Service Profile Pack Coventry & Warwickshire ICB

Midlands Specialised Delegation Programme

Date of issue: MAR 2024

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Introduction

This service profile pack contains essential high-level information regarding the 59 specialised services being delegated to your ICB on the 1st April 2024. It has been co-designed by ICB and NHSE representatives from the Clinical & Quality workstream of the Midlands Specialised Delegation Programme and provides some examples of the clinical case for change and how delegation will better support better services for patients. It includes information about the services that are being delegated, where they are being provided, the volume of current activity and the planning priorities for 2024/25.

A suite of service profiles containing details of clinical outcomes, patient safety concerns and workforce challenges will be available at the time of delegation. The service profile for Vascular Services is included as an example.

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1. Case for Change

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Why delegate specialised services?

ICBs and providers to have **freedom to design services and to innovate** in meeting the national standards where they take on delegated or joint commissioning responsibility

ICBs and providers able to **pool specialised budget and non-specialised budgets** to best meet the needs of their population, tackle health inequalities and to join up care pathways for their patients

ICBs and providers able to use world class assets of specialised services to **better support their communities closer to home** (e.g. designing local public health initiatives, greater diagnostics and screening)

Quality of patient care

Patients will receive more **joined up care** – better communication and sharing of information between professionals and services.

More of a **holistic, multi-disciplinary approach** to care. A range of professionals can be involved in planning a patient's care.

Increase focus and investment on **prevention**.

Patients will receive the **right care at the right time in the right place**.

Better **step-down care** to support patients who are ready to leave specialised care.

Equity of access

Population based budgets means decisions on spend are based on the **needs of a local population** – the demographics, health behaviours etc rather than on activity in hospitals.

Specialised clinical expertise will have a role in managing population health and to **challenge underlying drivers of health inequalities**.

Providers and professionals working collaboratively, free from organisational constraints and commissioning boundaries, will help improve **quality of care and tackle unwarranted variation**.

Opportunity to **level up access across the country**

Value

Investment in preventative care could **reduce demand** for specialised services.

Providers and professionals can **better manage patient demand**, even when one part of the system becomes stretched. Patients can be re-directed or transferred so they have faster and better access to treatment

A whole system approach creates opportunities **to protect and build 'workforce resilience'**, as shown during the pandemic.

Pooled/delegated budgets allow **underspends to be shared or reinvested** and avoids commissioning pressures on any one organisation.

- Accessible care
- Tailored care
- Seamless care
- Effective care
- Preventative care

Case study examples of benefits are included in Appendix A.

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2.Contracted Delegated Services by Provider

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Contracts Overview

- The contract portfolio for Specialised Services in the Midlands in 2023/24 includes
  - 27 Main NHS Provider Contracts
  - 2 NHS Standalone Service Contracts
  - 4 Standalone Independent sector Contracts
- These contracts are currently managed for NHS England by the Midlands Acute Specialised Commissioning (MASC) Team
- Following the delegation of the 59 Specialised Services in April 2024, the MASC Team will continue to manage these contracts on behalf of the 11 ICBs for delegated services and on behalf on NHSE for retained services.

- **The next slide contains a list of which delegated specialised services are provided by Trusts within the Coventry & Warwickshire system.**

- **Further details including the following contact details is available in Appendix 1.1;**
  - Commissioning Lead
  - Contract Manager
  - Quality Lead
  - Finance Lead

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Specialised Services provided by Trust in Coventry & Warwickshire ICS

University Hospitals Coventry & Warwickshire
Adult specialist rheumatology services
Adult specialist cardiac services
Adult specialist endocrinology services
Adult specialist neurosciences services
Adult specialist ophthalmology services
Adult specialist orthopaedic services
Adult specialist renal services
Adult specialist vascular services
Adult thoracic surgery services
Bone conduction hearing implant services (adults and children)
Complex spinal surgery services (adults and children)
Fetal medicine services (adults and children)
Specialist adult gynaecological surgery and urinary services for females
Specialist services for adults with infectious diseases
Major trauma services (adults and children)
Radiotherapy services (adults and children)
Specialist cancer services (adults)
Specialist cancer services for children and young adults
Specialist colorectal surgery services (adults)
Specialist ear, nose and throat services for children
Specialist endocrinology services for children
Specialist gynaecology services for children
Neonatal critical care services
Specialist ophthalmology services for children
Specialist plastic surgery services for children
Specialist rheumatology services for children
Specialist services for complex liver, biliary and pancreatic diseases in adults
Specialist paediatric urology services
Adult Critical Care

