes to CCGs will be based on any changes to national legislation. National guidance has been published which provides an employment commitment for staff working in CCGs. NHS leaders in Lancashire and South Cumbria do not intend any redundancies as part of the system developments.

Question: Please provide details of the costs of those redundancies

Response: Not applicable based on above response.

Question: Please provide details of the costs of winding up the 8 CCGs

Response: Work to respond to changes to national legislation is underway however we do not at this stage have details of the costs of closing CCG organisations. When this is available it will be published. The changes to CCGs remain subject to a legislative process which is expected to begin during July.

Question: Please provide a list of all members of this board, particularly those elected at County and/or Borough level.

Response: The ICS Board membership is outlined in the Terms of Reference which is available online here: https://www.healthierlsc.co.uk/icsboard

Question: What arrangements have been made for scrutiny of this strategic commissioning board and of the ICS Board? Where and when do these scrutiny committees meet? what is their remit? please provide details of the members of those scrutiny committees.

Response: Information regarding the remit and frequency of the ICS Board are included in the Terms of Reference available here: https://www.healthierlsc.co.uk/icsboard

Information regarding the remit, legislation and frequency of the Strategic Commissioning Committee are included in the Terms of Reference available here: https://www.healthierlsc.co.uk/strategiccommissioningcommittee

Question: Each CCG has had a medicines optimisation scheme, please provide the purported savings on reducing medicines spending and please provide separately the cost to each CCG of running the medicines optimisation schemes. Do the savings outweigh the costs? please show your figures

Response: CCGs in Lancashire and South Cumbria have different arrangements and schemes in place for medicines optimisation which means we are unable to answer this question and provide the detail requested at this stage. Colleagues are working together to develop how medicines optimisation will be managed across Lancashire and South Cumbria as part of the developments in integrated care. As soon as this information along with details of spending and savings is available it will be shared in a future Strategic Commissioning Committee meeting.