Lancashire County Council

Health Scrutiny Committee

Tuesday, 1st February, 2022 at 10.30 am in Cabinet Room 'A' - The Tudor Room, County Hall, Preston

Agenda

Part I (Open to Press and Public)

No.	Item	
1.	**Apologies**	
2.	**Disclosure of Pecuniary and Non-Pecuniary Interests** Members are asked to consider any pecuniary and non-pecuniary interests they may have to disclose to the meeting in relation to matters under consideration on the agenda.	
3.	**Minutes of the Meetings held on 2 and 16 November 2021**	(Pages 1 - 10)
4.	**Enhanced Network Model of Acute Stroke Care and Rehabilitation in Lancashire and South Cumbria**	(Pages 11 - 60)
5.	**Update on Housing with Care and Support Strategy**	(Pages 61 - 90)
6.	**Report of the Health Scrutiny Committee Steering Group**	(Pages 91 - 114)
7.	**Work Programme 2021/22**	(Pages 115 - 124)
8.	**Urgent Business** An item of urgent business may only be considered under this heading where, by reason of special circumstances to be recorded in the minutes, the chair of the meeting is of the opinion that the item should be considered at the meeting as a matter of urgency. Wherever possible, the chief executive should be given advance warning of any member's intention to raise a matter under this heading.	

Lancashire County Council

9. Date of Next Meeting

The next meeting of the Health Scrutiny Committee will be held on Tuesday 22 March 2022 at 10.30am, County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday 16th November 2021 at 10.30 am in Committee Room 'A' - The Tudor Room, County Hall, Preston

Present:

County Councillor David Westley (Chair)

County Councillors

C Haythornthwaite	E Pope
L Collinge	S Rigby
S Jones	K Snape

Co-opted members

Councillor Margaret France, (Chorley Council)
Councillor Julie Robinson, (Wyre Borough Council)
Councillor Viv Willder, (Fylde Borough Council)

Councillor Margaret France replaced Councillor Alex Hilton at this meeting only.

County Councillor Mohammed Iqbal, County Councillor Stuart Morris, County Councillor Jackie Oakes, County Councillor Lian Pate, Councillor Sue Gregson, Councillor David Howarth and Councillor Jennifer Mein attended the meeting virtually, via Microsoft Teams.

1. Apologies

Apologies were received from Councillor Barbara Ashworth (Rossendale Borough Council), Councillor Alex Hilton (Chorley Council) and Councillor Jenny Molineux (Hyndburn Borough Council).

2. Disclosure of Pecuniary and Non-Pecuniary Interests

None.

3. Minutes of the Meeting Held on 14 September 2021

Resolved: That the minutes of the meeting held on 14 September 2021 be confirmed as an accurate record.

4. Increasing vaccination uptake and addressing inequalities

The Chair welcomed to the meeting Paul Havey, Director of the Lancashire and South Cumbria Vaccination Programme, Jamie Sweet, Programme Operational

Lead, Carole McCann, Associate Director and Senior Nursing Support, and Abdul Razaq, Interim Consultant in Public Health at Lancashire County Council.

The committee considered a presentation (circulated to members in advance of the meeting) delivered by Paul Havey, Carole McCann, and Jamie Sweet on Covid-19 vaccination uptake and the steps taken to address inequalities in relation to the vaccination programme. A copy of the presentation is set out in the minutes. It was highlighted that:

- To date, over 80% of eligible Lancashire residents had received a first dose of the Covid-19 vaccination and over 70% had received a second dose. Vaccine uptake amongst 12–15-year-olds was still low, with only 31.2% receiving a first dose.

- Generally, once people received a first dose, they were likely to return for a second dose. Lancashire was making good progress compared to other regions in North West and across the UK.

- Phase 3 of the vaccination programme included the delivery of third doses (or 'boosters') and the evergreen offer for first and second doses. Phase 3 was being delivered by the primary care network, by community pharmacies, by vaccination centres and, on a smaller scale, at hospitals.

- Between May and July 2021, Lancashire and South Cumbria experienced the highest rate of infection nationally. To address the surge, vaccinations were offered hyper-locally. For example, 35,000 vaccinations were delivered in East Lancashire in a 6-week period by pop-up, mobile and existing vaccination sites. Working with local authorities also encouraged people who were hesitant to get vaccinated; the support of staff at Lancashire County Council had been integral to the programme's success.

- Walk-in appointments and the offer provided by mobile vaccination vans were key to reaching communities. The van visited schools, supermarkets, shopping centres, homeless shelters, places of worship and Gypsy Roman Traveller communities, for example, to deliver roughly 100,000 vaccinations since the end of May 2021.

- Some groups were harder to reach or underrepresented compared to others. Work with the Caribbean and African Health Network (CAHN) helped to promote the vaccine among Lancashire's Black Caribbean and African populations. Home visits were organised for young people with serious underlying health conditions who struggled to attend vaccination centres. Partnering with football clubs to promote the programme through player vaccinations, social media and match-day messaging was also effective.

- To engage the younger population, the vaccination van attended college enrolment days to offer the vaccine conveniently. Despite the focus of Phase 3 of the programme on delivering a third dose to the older and more vulnerable population, the programme continued to target younger cohorts. Social media, such as the #AskAuntieCarol campaign, was used to myth-bust and promote the vaccine to this audience.

- Lancashire and South Cumbria covered approximately 40 Gypsy Roma Traveller community sites. 3 sites in Lancashire had been identified as pilot sites to begin discussing the vaccination and educating residents about its benefits. Initial engagement was conversational, but later visits provided the vaccine through the mobile van and pharmacy teams. In addition to increasing vaccine uptake, this engagement with Gypsy Roma Traveller communities promoted access to other local health services, which this group often failed to engage with until the point of emergency. 20 vaccinations were delivered across the 3 pilot sites, with a return visit planned in 8 weeks' time to administer first and second doses.

- The CAHN were commissioned to engage with Black African and Caribbean residents, working with community and faith leaders. Efforts to promote the vaccine culminated with the Windrush Event at Preston Cricket Club in September 2021, to which a mobile vaccination unit attended to offer the vaccine and have educational conversations with attendees. Engagement with this community group was ongoing, including awareness raising about the impact of the pandemic.

- Lancashire County Council had drawn attention to the vulnerability of Lancashire's migrant workforce. Accordingly, the programme engaged with three of the largest employers in the area – plants and factories which were susceptible to covid outbreaks. Initially, educational visits provided leaflets in the workers' native languages and subsequently two sites accepted the offer of a mobile vaccination unit to facilitate vaccinations for all staff during working hours. Although vaccine uptake was slow, important educational work was carried out.

- The 'in school' vaccine offer was to be completed by the end of November 2021; however, 12- to 15-year-olds were now able to book a vaccination appointment through the national booking system. Information on walk-in appointments was also available on the Lancashire and South Cumbria ICS website.

- As part of Phase 3, all eligible care homes had received a visit by 31 October 2021 to offer the third dose of the vaccine to residents. The vaccine offer (for both Covid-19 and flu) for housebound patients also continued, possibly to be delivered by an additional workforce in the future.

In response to questions and points raised by members, the following information and assurances were provided:

- The reasons for non-vaccination were multifaceted, however with colleagues in Public Health it was possible to identify groups and geographical areas where uptake was especially low. Sometimes individual conversations with people were the best approach to myth-busting, and in other circumstances it was necessary to engage with an entire community.

- It was acknowledged that communication to pregnant people about the vaccination across the whole country had been poor. Some targeted programmes had been delivered, such as the vaccination van visiting antenatal clinics in East Lancashire. More information on the availability of third doses to pregnant people would be provided to the committee after the meeting.

- Work was ongoing to understand why people struggled to access third doses of the vaccine and to streamline the information provided to each community and town. The discussed case of a walk-in centre in Burnley turning residents away if they did not have an appointment would be investigated by officers.

- In relation to confusion about eligibility, residents were encouraged to visit a vaccination centre for their third dose as soon as they became eligible, rather than waiting for a letter or text invitation. More work was needed to reinforce the message that it was possible to book online for a third dose 26 weeks after receiving the second dose.

- Some people had not accessed the vaccination programme at all, which caused concern because community transmission would put them most at risk of contracting Covid-19. Lesson could be learned from a programme in the North East of England which had recently tried to reach this group through doorstep visits and individual phone calls. The data available during Phase 3 of the programme to identify where vaccine uptake was slower was far richer than the information available during Phases 1 and 2; this would help to identify ways to encourage vaccination. It was also possible to use those negatively impacted by Covid-19 within their communities to highlight the importance of the vaccine locally, such as through telling their stories. Ultimately, the message about the evergreen vaccination offer needed to be clearly and simply conveyed – something that elected members could support with.

- The national programme was aware of the need to include the third dose of the vaccine on the NHS app so that people could demonstrate they were fully vaccinated.

- There was a limit to the programme's capacity to prevent anti-vax protesters gathering outside vaccination sites. There had been a limited number of incidents to date involving the police, but generally incidents were hard to prevent and therefore required reactive actions. The programme continued to work with the police to protect citizens.

- Future plans for the mobile vaccination units, including over the Christmas period, would be determined by the data available and each situation or event would be individually assessed. Feedback to date suggested that offering the vaccine at social events, such as Christmas markets, was not always well received. Instead, these events were best utilised as educational opportunities. However, the team remained open-minded about attending any future events that would increase vaccination uptake.

- Data relating to number of eligible residents who had not received a second dose of the vaccine would be made available to the committee after the meeting. It was noted that the numbers were slightly reducing as a result of the legacy programme.

- The indicators of success were distinct to each group or cohort of the population. For instance, among the older population, based on historic uptake, it was expected that 90-95% would eventually be fully vaccinated. For the school-aged population, the proportion of vaccinated people may only reach 50%. The biggest, current concern was with so-called Cohort 6, people aged less than 50 who were considered high risk due to serious health vulnerabilities. It was possible that emerging technologies, such as an oral tablet, would help to reach people in this cohort who were unwilling to receive the vaccine. Work was ongoing nationally to get new, alternative therapies approved for use.

- The vaccination programme for winter 2022-23 was unlikely to match the scale of the 2021-22 programme. Ultimately, however, the government would determine the level of vaccination for future years and at this stage it was unknown what it would look like.

- The NHS collected data on the number of unvaccinated people in hospital and intensive care with Covid-19, but it was difficult to publish due to its personal nature. It was noted that sharing related figures might persuade people to get vaccinated. It was agreed for the most part that people's decision to receive the vaccine should come from willingness and education, rather than by compulsion. Decisions on mandatory vaccination and vaccine passports, for example, would be made by government based on the incidence of Covid-19 nationally.

- It was important to stress that the term 'fully vaccinated' now described people who had received their first, second and third doses of the vaccine. It was anticipated that changing the narrative to include the third dose would encourage people to come forward for their second and third doses.

- Lessons could be learned from the county council's internal audit of Phases 1 and 2 of the vaccination programme and the future audit of Phase 3. The NHS also had its own audit and assurance processes. Local and national data would drive the future of the vaccination programme, including the best approach to engage with communities. The programme also benefitted from Abdul Razaq's position on the NHS England Vaccine Equalities Board, which facilitated shared learning and insight on a national scale about vaccine inequalities.

- It was likely that Covid-19 would become endemic and the risk of Covid-19 alongside other viruses was important to consider. Whilst vaccination was the main line of defence against Covid-19 and flu, it was equally important for people to take non-pharmaceutical measures to limit transmission, such as regular hand washing and wearing a mask in public places.

- Delivery of the third dose of the vaccine to under-40s was planned to begin in the following week, but people would only become eligible to receive it 26 weeks after their second dose. As such, there would be a gradual increase in eligibility.

The committee thanked the NHS and county council officers for their ongoing work to deliver the vaccination programme. The Chair thanked officers for their presentation and responses to members' questions.

Resolved: That

i) The presentation on Covid-19 vaccination uptake and actions to address health inequalities, presented by the Lancashire and South Cumbria Integrated Care System, be noted;

ii) The summary of the Lancashire County Council audit assurance report and plans for a follow-up audit in 2022-23 following Phase 3, as presented at Appendix A, be noted; and

iii) NHS and county council officers be asked to take on board the comments and feedback of the Health Scrutiny Committee.

5. Report of the Health Scrutiny Committee Steering Group

The committee considered the report of the Health Scrutiny Steering Group followings its meetings held on 22 September and 13 October 2021.

Following a query about the complaints received from consultant pathologists regarding the proposed Lancashire and South Cumbria Pathology Collaboration, it was noted that the Chair had discussed the need for further staff consultation with the programme lead, Mark Hindle, and provided an email reply to the consultants on behalf of the county council's Health Scrutiny function.