George Elliot Hospital
Adult specialist services for people living with HIV
Specialist cancer services (adults)
Specialist gastroenterology, hepatology and nutritional support services for children
Neonatal critical care services
Adult Critical Care

South Warwickshire
Adult specialist rheumatology services
Adult specialist cardiac services
Specialist cancer services (adults)
Neonatal critical care services
Specialist rehabilitation services for patients with highly complex needs (adults and children)
Adult Critical Care

Coventry & Warwickshire Partnership
Adult specialist services for people living with HIV

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3. Activity Data by ICB

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Activity Overview

- Specialised Services are delivered to Midlands' patients at Trusts across the Midlands. In addition, some Midlands patients access Specialised Services in Trust outside of the Midlands region.
- Midlands' providers treat patients from the Midlands but also patients from other regions.
- The following slide (Slide 11) gives an overview of these activity flows for patients and providers in the Coventry & Warwickshire system for Month 1 to 9 of 2023
- Slide 12 aggregates the same information at a regional level and gives an overview of activity flows for patients and providers in the Midlands region for comparison.

Example

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG))	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	58,578	5,791	2,191	64,369	60,769	**66,560**

- **Further detail, including a drill-down to individual provider. is available in Appendix 2.1.**

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Total Activities for QWU: NHS Coventry & Warwickshire ICB

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	58,578	5,791	2,191	64,369	60,769	**66,560**
B03 - SPECIALISED CANCER SURGERY	49,203	4,638	5,918	53,841	55,121	**59,759**
B01 - RADIOTHERAPY	20,777	1,863	206	22,640	20,983	**22,846**
B02 - CHEMOTHERAPY	16,470	1,241	891	17,711	17,361	**18,602**
E06 - METABOLIC DISORDERS	-	-	17,581	-	-	**17,581**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	239	1	17,151	240	17,390	**17,391**
D04 - NEUROSCIENCES	11,293	3,378	2,403	14,671	13,696	**17,074**
E03 - PAEDIATRIC MEDICINE	1,492	119	11,824	1,611	13,316	**13,435**
D01 - REHABILITATION AND DISABILITY	6,592	4,064	2,647	10,656	9,239	**13,303**
E08 - NEONATAL CRITICAL CARE	10,039	2,186	472	12,225	10,511	**12,697**
A05 - CARDIOTHORACIC SERVICES	5,170	2,271	3,588	7,441	8,758	**11,029**
E02 - SPECIALISED SURGERY IN CHILDREN	1,565	261	4,827	1,826	6,392	**6,653**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	3,051	255	2,693	3,306	5,744	**5,999**
A02 - HEPATOBILIARY AND PANCREAS	2,299	186	892	2,485	3,191	**3,377**
E05 - CONGENITAL HEART SERVICES	-	-	3,037	-	-	**3,037**
E04 - PAEDIATRIC NEUROSCIENCES	-	-	2,170	-	-	**2,170**
A09 - SPECIALISED RHEUMATOLOGY	1,417	177	358	1,594	1,775	**1,952**
A01 - SPECIALISED RESPIRATORY	-	-	1,652	-	-	**1,652**
F03 - HIV	1,099	-	157	-	1,256	**1,256**
D03 - SPINAL SERVICES	629	193	140	822	769	**962**
A03 - SPECIALISED ENDOCRINOLOGY	261	31	493	292	754	**785**
A04 - VASCULAR DISEASE	409	42	259	451	668	**710**
F04 - INFECTIOUS DISEASES	-	-	670	-	-	**670**
E07 - PAEDIATRIC INTENSIVE CARE	-	-	543	-	-	**543**
A08 - SPECIALISED DERMATOLOGY	240	14	114	254	354	**368**
D02 - MAJOR TRAUMA	184	101	39	285	223	**324**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	-	-	159	-	-	**159**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	79	8	37	87	116	**124**
A07 - SPECIALISED COLORECTAL SERVICES	96	13	6	109	102	**115**
E09 - SPECIALISED WOMENS SERVICES	31	11	27	42	58	**69**
D07 - SPECIALISED PAIN	-	-	40	-	-	**40**
Unknown	39	1	161	40	200	**201**
Grand Total	**191,252**	**26,845**	**83,345**	**218,097**	**274,597**	**301,442**

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Total Activities for Midlands Region

Activity Period: M01-M09 2023/24 (Apr 2023 – Dec 2023)

	A	B	C	A+B	A+C	A+B+C
NPoC (National Programme of Care (NPoC) Category and Clinical Reference Group (CRG)	Intra Activity	Imported Activity	Exported Activity	Total Activity by Providers in Mid ICB	Total Activity for Patients from Mid ICB	Grand Total
A06 - RENAL SERVICES	761,379	38,806	37,405	800,185	798,783	**837,589**
B03 - SPECIALISED CANCER SURGERY	723,206	8,546	74,570	731,752	797,776	**806,322**
B05 - CHILDREN AND YOUNG ADULT CANCER SERVICES	332,751	343	2,546	333,094	335,297	**335,640**
A05 - CARDIOTHORACIC SERVICES	225,064	8,465	18,289	233,529	243,353	**251,818**
B02 - CHEMOTHERAPY	190,405	17,030	27,686	207,435	218,091	**235,121**
B01 - RADIOTHERAPY	173,641	3,242	31,152	176,883	204,793	**208,035**
E03 - PAEDIATRIC MEDICINE	156,469	7,358	9,089	163,827	165,558	**172,916**
E06 - METABOLIC DISORDERS	154,286	3,165	401	157,451	154,687	**157,852**
D04 - NEUROSCIENCES	99,651	4,807	26,781	104,458	126,432	**131,239**
E02 - SPECIALISED SURGERY IN CHILDREN	103,670	2,598	11,090	106,268	114,760	**117,358**
E08 - NEONATAL CRITICAL CARE	105,630	1,225	9,172	106,855	114,802	**116,027**
D06 - SPECIALISED EAR AND OPHTHALMOLOGY SERVICES	92,348	1,555	5,811	93,903	98,159	**99,714**
D01 - REHABILITATION AND DISABILITY	45,596	1,068	2,513	46,664	48,109	**49,177**
A02 - HEPATOBILIARY AND PANCREAS	31,850	3,463	4,058	35,313	35,908	**39,371**
E05 - CONGENITAL HEART SERVICES	31,235	917	3,217	32,152	34,452	**35,369**
E04 - PAEDIATRIC NEUROSCIENCES	25,760	425	4,088	26,185	29,848	**30,273**
F03 - HIV	25,665	488	1,529	26,153	27,194	**27,683**
A09 - SPECIALISED RHEUMATOLOGY	23,300	79	2,256	23,379	25,556	**25,635**
A04 - VASCULAR DISEASE	20,593	516	2,420	21,109	23,013	**23,529**
A01 - SPECIALISED RESPIRATORY	15,767	90	4,701	15,857	20,468	**20,558**
A03 - SPECIALISED ENDOCRINOLOGY	17,142	563	2,381	17,705	19,523	**20,086**
E07 - PAEDIATRIC INTENSIVE CARE	13,978	221	2,659	14,199	16,637	**16,858**
D02 - MAJOR TRAUMA	5,499	516	201	6,015	5,700	**6,216**
D03 - SPINAL SERVICES	4,113	296	549	4,409	4,662	**4,958**
A08 - SPECIALISED DERMATOLOGY	3,594	14	1,074	3,608	4,668	**4,682**
F06 - SPECIALISED IMMUNOLOGY AND ALLERGY SERVICES / E03 - PAEDIATRIC MEDICINE	2,640	74	804	2,714	3,444	**3,518**
E09 - SPECIALISED WOMENS SERVICES	2,661	10	117	2,671	2,778	**2,788**
D10 - SPECIALISED ORTHOPAEDIC SERVICES	2,081	460	66	2,541	2,147	**2,607**
F04 - INFECTIOUS DISEASES	120	-	2,202	120	2,322	**2,322**
D07 - SPECIALISED PAIN	812	3	901	815	1,713	**1,716**
A07 - SPECIALISED COLORECTAL SERVICES	970	7	135	977	1,105	**1,112**
Unknown	3,956	93	1,035	4,049	4,991	**5,084**
Grand Total	**3,395,830**	**106,444**	**290,897**	**3,502,273**	**3,686,727**	**3,793,170**

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4. Quality Dashboard Overview

Quality Dashboard Overview

The following slides provide the following information on delegated specialised services

- How many units in the Midlands are delivering the service?
- Is the service required to submit data to the Specialised Services Quality Dashboard? (see next slide for definition on an SSQD)
- Is the service supported by an Operational Delivery Network (ODN) or other Clinical Network?
- Is the team aware of any Serious Incidents (Sis) relating to the service?
- Is the team aware of any complaints relating to the service?
- Is the team aware of any CQC reports relating to the service?
- Is the team aware of any other intelligence relating to the service?