Resolved: That the report of the Health Scrutiny Steering Group be noted.

6. Work Programme 2021/22

The committee reviewed the Health Scrutiny Work Programme for 2021/22.

It was noted that an update on the New Hospitals Programme would be provided at a future meeting of the Health Scrutiny Committee once the longlist of options had been shortlisted and when more information could be provided on available funding. The Health Scrutiny Steering Group had considered the longlist, which was also available to the public, at its meeting held 22 September 2021 and had provided feedback to NHS officers during the meeting.

County Councillor Stuart Morris, Champion for Mental Health, suggested he could provide the committee with an update about activities in Lancashire related to mental health at a future meeting.

Resolved: That

i) The Health Scrutiny Work Programme for 2021/22 be noted; and

ii) The suggested update on mental health activities in Lancashire be considered by the Health Scrutiny Steering Group for inclusion on the Health Scrutiny Work Programme 2021/22.

7. Urgent Business

None.

8. Date of Next Meeting

It was noted that the next meeting of the Health Scrutiny Committee was scheduled to be held on Tuesday 14 December at 10.30 am, at County Hall, Preston.

L Sales
Director of Corporate Services

County Hall
Preston

Lancashire County Council

Health Scrutiny Committee

Minutes of the Meeting held on Tuesday 2nd November 2021 at 10.30 am in Cabinet Room 'A' - The Tudor Room, County Hall, Preston

Present:

County Councillor David Westley (Chair)

County Councillors

C Haythornthwaite	E Pope
J Burrows	S Rigby
M Iqbal MBE	K Snape
S Jones	

Co-opted members

Councillor Saeed Chaudhary, (Burnley Borough Council)
Councillor Alex Hilton, (Chorley Borough Council)
Councillor Jennifer Mein, (Preston City Council)
Councillor Julie Robinson, (Wyre Borough Council)

County Councillor Nweeda Khan replaced County Councillor Jackie Oakes at this meeting only.

County Councillor Lizzi Collinge, County Councillor Nweeda Khan, County Councillor Stuart Morris, County Councillor Lian Pate, Councillor Barbara Ashworth, Councillor Gina Dowding and Councillor Sue Gregson attended the meeting virtually, via Microsoft Teams.

Apologies were received from County Councillor Jackie Oakes, Councillor Viv Willder and Councillor David Howarth.

Postponement of Meeting
Following a delay to the meeting start time and due to unforeseen technical difficulties, the Chair resolved to adjourn the meeting to a future date and time; the date and time of the postponed meeting to be agreed.

Abdul Razaq, Interim Consultant in Public Health at Lancashire County Council thanked the NHS officers in attendance for their time.

L Sales
Director of Corporate Services

County Hall
Preston

Health Scrutiny Committee
Meeting to be held on Tuesday, 1 February 2022

Electoral Division affected:
(All Divisions);

Corporate Priorities:
N/A

Enhanced Network Model of Acute Stroke Care and Rehabilitation in Lancashire and South Cumbria
(Appendix 'A' refers)

Contact for further information:
Gary Halsall, 01772 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Brief Summary

A presentation on the proposed Enhanced Network Model of Acute Stroke Care and Rehabilitation in Lancashire and South Cumbria will be delivered at the meeting. A copy of the full business case is set out at Appendix 'A'.

Recommendation

The Health Scrutiny Committee is asked to provide feedback on the Lancashire and South Cumbria Enhanced Acute Stroke Services Business Case to inform next steps and the future implementation of the programme.

Detail

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.

This business case (Appendix 'A') 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.

The following representatives from the local NHS are due to attend the meeting to present on the full business case:

- Aaron Cummins, Senior Responsible Officer for the stroke programme and Chief Executive of Morecambe Bay Hospitals;
- Cath Curley, Clinical Director of the ISNDN and Stroke Consultant nurse;
- Elaine Day, Manager of the Lancashire and South Cumbria Integrated Stroke and Neuro Delivery Network (ISNDN);
- Anthony Gardner, Director of planning and performance;
- Kate Maynard, Chair of the Operational and Implementation Group;
- Hayley Michell, Interim Stroke Programme Director;
- Sharon Walkden, Project Manager, Stroke Programme; and
- Phil Woodford, Chair of the Patient and Carer Stroke and Neuro Assurance Group.

The Health Scrutiny Committee is asked to provide feedback on the Lancashire and South Cumbria Enhanced Acute Stroke Services Business Case to inform next steps and the future implementation of the programme.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Appendix A

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

Full Business Case

July 2021

Version 1.0

Contact Officers:

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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

Table of Contents

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

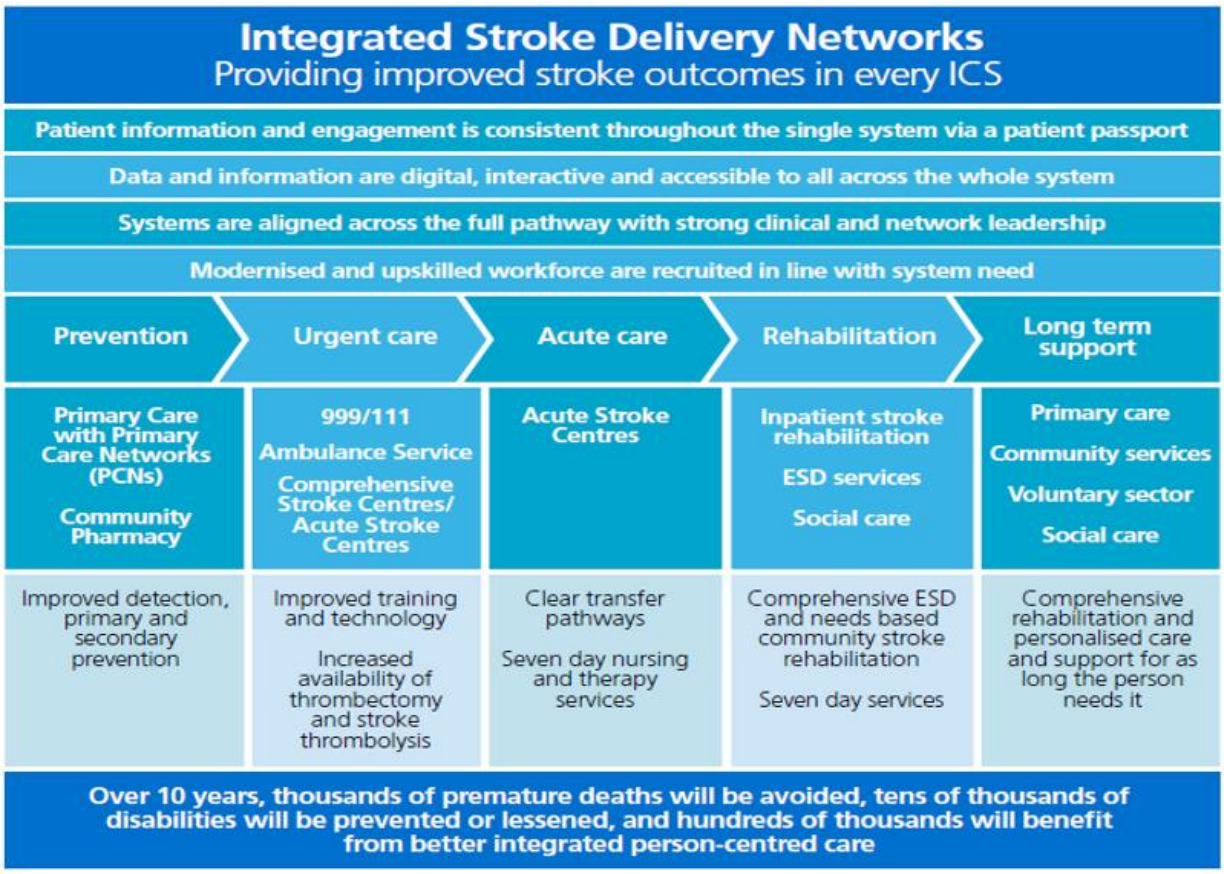
Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability. Approximately 100,000 people in the United Kingdom have a stroke every year, and 50% of stroke survivors will be left with disability (physical, communication, cognitive, 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. Residents ordinarily attending Furness General Hospital will continue to do so for triage and initial treatment before transferring to the Comprehensive Stroke Centre in Preston for 24 hour care for up to 3 days. Residents ordinarily attending Royal Lancaster Infirmary 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.

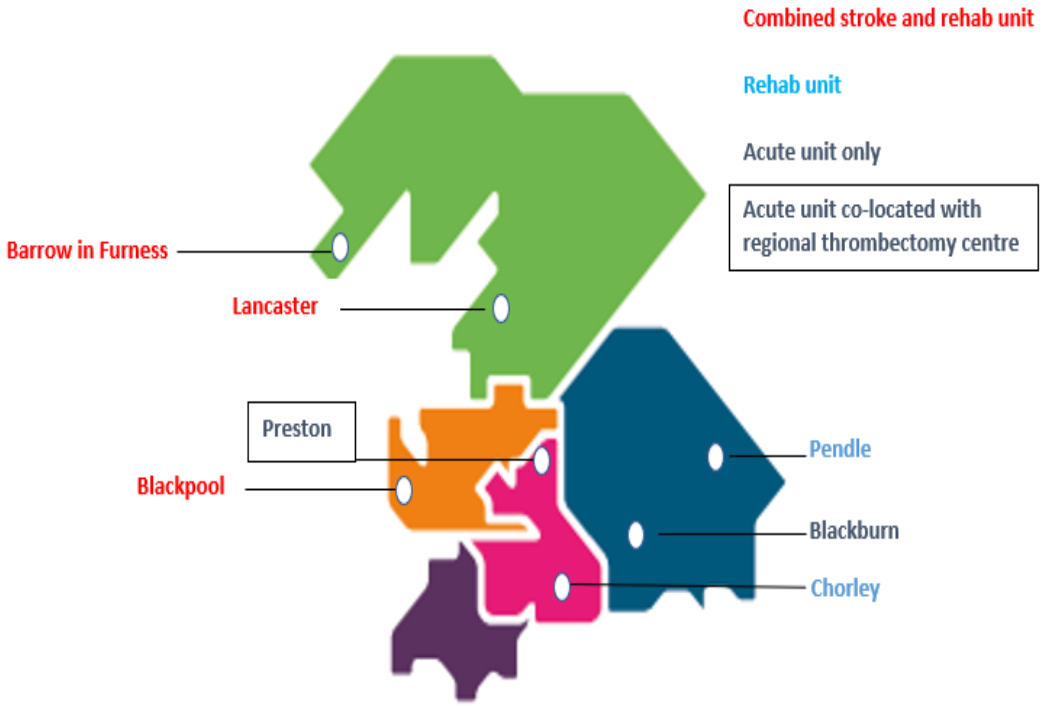
Inequalities exist between different population groups: men, older people, ethnic groups, and those of lower socioeconomic status have higher risk of stroke. Stroke risk is twice as high in the most deprived groups compared to the least deprived and the subsequent death is 26% more likely[1].

[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 9am-5pm, 5 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.

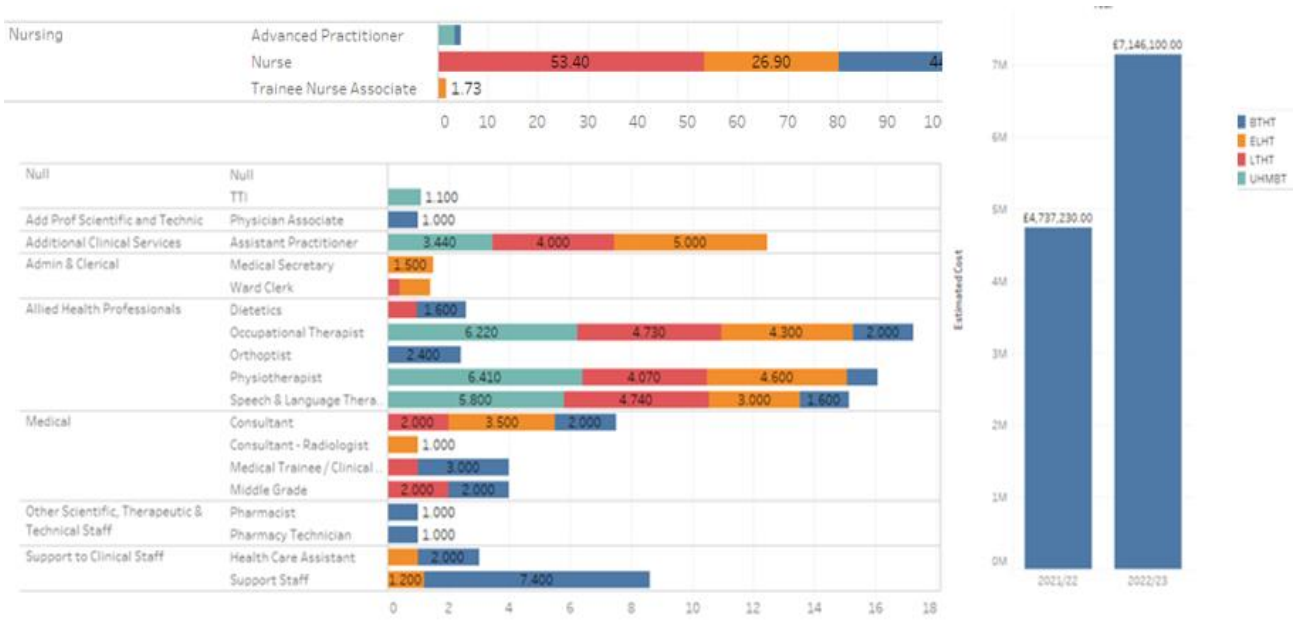
The L&SC ISNDN workforce work stream will be working closely with Health Education England and ICS workforce leads to solidify our understanding of the future supply stroke specialist staff. Using HEE STAR methodology, we will be exploring innovative ways to bolster workforce supply; navigating opportunities 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.

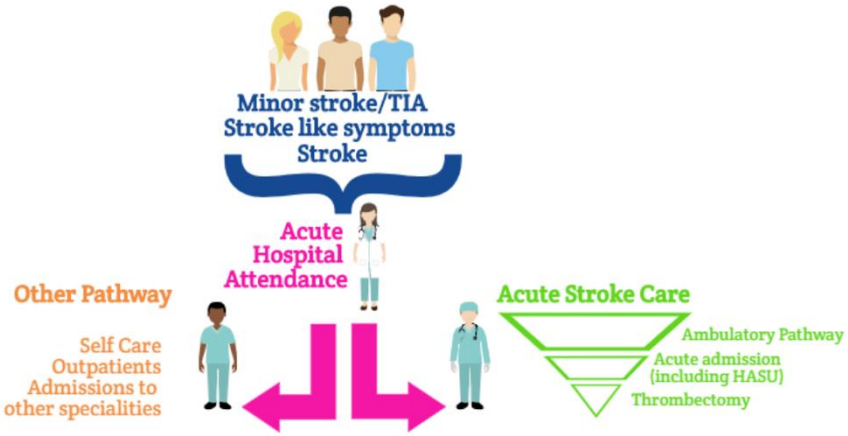
[7] Stroke Unit Trialists' Collaboration Organised inpatient (stroke unit) care for stroke. Cochrane Database Syst Rev. 2013 Sep 11;9:CD000197. doi: 10.1002/14651858.CD000197.pub3.

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:

Residents ordinarily attending Furness General Hospital 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 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.

Residents ordinarily attending Royal Lancaster Infirmary 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 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, additional 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 cost based on 2019/20 uplifted to reflect current cost under block payment structure*

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

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 £13.8m 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

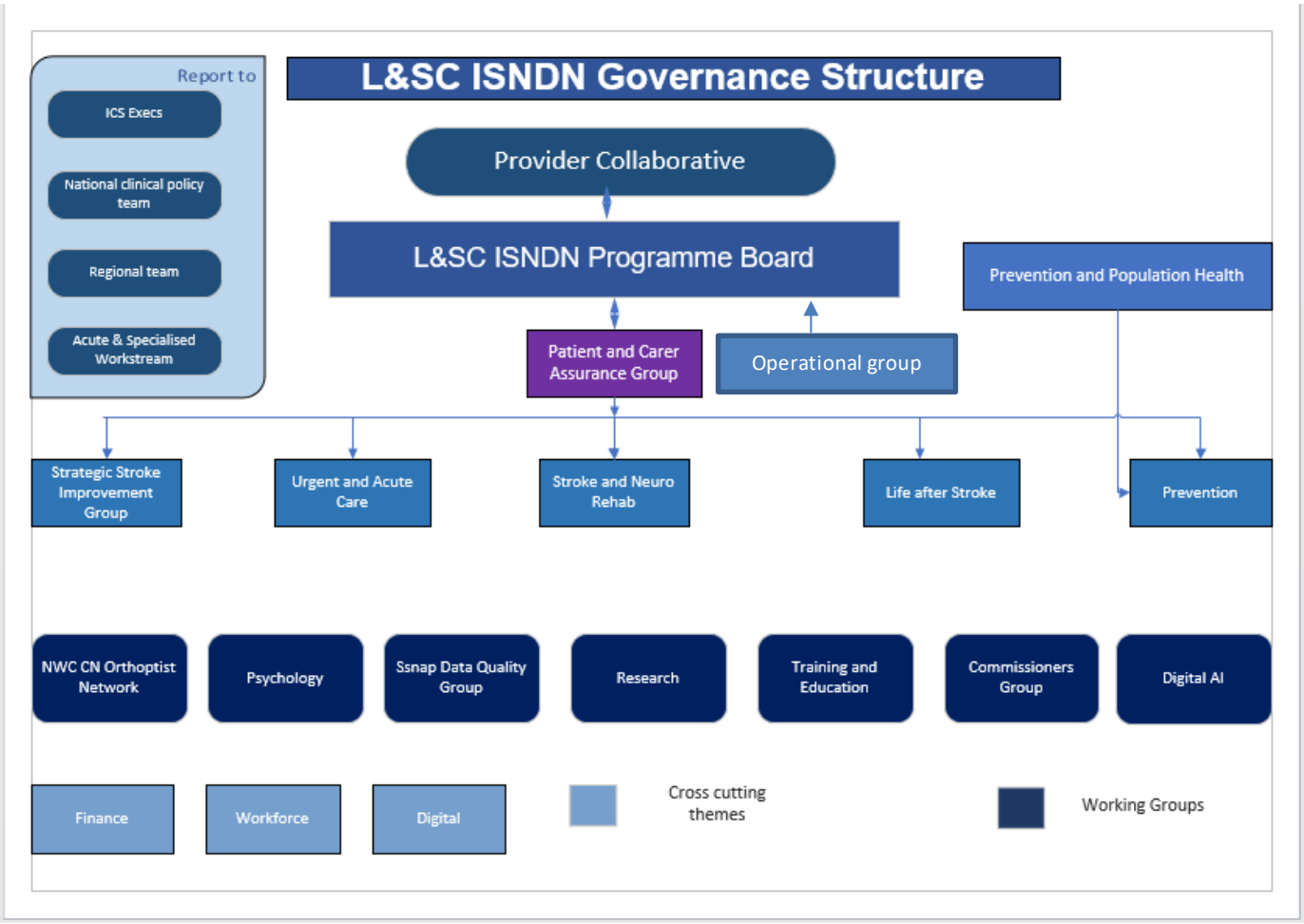
Component	Costs	ROI
ED Triage and Ambulatory emergency care pathway in all stroke receiving hospitals can filter up to 74% of stroke mimics away from an acute stroke bed to more appropriate pathways of care, reducing avoidable cost.	£606,700 staffing Ambulatory care £242,900 staffing ED triage £750,000 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

Health Scrutiny Committee
Meeting to be held on Tuesday, 1 February 2022

Electoral Division affected:
(All Divisions);

Corporate Priorities:
Caring for the vulnerable;

Update on Housing with Care and Support Strategy
(Appendix A refers)

Contact for further information:
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joanne.reed@lancashire.gov.uk

Brief Summary

This report provides an update on current progress with implementation of the Housing with Care and Support Strategy 2018-2025 which sets out the County Council's vision for extra care housing for older people and apartment developments for working age adults with disabilities.

Recommendation

The Health Scrutiny Committee is recommended to note:

1. Progress with developing new extra care schemes

2. Progress with reshaping supported living services by developing new apartments and bungalows and the decommissioning of some shared properties

3. Actions identified as next steps

Background

The Housing with Care and Support Strategy 2018 to 2025 outlines the Authority's vision for supported housing services for older people and working age adults with disabilities. Health Scrutiny Committee received a presentation on the Strategy in April 2019.

This report provides an update on progress in implementing the Strategy, which is especially relevant in the context of the new White Paper, People at the Heart of

Care, which describes the role of housing, including supported housing, in relation to promoting independence and meeting care needs.

Whilst there are different terms used for housing with care and support, the Strategy uses the term Extra Care (normally a minimum of 60 units) for developments for older adults and Apartments (typically 6 to 12 units) for developments for working age adults with disabilities. In both cases, accommodation has been designed, built, or adapted to meet the care and support needs that its tenants or owners may have now or in the future. In addition, care and support is available to people living in the accommodation on a 24/7 basis.

The Strategic aims of the strategy are outlined below:

- To have at least one Extra Care scheme for older adults in each district and about 1,000 homes by 2025
- To reduce the number of shared houses and increase the number of Flat Schemes for younger adults with disabilities
- To improve the Housing with Care and Support options for people with complex needs and conditions
- To provide a home for life and a viable and genuine alternative to residential care settings
- To provide ongoing care and support which delivers cost savings to the health and care system
- To provide a wider community resource and facilities to connect and benefit local residents
- To benefit the wider housing market through regeneration and releasing family housing

The Strategy stresses that the number of developments can only be maximised through strong partnership working between the county council, district councils, health organisations, service users, communities, providers, and landlords.

Needs

Extra Care Housing for Older Adults:

The Strategy stated that "Nationally, the current average level of provision equates to 15 units per 1,000 people aged 75 or over . …. The indicative figures shown below demonstrate the potential need for Housing with Care and Support for older people in Lancashire based on 15 units per 1,000 people aged 75 or over…. The estimated potential demand of 2,117 Extra Care units is much higher than the approximate 1,000 units being proposed in this strategy (see strategic aims above). This is because we want to:

- set an ambitious target whilst at the same being realistic about what can be delivered during the lifetime of this strategy, and

- evaluate the actual impact and get a better understanding of future demand prior to any further expansion".

District	Estimated nos. of units needed (national benchmark)	Existing Purpose-built Extra Care units/flats	Existing Combined Sheltered/Extra care schemes	New Schemes under Discussion or in Development
Burnley	134	0	0	2
Chorley	206	65	0	1
Fylde	194	0	1	2
Hyndburn	123	0	2	1
Lancaster	238	0	0	2
Pendle	138	0	0	1
Preston	165	60	1	1
Ribble Valley	125	0	1	Early discussions taking place
Rossendale	107	42	0	Discussions commencing with new Strategy Manager
South Ribble	204	0	2	1
West Lancashire	217	111	1	1
Wyre	265	72	0	1
Total	**2117 Initial target by 2025 of 1,000**	**350 (197 since 2019)**	**331 combined**	**Approximately 750 units**

In addition, we have developed a needs tool which brings together the following information for each ward:

- Number of people who are aged 65 years old or over
- Number of people aged 65 years and over with a long-term health problem or disability that limits activity a lot
- % of people living in social rented and privately rented accommodation
- % of older people who are income deprived
- Number of people living alone
- Crime per 1,000 population
- Number of people in receipt of Attendance Allowance
- Number of people in receipt of Home Care and Direct Payments
- Long-term residential care admissions
- Number of people receiving disabled facilities grants

The tool then ranks the wards within each district in terms of need for extra care as defined by the above datasets. The data is currently in the process of being updated.

People of working age with disabilities:

In relation to apartment developments, we have completed an independent demand survey which predicts that across Lancashire there will be an increased demand for supported living for working age adults of 498 bed spaces to be delivered by 2030. We are working with housing providers and developers to build new apartments in areas where we have a high demand. We will provide a greater choice for people who want to live more independently

Progress

There has been good progress over the last few year, including positive relationships established with landlords, care providers and Homes England. However, there are also a range of challenges which impact on our ability to develop services:

- Availability of land in appropriate locations
- Increase in development costs and the availability of capital and revenue
- Challenges facing the health and social care workforce
- The staffing and supply impacts of the pandemic
- Operational issues such as fire safety where we are working with providers on an individual property basis

A presentation outlining progress in relation to both extra care and apartment developments is attached at Appendix A.

The following information is included within the presentation on extra care:

- Key characteristics and benefits of extra care
- Schemes completed since 2019 and new schemes being discussed or under development
- Feedback from tenants
- Staff, and hopefully tenants, from Lighthouse View will be giving their views on the impact of Extra Care at the meeting

The following information is included within the presentation on apartment developments for working age adults:

- Details of new developments, the number of decommissioned shared living properties and savings generated
- Added benefits of supported housing apartment and bungalows
- Feedback from service users

Next steps

Partnership Working

The next steps are focussing on ways of overcoming the challenges outlined above. The Housing with Care and Support Strategy recognises that the key to developing supported housing is partnership working. Whilst the County Council has many positive relationships with districts and registered housing providers, strengthening and having more consistent relationships across districts and other organisation would help us to move this agenda forward more quickly.