Example

Priority	Service	Units	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
		There are 61 sites in the Midlands delivering ACC (Adult Critical Care)	There are SSQDs relating to ACC	There is a Network for ACC	There are SIs relating to ACC	There are no complaints relating to ACC	There is a CQC report relating to ACC at UHB	There network peer reviews and a GIRFT report relating to ACC

Specialised Services Quality Dashboard (SSQD)

- SSQDs are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. SSQDs are a key tool in monitoring the quality of services, enabling comparison between service providers and supporting improvements over time in the outcomes of services commissioned by NHS England.
- For each SSQD, there is a list of agreed measures for which data is to be collected. Healthcare providers, including NHS Trusts, NHS Foundation Trusts and independent providers, submit data for each of the agreed measures.
- Each SSQD is 'refreshed' with up-to-date outcomes submitted from national data sources, and where necessary healthcare providers, on a quarterly basis. The information provided by the SSQDs is used by NHS England specialised services commissioners to understand the quality and outcomes of services and reasons for excellent performance. Healthcare providers can use the information to provide an overview of service quality compared with other providers of the same service.

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Quality Overview Dashboard (1 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
1	ACC	61	Y	Y	Y	N	1 UHB	Network Peer Reviews, GIRFT
2	Cancer- Chemotherapy	43	Y	Y	Y	N	N	GIRFT
3	Cirrhosis of the liver	36	Y	Y	N	N	N	N
4	Neonatal Care	25	Y	Y	Y	N	N	Network Peer Reviews
5	Cardiology: implantable cardioverter defibrillator (ICD)	17	Y	Y	Y	N	N	National Audit
6	Cardiology: primary percutaneous coronary intervention (PPCI) (Adult)	11	Y	Y	N	N	N	National audit, GIRFT
7	Cardiac MRI	11	Y	Y	N	N	N	National audit, GIRFT
8	In centre haemodialysis: main & satellite units	11	Y	Y	Y	N	N	N
9	Cardiac surgery (Adults)	10	Y	Y	Y	N	N	National Audit, GIRFT
10	Haemophilia (All ages)	10	Y	Y	N	N	N	National Audits
11	Fetal medicine – (West Mids has AIP & Fetal Med)	9	Y	Y	N	N	N	National Audits
12	Cancer: anal	8	Y	Y	N	N	N	National Audits, GIRFT
13	Specialised kidney, bladder, & prostate cancer services	8	Y	Y	Y	N	N	GIRFT
14	Cardiac: electrophysiology & ablation services	7	Y	Y	N	N	N	National Audits, GIRFT
15	Thoracic surgery (adults)	6	Y	Y		N	N	N
16	Hepatobiliary & pancreas (Adult)	6	Y	Y	N	N	N	N
17	Cancer: pancreatic (Adult)	5	Y	Y	N	N	N	N
18	Cancer: malignant mesothelioma (Adult)	4	Y	Y	N	N	N	N
19	Level 3 - Paediatric Critical Care	4	Y	Y	N	N	Y	GIRFT
20	Adult congenital heart disease (ACHD)	2	Y	Y	N	N	N	National Audits, GIRFT(Cardiology)
21	Stereotactic radiosurgery & stereotactic radiotherapy (Intracranial) (All ages)	2	Y	Y	N	N	N	N
22	Testicular cancer	2	Y	Y	N	N	N	GIRFT