Consequently, a registered housing provider forum has recently been set up by the County Council to which district council staff have been invited. Discussions are also taking place regarding the best way of strengthening relationships with district councils in relation to the housing agenda, including supported housing. In addition, an interim director has recently joined the County Council with a housing background, who is also helping to accelerate this work as covid has illustrated that the public are seeking alternatives to traditional options such as care homes.

Projecting Levels of Need:

With regard to extra care, estimating levels of need is difficult as it includes not only analysis of population, health and social care data, but also the impact of care and support models and perceived value for money. As outlined above, the current figures are based on a national benchmark and a local tool. As a result of more purpose-built extra care developments opening, demand information will also be evaluated. Needs figures will continue to be updated and reviewed to ensure that we are able to project the need for services over a longer period given the length of time that it takes to build extra care.

Promotion of Extra Care:

The promotion and marketing of the benefits and opportunities afforded by more independent living will gather pace as new buildings and opportunities arise. People who may benefit from such housing developments and those who make referrals to them will need to be kept up to date with the progress and benefits to ensure continued success and maximum occupation of new developments.

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Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

Finance

N/A

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel
Housing with Care and Support Strategy 2018-2025: https://www.lancashire.gov.uk/media/912048/housing-with-care-strategy.pdf	September 2018	Sarah McCarthy 01772530551

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny

Housing with Care and Support Strategy Update

1st February 2022

Lancashire County Council

Extra Care in Lancashire

Lancashire County Council

Key Features and Benefits for People living in Extra Care

- Care and support staff on site 24/7
- Additional care and support through a package of home care if needed
- 24-hour emergency help through an alarm system
- A minimum age for residents, usually 55
- Self-contained flats allow people to live safely and independently for longer
- Accommodation for short term needs such as hospital avoidance or convalescence following a hospital stay is being explored
- Communal lounges allow people to socialise as and when they feel like it
- Social activities arranged for residents and the wider community
- On site facilities such as hairdressers, bistros/cafes and even a dance floor!

- The ambition of Lancashire County Council's **Housing with Care and Support Strategy 2018– 2025** is to have at least one Extra Care facility in each district of Lancashire and about 1,000 homes by 2025
- Extra Care housing offers independent living for 55+ with a range of facilities and support options on site
- **Key Progress to Date**
  - 3 new schemes (197 flats) in Chorley, Fleetwood and Preston opened since 2019
  - Total schemes now operating: 5 purpose-built schemes (350 flats) and 8 combined sheltered and extra care schemes (331 flats including sheltered and extra care flats)
  - 1 new scheme in Chorley will open in 2022
  - 14 new schemes under discussion or development which would deliver around 750 new units (schemes with identified sites included). This includes one on the site of new/replacement LCC run care home in Wyre
  - A Needs Analysis Tool is now available to assist developers and providers in their assessments and considerations of potential locations for new schemes
  - Cabinet have confirmed that LCC will consider contributing land, where available and appropriate, but will not be establishing a capital programme pot


Primrose Gardens Chorley


The Courtyards, Preston

New Developments
Delivered since 2019

- Primrose Gardens, Chorley. 65 apartments

- Lighthouse View, Fleetwood. 72 apartments

- The Courtyards, Preston. 60 apartments

Lancashire County Council

District	Existing Purpose built Extra Care units/flats	Existing Combined sheltered/extra care schemes	**New Schemes under Discussion or in Development**
Burnley	0	0	Burnley hospital site (90 units) subject to planning approval Second scheme with identified site under discussion
Chorley	65	0	Tatton Gardens(62 units) completion due August 2022
Fylde	0	1	2 schemes under discussion with specified sites
Hyndburn	0	2	Preferred site identified and discussions taking place
Lancaster	0	0	University of Cumbria (Lancaster site) 92 units, planning approval obtained, subject to funding, completion 2024 Second scheme - planning application for scheme in north Lancaster submitted (60-75 units)
Pendle	0	0	Bankhouse Road site, Nelson, - 2 registered providers submitting proposals
Preston	60	1	Miller Street (61 units) planning approval and funding in place/completion 2024
Ribble Valley	0	1	Early discussions taking place
Rossendale	42	0	Discussions commencing with new Strategy Manager
South Ribble	0	2	West Paddock (Leyland), 72 units, subject to planning approval
West Lancashire	111	1	Toby Inn site, Skelmersdale, 60 units (subject to planning and funding approval) completion 2024
Wyre	72	0	Garstang (Bowgreave rise) (60 units)

Burnley Hospital Site – Extra Care

- 90 units
- Calico
- Planning application submitted

Joint Working and Access to Extra Care

Lessons Learned and Improved Ways of Working for the Future

Joint Allocation Panels are in place for all schemes which promote joint working and improved awareness and communication between LCC, landlords and care providers

Extend use of Housing Portal to extra care to improve awareness of Extra care amongst social workers

Improved referral pathway for social workers – task group has developed proposals which are under consideration

Consultation is being undertaken with landlords, district councils, social care providers and LCC social care teams to understand the lessons learned from the 3 new recently opened schemes in relation to:

- Design, planning and build
- Care and support model
- Allocations policy
- Needs assessment, commissioning and procurement

The lessons learned will be applied as more new schemes are developed

A more joined up approach to accelerate new developments - the County Council and District colleagues are establishing a more joint approach to accelerate the pace of new developments

Feedback from from Tenants at Primrose Gardens and The Courtyards

Primrose Gardens

- “I love the company I have here, the staff are great, and I feel safe and secure. I am very happy here at Primrose Gardens”
- ”We feel really secure here and don’t worry about our safety. We are in central location and can to anywhere from where we are”
- “EVERYTHING- The apartments are modern and gorgeous; the staff are friendly and helpful. The location is fantastic. We love the activities and entertainment that is provided”

The Courtyards

- “I moved up from Bristol to be near my family. After my husband died, I felt isolated in my bungalow. When I moved into The Courtyards, I cried tears of joy! The staff are brilliant, and I’ve made so many friends already. There’s a real community spirit that you don’t get when living alone.”
- “I moved to The Courtyards with my wife, who has some health problems. We don’t need care services yet, but it is reassuring to know its here when we do. We feel completely safe here. I’ve already made myself at home on the outdoor exercise equipment. Touches like that make a real difference.”

Lancashire County Council

Lighthouse View Extra Care Fleetwood

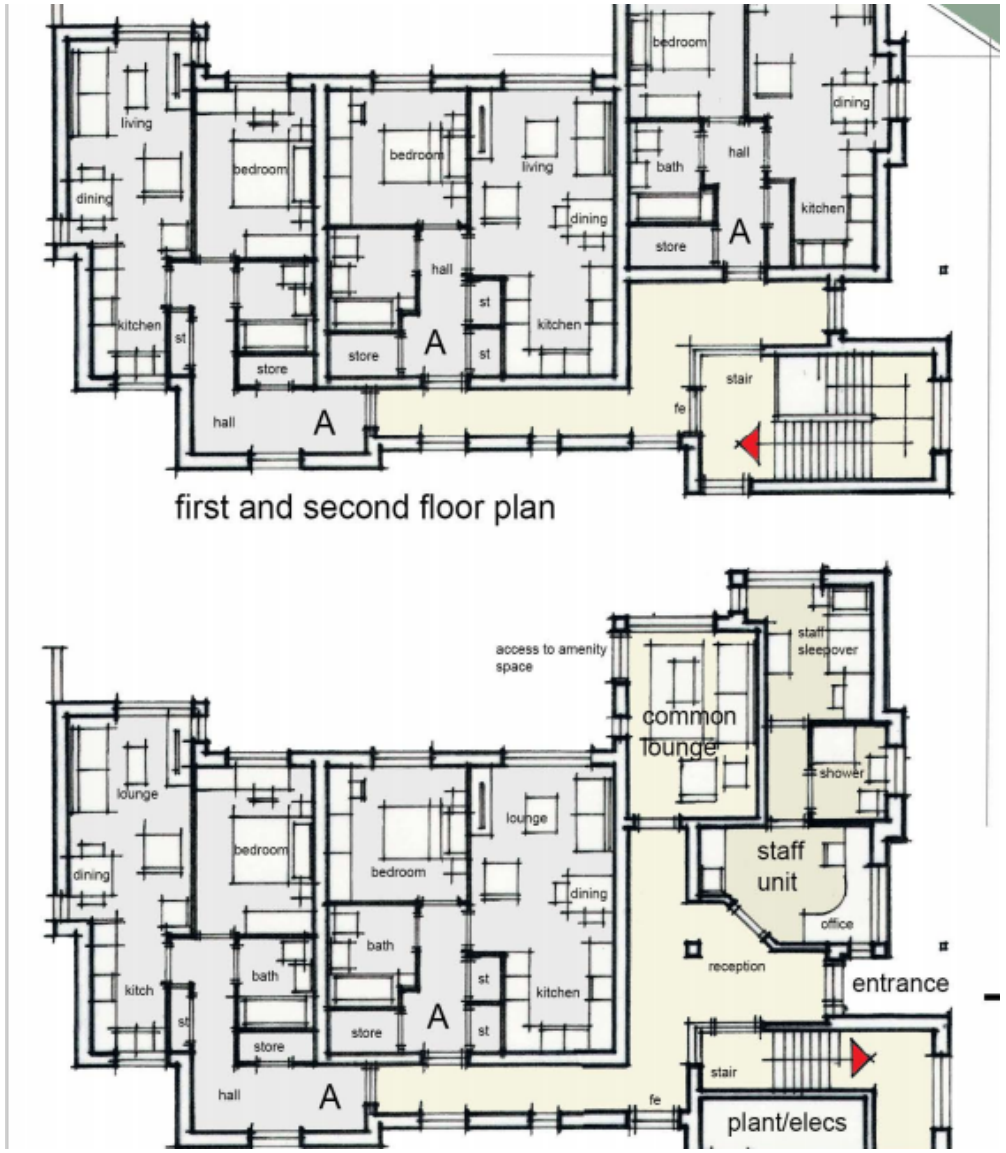
Diane Emmison, Supported Housing Manager (Regenda Homes)

Lancashire County Council

Supported Accommodation in Lancashire

Lancashire County Council

- The ambition of Lancashire County Council's Housing with Care **and Support Strategy 2018– 2025 is to modernise the** supported housing offer.
- Supported living accommodation offers independent living, with care and support, for working age adults with a learning and/or physical disability
- New apartment and bungalow settings are replacing traditional 'shared living' properties.
- The new settings will offer individuals their own front door, choices of furniture, access to communal areas and opportunities to live as part of a community whilst maintaining a degree of independence.
- **Key Progress to Date**
  - 106 new homes delivered to date
  - 89 new homes in the development pipeline for completion in 2022
  - 21 properties have been retired across Lancashire
  - £1.3million savings achieved
  - A new Referral Pathway has been developed to increase awareness of the offer and to ensure the right decisions are made for the people living in these new homes.



New Developments Delivered

- Strawberry Court Morecambe x 6 apartments
- Albion Street Padiham x 7 apartments
- Edge End Lane Great Harwood x 6-person house
- Lime Place Colne x 11 apartments
- Christchurch Accrington x 10 apartments
- Noel Road Lancaster x 4 apartments
- The Limes Nelson x 7 apartments
- Foxhills Nelson x 10 Bungalows
- Bright Street Colne x 10 Bungalows
- Florence Avenue Burnley x 6 Bungalows
- Orchard Road St Anne's x 7 apartments
- Balshaw Avenue Chorley x 5-person bungalow
- Waterford Close Preston x 5-person house
- Claret Close x 7 Bungalows
- Mayfield Avenue Preston 1 of 4 single tenancies
- Hub & Spoke x 4 single tenancies linked to Albion Street Padiham

Florence Avenue Burnley

Bright Street Colne

New Development Pipeline 2022

Slyne Road Lancaster

- Higher Morrises Farm, Leyland x 7 apartments & 1 bungalow
- Parkinson House, Preston x 6 apartments
- Slyne Road, Lancaster x 12 apartments
- Cumberland Court, Lancaster x 8 apartments
- University Of Cumbria, Lancaster x 12 apartments
- Eldon Street, Preston x 14 apartments
- Brook Street, Chorley x 12 apartments
- Sycamore Avenue, Burnley x 6 apartments
- Wellfield Drive, Burnley x 4-person property

The Good Neighbour Scheme

The **Good Neighbour Scheme** offers subsidised rents in return for informal support

The Good Neighbour may be a student nurse or social worker who has enhanced DBS and interest in LDA/ MH

- Check on neighbours to make sure they are well
- Develop friendships with neighbours, help out with small tasks such as shopping, changing a light bulb, taking a walk or walking the dog
- Assist neighbours with utilising technology such as online shopping or helping with a Zoom meeting
- Help out in an emergency situation such as a water leak, severe weather or an evacuation due to fire

Slyne Road, Lancaster

- Planning consent granted
- Onsite ripping out
- 12 months handover August 2022
- Delay due to planning delays (Covid 19)

Cumberland Court - Lancaster

- Purchase in progress – Registered Provider Halo
- Anticipated handover date March 2022
- 4 apartments (6 person)

2 x Ground Floor for 1 person

2 x First Floor for 2 people

Florence Avenue, Burnley

- Keith says he is very proud of his new bungalow and really enjoys mowing his lawn

Orchard Road, St Anne's

Service User Quotes

- “I’ve waited all my adult life to live independently and my flat is my safe space. I’ve grown more independent, become more social and love where I live”

- “The new flat scheme has allowed me to live how I’ve always wanted”

Orchard Road, St Annes

- Staff quote

“it has been a pleasure to be here from the beginning to see the project unfold into such a positive and welcoming environment.

The people we support who live here are a pleasure to be around and have settled into their new homes with such enthusiasm and dedication to making their flats person centred and homely”.

Added Value and Benefits for People living in Supported Accommodation

- Increased independence
- Less restrictive living
- Own space, front door, choice of furniture
- Increased choice in how to live
- Making new friendships
- Living in the heart of a community
- Greater access to social activities and opportunities for volunteering and employment

Lancashire County Council

Orchard Road, St Anne's

Summary of Current Position

- Some fantastic progress over the last few years
- The pandemic has highlighted the need for more flexible housing options for older people and working age adults with a disability
- Lancashire has great ambition and some very interested and willing developers and registered providers, and good working relationships with Homes England
- Some challenges do exist, not just in Lancashire
- Development costs are significantly higher than a year ago
- Some developers are withdrawing plans as the figures simply don't add up
- Availability of land is a key constraint
- The lack of workforce across the whole of health and social care is also impacting on extra care and supported living settings
- Increase in demand for assessments and an increase in complexity of need is causing some delays in identifying appropriate settings for some
- Fire safety risk has become a national issue, consequently we are working with providers on individual property basis

Lancashire County Council

Thank you for listening

Questions?

Lancashire County Council

Health Scrutiny Committee
Meeting to be held on Tuesday, 1 February 2022

Electoral Division affected:
(All Divisions);

Corporate Priorities:
N/A

Report of the Health Scrutiny Steering Group
(Appendix 'A' refers)

Contact for further information:
Gary Halsall, Tel: 01772 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Brief Summary

Overview of matters presented and considered by the Health Scrutiny Steering Group at its meetings held on 10 November, 1 December 2021 and 5 January 2022.

Recommendation

The Health Scrutiny Committee is asked to receive the report of its steering group.

Detail

The steering group is made up of the chair and deputy chair of the Health Scrutiny Committee plus two additional members, one each nominated by the Conservative and Labour Groups.

The main purpose of the steering group is to manage the workload of the committee more effectively in the light of increasing number of changes to health services which are considered to be substantial. The main functions of the steering group are listed below:

1. To act as a preparatory body on behalf of the committee to develop the following aspects in relation to planned topics/reviews scheduled on the committee's work plan:

    - Reasons/focus, objectives and outcomes for scrutiny review;
    - Develop key lines of enquiry;
    - Request evidence, data and/or information for the report to the committee;
    - Determine who to invite to the committee;

2. To act as the first point of contact between scrutiny and the health service trusts and clinical commissioning groups;

Lancashire County Council

3. To liaise, on behalf of the committee, with health service trusts and clinical commissioning groups;

4. To make proposals to the committee on whether they consider NHS service changes to be 'substantial' thereby instigating further consultation with scrutiny;

5. To act as mediator when agreement cannot be reached on NHS service changes by the committee. The conclusions of any disagreements including referral to secretary of state will rest with the committee;

6. To invite any local councillor(s) whose ward(s) as well as any county councillor(s) whose division(s) are/will be affected to sit on the group for the duration of the topic to be considered;

7. To develop and maintain its own work programme for the committee to consider and allocate topics accordingly.

It is important to note that the steering group is not a formal decision-making body and that it will report its activities and any aspect of its work to the committee for consideration and agreement.

- **Meeting held on 10 November 2021**

Local NHS Winter Preparations

The Chair welcomed to the meeting David Bonson, Director of Urgent and Emergency Care at the Lancashire and South Cumbria Integrated Care System (ICS).

The Steering Group considered a presentation, delivered by David Bonson, about local NHS winter preparations. It was highlighted that:

- Preparing for winter involved planning with partners across the whole system. Each area had its own A&E Delivery Board, usually chaired by the local NHS Trust Chief Executive, to bring together partners to discuss impacts on the urgent care system. This facilitated a bottom-up process for winter planning, rather top-down planning by the ICS, and meant each area devised its own plan to increase capacity during winter.

- In addition to working with each A&E Delivery Board, the ICS provided a coordinating role across the whole Urgent and Emergency Care Network to share good practice and plans.

- Winter planning had started earlier than usual this year as the ICS recognised the pressures of the pandemic still affecting the health and care sector. For instance, over summer 2021 a workshop had been arranged with key partners to discuss the lessons learned from the pandemic.

- Every year, NHS England and NHS Improvement North West developed its own assurance process and checks. This year, A&E Delivery Boards had been asked to review their winter plans against key questions and submit their responses by the end of September. Similarly, the ICS had submitted its response by mid-October. This exercise had helped to identify the biggest risks posed to local delivery plans, which every A&E Delivery Board had identified as the workforce.

- Each A&E Delivery Board had its own initiatives and priorities within the resources available. Additional resources had been provided nationally for increased 999 and 111 service capacity, £2.2m additional funding had been allocated from the Ageing Well Fund for the 2-hour Urgent Community Response service, and £76.m had been allocated to Lancashire and South Cumbria from the National Primary Care Access Fund. The latter aimed to improve same-day accesses to primary care and the resilience of the NHS urgent care system. Despite these extra resources, workforce and recruitment remained a key challenge to the delivery of local plans.

- The Lancashire and South Cumbria Hub (Gold Command) had been established to bring partners together and provide support across the whole system. The Hub was operational 7 days a week and provided a single point of communication across the North West region. So far it had successfully facilitated tactical responses and plans which required system-wide collaboration.

- Nationally, key concerns for the winter included 12-hour waits in Emergency Departments, the timely discharge of patients without clinical criteria to reside, and ambulance handover delays at Trusts. In Lancashire, a previous focus on ambulance delays had led to the introduction of better systems and processes such that the ICS was the best performing in the North West. Nonetheless, it remained a priority.

- A 6-point recovery plan had been devised with the North West Ambulance Service (NWAS). The agreed system actions were to focus on hospital handovers, to focus on mental health so that patients avoided visiting the Emergency Department where possible, and to avoid the conveyance of patients in ambulances by looking to alternative approaches. The agreed NWAS actions were to provide additional double-crewed ambulance capacity, to reduce the conveyance of patients in order to generate ambulance capacity, and to maximise the use of staff by reducing 'lost hours'.

- Communication and engagement across all levels of the system was key, particularly to encourage patients to make the right choices, such as using the 111 online service first. The communication strategies made use of social media and targeted deprived communities to promote the use of pharmacies and flu vaccinations, for example. The ICS was also working with Healthwatch

Lancashire to assess whether patients try an alternative before attending A&E, and whether those alternatives were helpful to them.

During a period of discussion and in response to questions from members, the following points were raised:

- Technically, the figure reported nationally for patient wait times was the time following a decision to admit. Increasingly, however, the figures on 12-hour waits in Emergency Departments covered a patient's true wait time, from arrival to departure, and therefore gave a better view of the patient experience. A set of proposed measures were expected to replace old guidance on recording wait times.

- SDEC stood for Same Day Emergency Care and covered patients who did not need to be admitted to hospital yet required further investigation or treatment on the day.

- Generally, staff within the ICS were worried about the winter months, particular about the pressure that would be placed on an already strained workforce. Work was ongoing to support frontline staff and their health, and to discuss with local council officers about increasing service capacity by engaging the voluntary sector without destabilising the work of the council.

- The good working relationships across the Lancashire and South Cumbria network had been strengthened during the pandemic and there was a willingness from partners to work together to find solutions. One of the challenges to urgent care included the complex arrangements between multiple organisations, each with varying responsibilities in a complex care pathway. Planning and handover between organisations was not always seamless, yet making plans to resolve such long-term, strategic issues was difficult whilst frontline staff only had capacity to plan for the next day. A similar problem faced primary care as communicating with different, independent GPs holding different types of contract was difficult.

- It was key that ambulance staff had alternative options to just transporting a patient to A&E. The ambulance service was able to contact GPs for advice and linking with the 2-hour Urgent Response Team would reduce the likelihood of admitting a patient to hospital or the need to provide an ambulance at all. Improved communication with primary care would lead to fewer hospital admissions by providing ambulance crews with an alternative care option to A&E.

- Generally, hospitals tried to maintain separation between SDEC patients and A&E patients, however some SDEC departments were small and quickly contributed to the visible congestion in A&E. Only patients with life threatening situations should be in A&E, but the number of people passing through A&E was too great to maintain separate pathways.

The Chair thanked David for the presentation on local NHS winter preparations.

Resolved: That the presentation on local NHS winter preparations be noted.

NHS 111: First 12 months

The Chair welcomed to the meeting, Jackie Bell, 111 Head of Service at the North West Ambulance Service NHS Trust.

The Steering Group considered a presentation, delivered by Jackie Bell, which provided an overview of the first 12 months of the NHS 111 service. It was highlighted that:

- During the pandemic, 111 First became standard practice and it helped to reduce the risk of Covid-19 by preventing patients visiting A&E unnecessarily. If needed, patients were given a booking slot (not an appointment) to visit A&E, which helped to manage the number of people in Emergency Departments at any one time and to triage patients to the correct service from the outset.

- The minimum viable product of 111 First included significantly increasing the capacity of the 111 Service, making alternative secondary care services available to 111 service users, implementing an Emergency Department booking and referral system, evaluation and monitoring, and an effective communications strategy.

- The North West Ambulance Service had achieved a number of key developments for 111 First, including: the recruitment and training of additional advisors; increasing clinical capacity to validate Emergency Department outcomes and to direct patients to the correct service; ensuring all clinical pathways were reflected in the Directory of Service; connecting with GPs to book directly into their appointment systems; implementing a booking system for Emergency Departments in order to review patients before their arrival at A&E; developing a robust communications plan (though this could not be realised due to the pressures of the pandemic); and evaluating the impact of 111 First.

- Analysis of service activity highlighted that, despite the increased number of calls to 111 due to the pandemic, more patients had been triaged in September 2021 than in September 2020. In Lancashire and South Cumbria, the number of callers recommended to visit A&E stayed consistent from September 2020 to September 2021, however the number of callers recommended to attend primary/community care or not to attend another service increased. This prevented people arriving at A&E unnecessarily and demonstrated that clinical assessment services were fulfilling their role. For

instance, only 1,528 of the 3,133 Emergency Department referrals received ended up visiting A&E; the remainder were referred to other services.

- Patient feedback was collected continuously for 111 service users, but a specific NHS 111 survey had also been completed by 1,577 respondents between August and October 2020. 95% of respondents were satisfied that NHS First met their needs. 90% were provided with a booking slot for a service and 5% needed 999 ambulance intervention. For the 7% of respondents who did not describe their experience as 'good' or 'very good', the long wait at A&E or the long wait before their call to 111 was answered were key factors.

- Possible challenges to the service during Winter 2021 included high demand for 111, 999 and out-of-hours NHS services, as well as the availability of booking slots at Emergency Departments.

In response to questions from members, it was clarified that:

- Data on the waiting times at individual hospitals in Lancashire and South Cumbria would be provided to members after the meeting, plus data from Southport General Hospital.

- The total number of abandoned calls (a third of all 111 calls received) included calls lasting a minimum of 30 seconds. The call profile had completely changed since February 2021, with the peak number of calls now received at 9 am, rather than after 6.30 pm. It was felt that the busyness and unavailability of primary care services had contributed to this shift, with callers unable to book at GP appointment by 9 am. The number of 111 calls received far outstripped the service's capacity, hence the high number of abandoned calls. Nationally, all 111 services were experiencing similar challenges, which would be alleviated in the short term by extra funding received for the winter months.