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Quality Overview Dashboard (2 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
23	Cancer: Clinical chemotherapy	28	N	Y	N	N	N	N
24	Cancer: chemotherapy ITC	18	N	Y	N	N	N	N
25	Cancer chemotherapy Higher Intensity	14	N	Y	N	N	N	N
26	Renal – assessment & prep for renal replacement therapy	10	N	Y	N	N	N	N
27	Haemodialysis to treat established renal failure	10	N	Y	N	N	N	N
28	Peritoneal dialysis to treat established renal failure	10	N	Y	N	N	N	N
29	Renal dialysis – intermittent haemodialysis & plasma exchange to treat acute kidney injury	10	N	Y	N	N	N	N
30	Level 2 - Paediatric Critical Care	8	N	Y	N	N	I KGH	N
31	Complex spinal surgery (All ages)	8	N	Y	N	N	N	N
32	Paed surgery: surgery (and surgical pathology, anaesthesia & pain)	7	N	Y	N	N	N	N
33	Colorectal: transanal endoscopic microsurgery (TEMS)	7	N	Y	N	N	N	N
34	Specialised HIV services (Adults)	7	N	Y	N	N	N	N
35	Specialised cancer surgery: non-surgical	6	N	Y	N	N	N	N
36	Paed medicine: respiratory	5	N	Y	Y	N	N	N
37	Neurosciences: specialised neurology (Adults)	5	N	Y	N	N	N	N
38	Cardiology: inherited cardiac services (All ages)	5	N	Y	N	N	N	N
39	Neurosurgery: Adults	4	N	Y	Y	N	N	N
40	Brain & other rare CNS tumours	4	N	Y	N	N	N	N
41	Major trauma (Adult)	4	N	Y	Y	N		Network Peer Reviews
42	Specialised services for haemoglobinopathy (All ages): haemoglobinopathies coordinating care centres	3	N	Y	N	N	N	N
43	Major trauma (children)	2	N	Y	Y	N	N	Network Peer Reviews
44	Paed surgery: chronic pain	2	N	Y	N	N	N	

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Quality Overview Dashboard (3 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
45	Specialised immunology (All ages)	13	Y	N	N	N	N	National Audits, GIRFT
46	Vascular disease: arterial	11	Y	N	Y	N	N	National Audits, GIRFT
47	Specialised rheumatology services (Adult)	10	Y	N	N	N	N	Y GIRFT
48	Haemophilia (All ages)	10	Y	N	N	N	N	Y National Audits
49	Implantable hearing aids for microtia, bone anchored hearing aids.…	7	Y	N	N	N	N	N
50	Paed medicine: rheumatology	7	Y	N	N	N	N	N
51	Specialised complex surgery for urinary incontinence and vaginal prolapse (16yrs & above)	7	N	N	N	N	N	N
52	Colorectal: faecal incontinence (Adult)	6	Y	N	N	N	N	N
53	Interstitial lung disease	6	Y	N	N	N	N	QSIP self-assessment pilot
54	Intestinal failure (Adult)	6	Y	N	N	N	N	N
55	Specialised endocrinology services (Adult)	6	Y	N	N	N	N	N
56	Cystic fibrosis (children)	5	Y	N	N	N	N	N
57	Cystic fibrosis (Adult)	4	Y	N	N	N	N	N
58	Complex disability equipment: prosthetic specialised services (all ages) with limb loss	3	Y	N	N	N	N	N
59	Positron emission tomography – computed tomography (PET CT) (All ages)	3	Y	N	N	N	N	N
60	Cleft lip and/or palate	3	Y	N	N	N	N	N
61	Complex gynae: congenital gynae anomalies (Children 13yrs & above and adults)	4	Y	N	N	N	N	N
62	Fetal medicine (East Midlands don't have network)	3	Y	N	N	N	N	N
63	Specialised resp services (Adult): severe asthma	3	Y	N	N	N	N	N
64	Metabolic disorders (Children)	3	Y	N	N	N	N	N
65	Metabolic disorders (Adult)	1	Y	N	N	N	N	N
66	Adult highly specialist pain management services	1	Y	N	N	N	N	N
67	Spinal cord injuries	1	Y	N	N	N	N	N
68	Complex gynae/female urology: genito-urinary tract fistulae (Girls & women aged 16yrs & above)	1	Y	N	N	N	N	N

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Quality Overview Dashboard (4 of 4)