- It was anticipated that demand for 111 services would normalise after the pandemic, however it continued to be 35-40% higher than pre-covid levels. However, contracts for funding had not been revised to reflect the increase in demand.

- Data relating to 2020 and 2021 have been provided to demonstrate the impact of 111 First, however data relating to previous years was used continuously to monitor changes in demand. It was difficult to find a new baseline because demand continued to vary on a weekly and monthly basis. Nonetheless, it was still possible to identify an overall increase. For example, 7,000-7,500 calls would be received on a typical Sunday pre-covid, which had risen to 10,000 calls on a typical Sunday.

- Due to the closure of GP surgeries over Christmas, it was expected that the 111 service would experience an increase in demand.

- Patient expectation was also affecting demand for services, with people wanting to be well immediately, or calling 111 if their GP did not administer antibiotics. To combat this, there was a strong need for a communications strategy about self-care and home remedies. The North West Ambulance Service was also working with the Cheshire and Mersey paediatric network to provide parents with specialist advice. It would be useful to build on this idea in Lancashire and South Cumbria.

- At some point, a new baseline would need to be established and reviewed, with a budget to match. At the moment, the provision of services could not keep up with demand.

The Chair thanked Jackie for the presentation on NHS 111 First and noted that the Steering Group had learned some interesting points about the need for additional funding and the problems facing primary care.

During a period of discussion about recruitment and funding in the NHS, the Steering Group felt there was a need for an education programme by Public Health in order to reduce demand for NHS services. It was also suggested that the Steering Group could review primary care services in Lancashire.

It was noted that the Health Scrutiny Committee had last received a report from Health Education England in March 2018. It was suggested that Health Education England be invited to a meeting of the Steering Group in 2022 to discuss local workforce risks, recruitment, and training in the NHS. Whereupon it was:

Resolved: That

i) The presentation on NHS 111 be noted; and

ii) That Health Education England be invited to attend a future meeting of the Health Scrutiny Steering Group to discuss workforce risks, recruitment, and training.

Outbreak management and infection control - Adult Social Care

The Steering Group reviewed a report about the management of Covid-19 outbreaks within adult social care settings in Lancashire, provide by the county council's Adult Social Care Service.

It was agreed that the Steering Group would seek assurance from the county council's Executive Director of Adult Services and Health & Wellbeing that outbreaks of Covid-19 were still being effectively managed in Lancashire's care homes and request more information from the Adult Social Care Service on the effectiveness of the controls in place to minimise the risk of Covid-19.

Resolved: That

i) The report on outbreak management and infection control be noted; and

ii) The Adult Social Care Service be asked to provide more information on current infection control measures in care homes.

Health Scrutiny Steering Group Briefing Report

The Steering Group considered a briefing report on recent news and developments relevant to the county council's administrative area and Health Scrutiny function.

It was noted that a report on the activity of the Joint Health Scrutiny Committee with Cumbria County Council would be presented to the Health Scrutiny Committee once the minutes of the meeting held on Tuesday 9 November had been produced by Cumbria County Council.

Resolved: That the Health Scrutiny Steering Group briefing report be noted.

- **Meeting held on 1 December 2021**

Continuing Healthcare and Joint Funding in Lancashire

The Chair welcomed to the meeting Ian Crabtree, Director of Adults Disability and Care Services and Saad Kafrika, County Operations Manager for Continuing Health Care (CHC) and Joint Funded Packages of Care, Lancashire County Council.

The Steering Group considered a briefing note on Continuing Healthcare and Joint Funding in Lancashire. During a period of discussion and in response to questions from members, it was highlighted that:

- The Midlands and Lancashire Commissioning Support Unit (MLCSU) provided the necessary administrative support to Clinical Commissioning Groups across the Midlands, Lancashire and South Cumbria. It was possible that the MLCSU would be subsumed by plans for the Integrated Care System in the future.

- Transformation of Continuing Healthcare in Lancashire and South Cumbria through a new hub and spoke model was being overseen by the Funded Care Implementation Board (FCIB), chaired by Talib Yaseen (Director of Transformation, Lancashire and South Cumbria Integrated Care System) and deputy chaired by Ian Crabtree. The new model would be implemented over a phased period beginning in April 2022.

- When a local authority provided funding for a patient's primary healthcare, in circumstances where the NHS failed to make a decision, there were two main

impacts on patients: a financial impact, for the care provided by the authority; and a potential health risk due to the lack of clinical oversight and case management from the NHS. Patients would still receive some input through their GP or nurse, for example, but oversight of these cases was instead provided by social care workers rather than the NHS.

- Due to the poor performance of Continuing Healthcare in Lancashire and South Cumbria, there was a backlog of incomplete referrals to respond to. The NHS had recognised the need to clear this backlog, however the county council had disputed the NHS' decision to award Continuing Healthcare for backlogged cases from the date the application was accepted, rather than from the date of the initial application (sometimes several years prior). Conversations to resolve this dispute were ongoing and making positive progress. Officers would update the Steering Group as decisions were agreed.

- As set out in the report, the MLCSU planned to write to all individuals with incomplete Continuing Healthcare referrals to ask whether they would like their application to be reviewed. Again, the county council and other local authorities disputed this decision as the letters required a technical understanding of Continuing Healthcare and the NHS had failed to direct people to adequate support.

- Although recognising that the NHS workforce was under huge pressure from the pandemic and vaccination programme, it was felt social care staff should not have to gather and collect evidence of health needs to justify Continuing Healthcare decisions. The county council was currently paying social care staff to carry out this work, despite legal responsibility residing with the NHS.

- Officers would investigate further the advocacy available to Continuing Healthcare patients through the Clinical Commissioning Groups. Generally, the Clinical Commissioning Groups and Integrated Care System had realised the importance of patient feedback and a patient forum was being developed, which would form part of Continuing Healthcare's infrastructure. Service user representatives had also attended the last meeting of the Funded Care Implementation Board (FCIB) and feedback was positive. Clarification would be needed in relation to the advocacy offer from Clinical Commissioning Groups. However, it was possible that the county council's advocacy services were providing support to affected individuals in the meantime, but this point would also need further investigation.

- The Judicial Review into Continuing Healthcare had been prompted by Rear Admiral Philip Mathias, who sought an overhaul of the current system and whose main concern was the unexplained variation in Continuing Healthcare decisions and outcomes across different Clinical Commissioning Groups. The High Court had declined the initial request and preparations were underway to

appeal that decision. Nonetheless, work was ongoing to respond to the concerns raised, as set out at Section 8 of the report.

- It was important that the Health Scrutiny Steering Group continued to scrutinise, from an external perspective, the relationship between county council and NHS officers, to ensure its effectiveness at achieving the desired outcomes.

It was agreed that Ian Crabtree would attend another meeting of the Steering Group in three months' time to update members on progress made to improve Continuing Healthcare in collaboration with the NHS.

It was agreed that members were concerned by the information provided in the report and that the Steering Group would continue to monitor improvements to Continuing Healthcare in Lancashire.

The Chair thanked Ian Crabtree and Saad Kafrika for their attendance and responses to members' questions.

Resolved: That

i) The briefing note on Continuing Healthcare and Joint Funding in Lancashire be noted; and

ii) County council and NHS officers be asked to present an update report on Continuing Healthcare and Joint Funding in Lancashire at a meeting date to be agreed.

Adult Social Care Workforce resilience, wellbeing, sufficiency - focus on domiciliary care

The Steering Group considered a briefing note on workforce resilience, wellbeing and sufficiency in Adult Social Care. During a period of discussion about the workforce challenges faced by the sector, it was agreed to request a written response from officers to the following questions:

1. In which specific areas and roles are there staff shortages in Lancashire and should longer-term plans be considered to address them?

2. What training programmes (such as National Vocational Qualifications) are available to social care staff on the job, which might provide incentives to progress and remain in the sector?

3. Is the lack of training and opportunities to increase proficiency a key reason for the sector's current staffing difficulties?

It was agreed that an item on Adult Social Care workforce would be added to the Health Scrutiny Work Programme and be scheduled for a Health Scrutiny Committee meeting in Spring 2022.

Resolved: That

i) The briefing note on Adult Social Care Workforce resilience, wellbeing and sufficiency be noted;

ii) Officers from Adult Services be asked to provide the Health Scrutiny Steering Group with a written response to its questions, as set out above; and

iii) A further report on Adult Social Care workforce be scheduled for a Health Scrutiny Committee meeting in Spring 2022.

Work Programme 2021/22

The Steering Group reviewed the Health Scrutiny Work Programme for 2021/22.

It was noted that the Health Scrutiny Committee meeting scheduled for 14 December 2021 would be cancelled due to the need to defer the two planned items, as follows:

- The report on the Enhanced Acute Stroke Services programme for Lancashire & South Cumbria had been deferred to the committee meeting on 1 February 2022, due to NHS officer availability.

- Confirmation about the report on the workforce GP shortage had not been received. There appeared to be some unease within the NHS about presenting to the Health Scrutiny Committee at this stage, amidst complex changes to the workforce resulting from the new Health and Care Bill, plans for the Integrated Care System and a proposed People Board. As an alternative, it was suggested that NHS officers attend the next scheduled meeting of the Steering Group on 5 January 2022 to provide members with relevant background information. Following that, the Steering Group could consider an appropriate time for a full report to the Health Scrutiny Committee.

During a period of discussion about cancelling the next meeting of the Health Scrutiny Committee, County Councillor Lizzi Collinge suggested holding a briefing meeting instead (for example about the Housing with Care and Support Strategy report) and expressed an unwillingness to disappoint members and co-opted members of the committee. It was noted that moving the aforementioned item from 1 February 2022 to 14 December 2021 would not give sufficient notice to Adult Services, who planned to bring providers and service users to the meeting.

The Chair also informed the Steering Group that he had looked at the work programme with Gary Halsall, Senior Democratic Services Officer, and reluctantly concluded (in agreement with the Chair of the Scrutiny Chairs and Deputies Forum)

that it was not feasible to bring any other items forward. It was also impractical to postpone the meeting to January 2022. Therefore, the Steering Group noted the decision to cancel the meeting of the Health Scrutiny Committee scheduled for 14 December 2021.

Due to the deferral of reports from December's Health Scrutiny Committee meeting, it was likely that the meeting scheduled for 1 February 2022 would cover three or four items, as set out by the revised Health Scrutiny Work Programme. However, it was noted that the county council's Public Health and Wellbeing Directorate had not yet responded to the committee's request for a report on early intervention and social prescribing.

A number of reports were currently planned for the next meeting of the Steering Group on 5 January 2022, though it was noted that:

- Officers had been unable to identify an NHS contact for the requested report about the high intensity user programme, but efforts to do so continued.

- The planned report on building and enduring a health protection function beyond Covid-19 would be deferred, due to the recent government and international response to new Covid variants.

- Following confirmation from David Blacklock, Chief Executive of Healthwatch Lancashire, that People First had secured the contract for Healthwatch services in Lancashire for three more years, the report on collaborative ways of working with Healthwatch Lancashire was also confirmed.

- Further updates on the New Hospitals Programme were expected. The Health Scrutiny Committee had agreed at its last meeting to review the shortlist of programme options once it was available, though a progress update to the Steering Group in January would still be useful. The Steering Group had also requested sight of the shortlist prior to publication.

It was highlighted that scrutiny of the New Hospitals Programme needed to be carefully managed and transparent. The Steering Group were informed that Healthwatch Lancashire had met with some of the campaign groups concerned with the programme and aimed to facilitate positive conversations between the groups and the programme's leadership. Members of the Steering Group were welcome to attend a meeting organised by Healthwatch Lancashire in December 2021, at which key themes of the campaign groups' concerns would continue to be identified and discussed.

In response to County Councillor Stuart Morris' request to present to the committee, as Champion for Mental Health, on mental health activities in Lancashire, it was agreed that an item would be added to the Health Scrutiny Work Programme for an appropriate time in Spring 2022.

Resolved: That

i) The suggestions to revise the Health Scrutiny Work Programme 2021/22, as discussed and set out above, be agreed; and

ii) The meeting of the Health Scrutiny Committee scheduled to be held on 14 December 2021 be cancelled.

Health Scrutiny Steering Group Briefing Report

The Steering Group considered a briefing report on recent news and developments relevant to the county council's administrative area and Health Scrutiny function.

It was agreed that the reports into concerns about the Urology and Trauma and Orthopaedics Services at the University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT), which had been shared with members via email, were alarming. The issues raised about culture were especially concerning.

In response to a query about asking Cumbria and Lancashire Joint Health Scrutiny Committee to review the reports into UHMBT, the Steering Group were informed that, as it was established on a discretionary basis, the joint committee had a wide remit. It was noted that a meeting of the joint committee was likely to be arranged for early 2022.

The Chair highlighted that the focus of the Steering Group should be on monitoring the implementation of the necessary changes.

The Steering Group agreed to request a summary of the full 250-page report, before reaching a decision on how to monitor improvements. It was agreed to invite NHS officers from UHMBT to attend the next meeting of the Steering Group to discuss the report in relation to both services.

Gary Halsall, Senior Democratic Services Officer also provided the Steering Group with the following additional information:

- At its meeting on Thursday 2 December, the Cabinet would consider revised Terms of Reference for the Lancashire Health and Wellbeing Board.

- The next meeting of the Joint Health Scrutiny Committee for Hyper-Acute Stroke Services across North Mersey and West Lancashire was likely to be arranged for Friday 28 January 2022. The date would be confirmed in due course.

- A new page dedicated to Adult Social Care had been launched on the county council's intranet.

Resolved: That

i) Officers from the University Hospitals of Morecambe Bay NHS Foundation Trust be invited to the meeting of the Health Scrutiny Steering Group on 5 January 2022, to present and discuss a summary of the report into concerns about the Trust's Urology and Trauma and Orthopaedics Services; and

ii) The Health Scrutiny Steering Group briefing report and additional information be noted.

- **Meeting held on 5 January 2022**

UHMBT - Urology and Trauma and Orthopaedic Services

The Steering Group noted that this item had been deferred to the meeting on Wednesday 9 February 2022, at 10.30 am, due to increased pressures on the University Hospitals of Morecambe Bay NHS Foundation Trust as a result of the Covid-19 pandemic.

Update following the last meeting: Adult Social Care Workforce resilience, wellbeing and sufficiency - focus on Domiciliary Care

The Chair welcomed to the meeting Tony Pounder, Director of Adult Services, who provided a presentation to respond to the Steering Group's questions, in relation to the Adult Social Care workforce, which were raised during the last meeting.

1. In which specific areas and roles are there staff shortages in Lancashire and should longer-term plans be considered to address them?

In response to this question, it was highlighted that workforce shortages were driven by several factors including demographic changes and the increasing number of people needing care services, competition in the labour market with better salaries and progression opportunities offered by other organisations, changes to immigration rules, and a lack of targeted recruitment across the care sector. In Lancashire, staff shortages were prevalent in rural and affluent areas and there were shortages of registered managers and nurses to support care homes in particular. As a long-term problem, a long term plan was needed to address these workforce problems.

2. What training programmes (such as National Vocational Qualifications) are available to social care staff on the job, which might provide incentives to progress and remain in the sector?

There already existed a number of training opportunities and the Government had expressed its willingness to expand these opportunities, particularly for frontline care staff, which would be funded in part by the coming National Insurance levy. It was costly for care companies to provide staff with training, so there was little incentive for smaller companies (of which there were between 500 and 600 in Lancashire) to invest in training. Investment was required from larger agencies and the

Government, although additional training would not resolve other factors, such as salary or the nature of care work.

3. Is the lack of training and opportunities to increase proficiency a key reason for the sector's current staffing difficulties?

Although training and development were important, others factors also contributed to the wider workforce problems faced by the sector. Job status, job satisfaction, and salary limits were key. Although temporary measures had helped to retain staff through the winter months, they were unlikely to solve the underlying problems which would affect the care sector for the next five years and beyond.

In response to questions from members, the following information was also provided:

- Figures about demographic changes and increasing care needs over the next 5 to 10 years would be provided to members after the meeting.

- Recently, the county council had focussed on increasing the care schemes available in Lancashire. Generally, smaller care homes provided a better quality of care, whereas larger care homes sometimes struggled to deliver reliable and personalised care. This created a gap between the requirements and aspirations of investors (generally into large care homes), and the reality of care quality as measured by the council and the Care Quality Commission.

- Improving care staff's wage would likely improve the competitiveness of social care in the job market. There had been a notable shift from local authorities and towards private provision of care over recent years, which had led to a more casualised workforce and resulted in more local authorities paying high rates for private companies to provide staff.

- In order to resolve long-term staffing problems, it was important that jobs in the care sector were not solely promoted as entry-level jobs that led, for example, to careers elsewhere. Nonetheless, better training and progression opportunities would help care staff to carry out their roles more effectively.

The Chair thanked Tony for his presentation and responses to the Steering Group's questions. It was noted that the information provided would be included in the report of the Steering Group to the Health Scrutiny Committee, which would provide another opportunity to discuss the issues raised. **[A copy of the presentation is set out at appendix A to this report.]**

New Hospitals Programme Update

The Chair welcomed to the meeting Rebecca Malin, Programme Director, and Jerry Hawker, Executive Director for the New Hospitals Programme.

The Steering Group considered an update report on the New Hospitals Programme and feedback from the public, staff and inclusion groups about the longlist of possible solutions. It was highlighted that:

- The formal shortlisting workshop was scheduled for 17 February 2022, at which attendees would use a pack of evidence (including stakeholder views gathered so far) to evaluate the longlist against agreed critical success factors.

- An update on the New Hospitals Programme could be provided to the Health Scrutiny Committee at is meeting on 22 March 2022, following the shortlisting workshop in February.

In response to questions from members, the following information was also provided:

- Public engagement would continue throughout the programme, regardless of the options shortlisted and the need for formal consultation.

- The critical success factors, which would be used to shortlist options, had been agreed at workshops held in October 2021. The shortlisting process would not be weighted, nor had the number of options to be shortlisted been agreed in advance. Patient representatives and wider stakeholders were invited to an informal meeting with senior staff before the shortlisting workshop, in order to discuss and understand the process.

- Following shortlisting, the options would be reassessed in more detail to identify the preferred way(s) forward and the need for formal public consultation. As part of a national programme, each stage of the process also required engagement with NHS England and the Department for Health and Social Care.

- From a financial perspective, it was necessary to balance capital affordability with revenue affordability. In the long term, new hospitals were likely to increase the efficiency of the workforce and therefore reduce associated costs. Without further consultation with the Department for Health and Social Care, it was important not to exclude any options too early.

- The programme aimed to gather cross-party support and welcomed the input and influence of county councillors.

- Healthwatch Lancashire had worked alongside NHS officers to carry out some of the programme's engagement with stakeholders, with a focus on a) the groups/patients least often heard; and b) campaign and pressure groups. Healthwatch's support would continue.

The Chair thanked officers for the update, and it was agreed that the New Hospitals Programme would be considered by the Health Scrutiny Committee at its meeting in March 2022.

Resolved: That

i) The update regarding the New Hospitals Programme be noted; and

ii) Officers be asked to present a report on the New Hospitals Programme to the Health Scrutiny Committee at its meeting on 22 March 2022.

Workforce and GP shortage position

The Chair welcomed to the meeting Paula Roles, Strategic Workforce Lead, and Sarah Sheppard, Director of People, from the Lancashire and South Cumbria Health and Care Partnership.

The Steering Group considered a presentation on workforce and GP shortages across Lancashire, a copy of which is provided in the minutes.

In response to questions from members, the following information was provided:

- It was currently unclear how workforce planning would be funded centrally under the infrastructure of the new Integrated Care Boards (ICBs). Health Education England was currently merging with NHS England and Improvement, and it had not yet been confirmed whether its role would change as a result.

- Recently there had been a significant expansion in the number of trainee GP places available and the number of medical school places across the North West, however there was an inevitable time lag between these measures and their impact on the workforce. There had also been huge investment into primary care roles that support GPs, such as physiotherapists, paramedics and mental health practitioners. Further detail about the additional roles used to supplement the GP workforce and benefit primary care would be provided to members after the meeting.

- Despite an increase in staff turnover over recent months, Lancashire and South Cumbria had good staff retention rates compared to national figures. Staff retention had improved during the pandemic due to a general slowing of recruitment and wider anxiety about starting new jobs. Generally, newly qualified staff only stayed in a role for one to two years, whereas more experienced staff remained in a role for longer. Currently, staff movement between local NHS Trusts was not well monitored. An improved retention strategy for Lancashire and South Cumbria was being developed and all local NHS Trusts were seeking to work better with agency staff to encourage them to take up permanent contracts. Concerns had also been raised about the impact that mandatory vaccination would have on the retention of staff.

The Chair thanked officers from the Lancashire and South Cumbria Health and Care Partnership for their presentation.

It was agreed that an updated report would be provided to the Steering Group in 12 months' time, to include information on the Integrated Care System's people function.

Resolved: That an update report on the NHS workforce and shortage of GPs be provided to the Health Scrutiny Steering Group in 12 months' time, at a meeting date to be agreed.

Healthwatch Lancashire – Identifying Collaborative Ways of Working

The Chair welcomed to the meeting David Blacklock, Chief Executive at People First and Kerry Prescott, Director of Healthwatch Cumbria and Lancashire.

During a period of discussion, it was highlighted that:

- Healthwatch Lancashire sought to establish a clearer working relationship with the Integrated Care System and, to that end, had accepted a non-voting seat on the Integrated Care System Board and its Strategic Commissioning Committee, plus other bodies.

- Healthwatch could be invited to attend the Health Scrutiny Committee's work programming session, which was held annually around June, so that Healthwatch Lancashire's work programme could be better aligned with that of the committee.

- Healthwatch Together was a collaboration of Healthwatch services from Blackburn, Blackpool, Cumbria and Lancashire which worked to coordinate work programmes and ensure they were effective in all areas of Lancashire.

- Healthwatch Lancashire was working closely with Healthwatch Sefton, in West Lancashire, because residents living in Ormskirk tended to visit Southport Hospital. This formed part of Healthwatch's recent work at A&E departments to understand why people attend A&E.

- First-hand patient experiences and stories were collected by Healthwatch and could be presented at committee meetings to support the committee's reviews. It was important to hear patient voices, but also to work collaboratively with NHS services and Trusts so that they were able to prepare and respond.

- Healthwatch could support the Steering Group by providing information about the local Frequent Attenders Programme.

It was agreed that Healthwatch officers would review Health Scrutiny Committee and Steering Group agendas in advance of their meetings and attend where they were able to add value.

The Chair thanked Healthwatch officers for their flexibility and willingness to work closely with the health scrutiny function.

Resolved: That Healthwatch Lancashire be invited to attend future meetings of the Health Scrutiny Committee and Health Scrutiny Steering Group, where they could

add value, and the next work programming session of the Health Scrutiny Committee.

Work Programme 2021/22

The Steering Group reviewed the Health Scrutiny Work Programme for 2021/22.

It was noted that:

- Confirmation about the report on early intervention and social prescribing had not been received from the Public Health team, but the committee meeting on 1 February 2022 would still cover two main items, as set out in the Work Programme.

- The Joint Health Scrutiny Committee for the Reconfiguration of Hyper-Acute Stroke Services across North Mersey and West Lancashire was due to meet at the end of January.

- The Work Programme would be updated to reflect the agreed outcomes of the meeting.

Members highlighted the importance of planning multiple items for future meetings of the Health Scrutiny Committee, so that meetings could still go ahead and be productive even in circumstances where one report had to be deferred.

Resolved: That the Health Scrutiny Work Programme 2021/22 be noted.

Health Scrutiny Steering Group Briefing Report

The Steering Group considered a briefing report on recent news and developments relevant to the county council's administrative area and Health Scrutiny function.

It was agreed that members would keep the reports regarding the University Hospitals of Morecambe Bay NHS Foundation Trust Urology and Trauma and Orthopaedic Services (Item 4), for consideration at the next Steering Group meeting on 9 February 2022.

Further to the Steering Group's decision that the Health Scrutiny Steering Group briefing report would be shared with the Health Scrutiny Committee, it was agreed that the report would be shared via email following Steering Group meetings, so that members and co-opted members of the committee received the information in a timely manner.

Resolved: That

i) The Health Scrutiny Steering Group briefing report be noted; and

ii) The Health Scrutiny Steering Group briefing report be shared with members and co-opted members of the Health Scrutiny Committee via email after meetings of the Health Scrutiny Steering Group.