Priority	Service	Total No. of Units in Midlands	Has SSQD Y/N	Has Network Y/N	Any SIs reported April 2022-present Y/N	Any complaints reported 2021-present Y/N	CQC Reports Y/N	Any other intelligence available on quality of care e.g. Peer Review Visits, national audits, GIRFT reports
69	Specialised HIV (Adults)	19	N	N	N	N	N	N
70	Specialised ophthalmology (Paeds)	10	N	N	N	N	N	N
71	Colorectal: transanal endoscopic microsurgery (TEMS) (Adult)	7	N	N	N	N	N	N
72	Paed medicine: gastro, hepatology & nutrition	7	N	N	N	N	N	N
73	Paed medicine: endocrinology & diabetes	6	N	N	N	N	N	N
74	Colorectal: complex IBD (Adults)	6	N	N	N	N	N	N
75	Specialised rehabilitation services for patients with highly complex needs (All ages)	6	N	N	N	N	N	N
76	Specialised allergy services (All ages)	6	N	N	N	N	N	N
77	Specialised dermatology services (All ages)	6	N	N	N	N	N	N
78	Neurosciences: specialised neurology (Adults)	5	N	N	N	N	N	N
79	Paed medicine: respiratory	5	N	N	N	N	N	N
80	Specialised ophthalmology (Adult)	5	N	N	N	N	N	N
81	Specialised orthopaedics (Adult)	5	N	N	N	N	N	N
82	Colorectal: distal sacrectomy (Adult)	4	N	N	N	N	N	N
83	Complex gynae – severe endometriosis	4	N	N	N	N	N	N
84	Paed medicine: haematology	4	N	N	N	N	N	N
85	Specialised ear surgery: cochlear implants	3	N	N	N	N	N	N
86	Complex disability equipment: communication aids	2	N	N	N	N	N	N
87	Metabolic disorders (lab services)	2	N	N	N	N	N	N
88	Environmental control equipment for patients with complex disability (All ages)	2	N	N	N	N	N	N
89	Paed medicine: renal	2	N	N	N	N	N	N
90	Paed medicine: specialised allergy services	2	N	N	N	N	N	N
91	Paed neuroscience: neurology	2	N	N	N	N	N	N
92	Paed medicine: immunology & infectious diseases	1	N	N	N	N	N	N

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5. Quality Service Profile
Specialised Vascular (Arterial) Services

(Included as an example of profiles to follow)

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Overview of the Quality Service Profiles

The following slides provide an example of the level of information held for each delegated specialised service. This Quality Service Profile for Vascular Services is provided as an example. The full suite of Quality Service Profiles is being prepared to be handed over at the point of delegation.

The following information is included in the Quality Service Profiles

- Which Midlands providers are delivering the service?
- What are the contact values and activity levels used for contract monitoring?
- What site are delivering the service?
- What local intelligence does the commissioning team hold about the service?
- What patient safety information does the quality team hold about the service?
- What information on clinical outcomes does the quality team hold about the service?
- What information on workforce and sustainability does the quality team hold about the service?

Further information in relation to Vascular Services is included in appendices 5.1-5.3.

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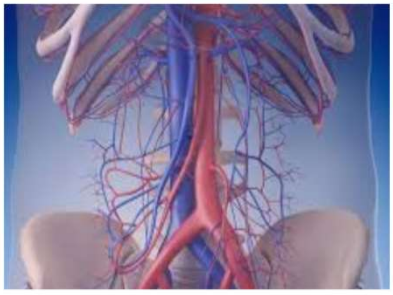
Specialised Vascular (Arterial) Services - Overview

Eleven (5 East & 6 West) Midlands Providers (Based on 2022/23 and all Points Of Delivery). Values based on SLAM.

			Contract Monitoring Actual Price	Contract Monitoring Actual Activity
Grand Total			£19,530,304	27,310
RJE : UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,236,112	4,243
RKB : UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,470,165	942
RNA : THE DUDLEY GROUP NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£89,878	657
RNS : NORTHAMPTON GENERAL HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£883,025	2,045
RR1 : HEART OF ENGLAND NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£5,956,526	2,033
RRK : UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£510,404	819
RTG : UNIVERSITY HOSPITALS OF DERBY AND BURTON NHS FOUNDATION TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,339,425	1,324
RWD : UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,271,398	3,552
RWE : UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£1,526,080	4,834
RWP : WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£860,810	827
RX1 : NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£2,681,339	4,047
RXW : THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	NCBPS30Z: Adult Specialist Vascular Services	22/23	£705,142	1,987

The 11 Arterial Centres in the Midlands have no, one or more spokes as listed below
(information based on Trust returns to the National Vascular Registry (NVR)):