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II:

N/A

Health Scrutiny Steering Group
ASC Workforce Challenges
5 January 2022

Tony Pounder, Director of Adult Services

Q1/ In which specific areas and roles are there staff shortages in Lancashire and should longer-term plans be considered to address them

Problem is long term and so longer term plans are needed:

- **Driven by demographic changes – more people needing care, fewer people in the workforce aspiring to these roles**
- **Patterns of movement and settlement in England**
- **Labour market competition from the NHS and other sectors – pay and prospects a major consideration**
- **Immigration rules**

Specific areas and jobs gaps:

- **Rural and more affluent areas of the county**
- **Registered Managers – those who lead and run care homes in particular**
- **Nurses for nursing home**
- **Homecare shortages in rural areas but increasingly all area**
- **Care homes – mixed picture**

Q2. What training programmes (such as National Vocational Qualifications) are available to social care staff on the job, which might provide incentives to progress and remain in the sector

- **Many opportunities – college, graduate level, on the job training**
- **Government keen on expanding opportunities – Build Back Better and the NI levy**
- **Training costs to companies doesn't incentivise them – 30% turnover, market structure is an impediment**
- **Training and qualifications should improve**
  - Quality of service
  - Competence of individuals
  - Experience of people receiving support
- **Training and qualifications doesn't however by itself solve the strategic workforce problems…may be a springboard to promotion or career progression**
- **Pay and the nature of the work will continue to weight heavily**

Q3. Is the lack of training and opportunities to increase proficiency a key reason for the sector's current staffing difficulties?

- Certainly doesn’t help!
- Status in importance, valuing the work, seeing progression
- People want to do a good job
- But not all can progress…and we need many more frontline staff and they need to see the rewards of job satisfaction, good pay and opportunities

Health Scrutiny Committee
Meeting to be held on Tuesday, 1 February 2022

Electoral Division affected:
(All Divisions);

Corporate Priorities:
N/A

Health Scrutiny Work Programme 2020/21
(Appendix 'A' refers)

Contact for further information:
Gary Halsall, 01772 536989, Senior Democratic Services Officer (Overview and Scrutiny), gary.halsall@lancashire.gov.uk

Brief Summary

The draft work programme for the Health Scrutiny Committee and its Steering Group is attached at Appendix 'A'.

The topics included in the work programme were identified at the work planning workshop held on 29 June 2021.

Recommendation

The Health Scrutiny Committee is asked to:

i. Consider key lines of enquiry for future meeting topics.

ii. Discuss any additional representation required from key officers/partners for future meeting topics.

Detail

A draft statement of the work to be undertaken by the Health Scrutiny Committee and its steering group for the 2021/22 municipal year is set out at Appendix 'A'.

The work programme will be presented to each meeting for consideration by the committee.

Members are requested to discuss and agree the draft work programme, discuss any additional representation from key officers/partners, and consider key lines of enquiry for future meeting topics.

Lancashire County Council

Consultations

N/A

Implications:

This item has the following implications, as indicated:

Risk management

This report has no significant risk implications.

Local Government (Access to Information) Act 1985
List of Background Papers

Paper	Date	Contact/Tel

None

Reason for inclusion in Part II, if appropriate

N/A

Health Scrutiny Committee Work Programme 2021/22

The Health Scrutiny Committee Work Programme details the planned activity to be undertaken over the forthcoming municipal year through scheduled committee meetings, task group, events and through use of the 'rapporteur' model.

The items on the work programme are determined by the committee following the work programming session carried out by the steering group at the start of the municipal year in line with the Overview and Scrutiny Committees' Terms of Reference detailed in the county council's Constitution. This includes provision for the rights of county councillors to ask for any matter to be considered by the committee or to call-in decisions.

Coordination of the work programme activity is undertaken by the chair and deputy chair of all of the scrutiny committees to avoid potential duplication.

In addition to the terms of reference outlined in the Constitution (Part 2 Article 5) for all Overview and Scrutiny Committees, the Health Scrutiny Committee will:

- Scrutinise matters relating to health and adult social care delivered by the authority, the National Health Service and other relevant partners.
- Review any matter relating to the planning, provision, and operation of the health service in the area, to invite interested parties to comment on the matter and take account of relevant information available, particularly that provided by the local healthwatch.
- In the case of contested NHS proposals for substantial service changes, take steps to reach agreement with the NHS body.
- In the case of contested NHS proposals for substantial service changes where agreement cannot be reached with the NHS, refer the matter to the relevant secretary of state.
- Refer to the relevant secretary of state any NHS proposal which the committee feels has been the subject of inadequate consultation.
- Scrutinise the social care services provided or commissioned by NHS bodies exercising local authority functions under the Health and Social Care Act 2012.

- Request that the Internal Scrutiny Committee establish as necessary, joint working arrangements with district councils and other neighbouring authorities.

- Draw up a forward programme of health scrutiny in consultation with other local authorities, NHS partners, the local healthwatch, and other key stakeholders.

- Acknowledge within 20 working days to referrals on relevant matters from the local healthwatch or local healthwatch contractor, and to keep the referrer informed of any action taken in relation to the matter.

- Require the chief executives of local NHS bodies to attend before the committee to answer questions, and to invite the chairs and non-executive directors of local NHS bodies to appear before the committee to give evidence.

- Invite any officer of any NHS body to attend before the committee to answer questions or give evidence.

- Recommend Full Council to co-opt on to the committee persons with appropriate expertise in relevant health matters, without voting rights.

- Establish and make arrangements for a Health Steering Group, the main purpose of which to be to manage the workload of the full committee more effectively in the light of the increasing number of changes to health services.

The work programme will be submitted to and agreed by the Health Scrutiny Committee at each meeting and will be published with each agenda.

The dates are indicative of when the Health Scrutiny Committee will review the item, however, they may need to be rescheduled and new items added as required.

Health Scrutiny Committee Work Programme

Topic	**Scrutiny Purpose** **(objectives, evidence, initial outcomes)**	**Lead Officers/organisations**	**Proposed Date(s)**
Lancashire & South Cumbria Pathology Collaboration	Seek assurances from the patient's perspective, impact on workforce; service provision in west Lancashire.	LSCFT	14 September 2021
Community Mental Health Transformation programme	Early engagement on the programme - background/case for change; how this will affect methods of service delivery; changes to accessibility and pathways including urgent; which partners involved, next steps and timescales	LSCFT	
Increasing vaccination uptake and addressing inequalities	Joint report from the NHS, the council for voluntary services, and the borough councils delivering the local vaccination programme.	LCC Public Health, Lancashire & South Cumbria ICS, CVS and borough councils	2 November 2021
Workforce GP shortage	Progress made in relation to recommendations of the 2017 scrutiny inquiry report	NHS England North West and Lancashire & South Cumbria ICS	14 December 2021 (cancelled)
Housing with Care and Support Strategy	Progress on the implementation of the strategy	LCC Adult Services	1 February 2022
Lancashire & South Cumbria - Enhanced Acute Stroke Services programme	Consider the business case for the reconfiguration of stroke services in the area.	Lancashire and South Cumbria Integrated Stroke and Neurorehabilitation Delivery Network (ISNDN)	
Disabled facilities Grants - TBC	Report on the differing allocations of Disabled Facilities Grants to district councils in Lancashire with a focus on discretionary grants	LCC Adult Social Care	22 March 2022
New Hospitals Programme	Update on options	Rebecca Malin and Jerry Hawker, New Hospitals Programme	
Shaping Care Together - TBC	Update on the programme	TBC	

Other topics to be moved on to the work programme at the appropriate time:

- Update on the activities of the County Council's Champion for Mental Health (CC S Morris Spring 2022 tbc)
- Lancashire and South Cumbria Pathology Collaboration (September 2022)
- Community Mental Health Transformation programme (tbc)
- Early intervention and social prescribing - Review of development and effectiveness – (tbc)

Appendix 'A'

Health Scrutiny Steering Group Work Programme

Topic	Scrutiny Purpose (objectives, evidence, initial outcomes)	Lead Officers/partners	Proposed Date(s)
Lancashire and South Cumbria Stroke Services briefing	Update on Acute Stroke Centres (previously referred to as Hyper Acute Stroke Services)	Jack Smith, Elaine Day, NHS England and Improvement	22 September 2021
New Hospitals programme briefing	Update on the programme	Jerry Hawker and Rebecca Malin, New Hospitals Programme	
Substantial variation protocol for Lancashire	Consider the implementation of a written protocol for Lancashire	Gary Halsall, LCC	
Initial Response Service	Report on the newly established service by Lancashire and South Cumbria NHS Foundation Trust	LSCFT	13 October 2021
Clatterbridge Cancer Centre	Blood cancer proposal	Jackie Moran, NHS West Lancashire Clinical Commissioning Group	
Lancashire and South Cumbria Pathology Collaboration	Concerns raised by pathologists	Gary Halsall, LCC	
Outbreak management and infection control – adult social care	Report on the key issues	Lisa Slack, Head of Service Quality, Contracts and Safeguarding Adults Service, LCC	10 November 2021
NHS 111	Findings and evaluation of the new NHS 111 First programme (resolution from committee's meeting held on 15 September 2020)	Jackie Bell, Head of NHS 111 Service, NWAS	
NHS winter planning	Assurance on measures and systems in place for the forthcoming winter.	Seamus McGirr and David Bonson, Lancashire and South Cumbria ICS	

Continuing Healthcare Assessments	Focus on county council resources, understanding the delay to finalising policies, and the effect on wider health outcomes	Ian Crabtree and Saad Khan, LCC	1 December 2021
Workforce resilience, wellbeing, sufficiency – Adult Social Care	Report on the key issues	Louise Taylor, Tony Pounder, LCC Adult Social Care	
Healthwatch Lancashire	Identifying collaborative ways of working	David Blacklock, People First/Health Lancashire	5 January 2022
Workforce GP shortage	Progress made in relation to recommendations of the 2017 scrutiny inquiry report	NHS England North West and Lancashire and South Cumbria ICS	
New Hospitals Programme	Update on shortlisting options - first phase	Rebecca Malin and Jerry Hawker, New Hospitals programme	
UHMBT – Urology and Trauma and Orthopaedic Services	Determine how to monitor improvements	University Hospitals of Morecambe Bay Hospitals NHS Foundation Trust and Dr David Levy, Chair of NHSE/I System Improvement Board	9 February 2022
Shaping Care Together - TBC	Update on the programme	TBC	
Fylde Coast Integrated Care Contract - TBC	Review of contract and recent CQC rating of Blackpool Hospital's Urgent and Emergency Care provision	TBC	
Quality Surveillance Group	Introduction and identifying collaborative ways of working	Jackie Hanson and Jane Scattergood, NHS England & NHS Improvement North West Region	
NHS Trust Quality Accounts	Review of NHS Trust Quality Accounts – formulating comments	Healthwatch Lancashire	10 March 2022
Continuing Healthcare Assessments - TBC	Update on progress	Ian Crabtree, Saad Kafrika, LCC and Talib Yaseen, Lancashire and South Cumbria ICS	
Health inequalities – people with learning disabilities - TBC	Report on the key issues	LCC Learning disabilities, autism and mental health	

Annual health checks and LeDeR programme - TBC	Written report and action plan on performance against the trajectory for discharge rates, Annual Health Checks (AHC) and Learning Disabilities Mortality Reviews (LeDeR) targets	Lancashire and Midlands Commissioning Support Unit/Lancashire and South Cumbria ICS	
Intermediate Care Services - TBC	Report on the key issues	LCC and Lancashire & South Cumbria ICS	
NHS Trust Quality Accounts	Review of NHS Trust Quality Accounts – formulating comments	Healthwatch Lancashire	6 April 2022
Preventative healthcare – healthy weight and obesity; NHS Health Checks (Healthy Hearts) Emotional and Mental Health – substance misuse and alcohol services - TBC	Overarching report identifying the key issues.	LCC Public Health	
			4 May 2022

Other topics to be scheduled:

- Health Education England – workforce risks, recruitment and training (see 10 Nov 21 Steering Group notes)
- High Intensity User Programme
- Lancashire and South Cumbria Enhanced Acute Stroke Services – update to steering group between March and May 2022
- Liberty Protection Safeguards – review of preparations before go live (April/October 2022?)
- Health and Care Bill 2021 – implications for health scrutiny
- NHS Workforce and Shortage of GPs (December 2022 – see 1 December 2021 notes)
- Vascular Service improvement and new model of care and Head and Neck programme
- Healthwatch reports:
    - COVID recovery and restoration - primary and elective care
    - Primary care - face to face engagement
    - Dental service shortage
    - Day Care Service improvement (LCC)

    - Community Diagnostic hubs
- Building and enduring health protection function beyond COVID – initial report on plans from LCC Public Health

Rapporteur activity:

- CC D Westley - Ian Barber, Lancashire Armed Forces Covenant Hub, ex-service personnel programme of engagement with GPs and health services

Briefing notes and bite size briefings to be requested:

- January 2022 - CQC Assurance of local authority Adult Social Care (CQC report to be presented to committee) – briefing note to steering group and bite size briefing for all members?
- Health and Care Bill – opportunities for population health – bite size briefing