	Arterial centre (Hub)	Associated Centre (Spoke)
East Midlands	Nottingham University Hospital (Nottingham City Hospital)	Kings Mill (Mansfield)
	University Hospitals Leicester (Glenfield)	
	University Hospitals of Derby and Burton (Royal Derby Hospital)	Chesterfield Royal Hospital
	Northampton General Hospital	Kettering General Hospital
	United Lincolnshire Hospitals (Pilgrim Hospital Boston)	ULHT Lincoln County Hospital
West Midlands	University Hospitals North Midlands (Royal Stoke)	County Hospital Stafford, Leighton Hospital Crewe;
	Shrewsbury & Telford Hospitals (Royal Shrewsbury Hospital)	Princess Royal Telford;
	Dudley Group Hospitals (Russell's Hall)	New Cross Wolverhampton, Manor Hospital Walsall;
	University Hospitals Birmingham (Birmingham Heartlands Hospital)	QE Birmingham, Good Hope Sutton Coldfield, Solihull Hospital, City Hospital Birmingham, Sandwell Hospital
	Worcester Acute Hospitals (Worcester Royal Infirmary);	
	University Hospitals Coventry & Warwickshire (Walsgrave)	George Eliot, Warwick Hospital



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Specialised Vascular (Arterial) Services - Overview

The Action on Vascular (AoV) Project Closure Report (2023) using **National Vascular Registry (NVR) data** included a summary of outstanding issues for the Midlands region.

- In 2018, there were 12 vascular Arterial Centres in the Midlands. Following a merger in the **West Midlands**, one centre ceased providing inpatient vascular care – **Queen Elizabeth, Birmingham.** This did not result in a compliant service at **UHB (Heartlands),** with IR staffing and activity levels being low.
- Of the remaining hospitals in West Midlands none is fully compliant. Activity and staffing are low in **SaTH**, activity is low at **Dudley** and **UHCW**, with **Carotid Endartectomy (CEA)** activity low at **UHNM** and finally, **IR** staffing is low at **WAH**.
- There have been no changes in the provider landscape in **East Midlands**. Three hospitals have **acceptable staffing but low activity - UHDB (CEA), NUH Abdominal Aortic Aneurysm (AAA)** and **UHL (AAA).** The challenges in **NGH** and **ULHT** have been partially mitigated by the link with **UHL**, but activity and staffing remain low.
- Based on current activity the region could support nine or ten arterial centres (if activity levels in the index procedures fall no further), but current patient flows result in all of the current centres failing to meet minimum activity requirements with the exception of **WAH.**
- Complex aneurysm procedures are currently undertaken at ten centres. Based on current activity the region is unlikely to be able to support more than three centres undertaking this work. Currently only one centre does more than 12 complex procedures per year **(UHB).**

Specialised Vascular (Arterial) Services

The below information is validated data as of 09/01/2024

Patient Safety		Clinical Outcomes	
Serious Incidents (consider PSIRF/LFPSE when available)	**Appendix 5.1** Details of two incidents reported between the period of April 2022 – present	**Notable examples of high performance / innovation**	None identified
Never Events	None identified	**Specialised Services Quality Dashboard (SSQD):**	**Appendix 5.2** Providers are required to submit; • Quarterly:13 quality indicators • Annually: 3 quality indicators Indicators include activity data for elective and emergency aneurysms, endarterectomy and amputation; as well as morbidity and mortality metrics
CQC Reports	None identified		
Workforce & Sustainability		**Mortality data**	Most recent National Vascular Registry report reveals no mortality outliers for the index procedures (aortic aneurysm surgery, carotid endarterectomy, amputation, lower limb revascularisation).
Workforce/ Recruitment & retention	GIRFT and Vascular Society recommend a minimum of 6 vascular surgeons and 6 Interventional Radiologists providing 24/7 cover in an arterial centre. Recruitment and retention of IR consultants is a challenge nationally and particularly for smaller centres. This can lead to service fragility and challenges in terms of sustainability (see below).	**GIRFT**	• National rollout of NCIP portal to consultant vascular surgeons is now under way - Getting It Right First Time - GIRFT Published 08 Jan 24 • arterial - Getting It Right First Time - GIRFT
GMC national training survey/ NETS – national education trainees survey	GMC NTS 2023 – no red flags, green flag for regional training in East Midlands (rated significantly better than expected)	**National Audits**	• National Vascular Registry State of the Nation report 2023 – HQIP Published: 09 Nov 2023 • Impact of the COVID-19 pandemic on vascular surgery in the UK (NVR) – HQIP Published: 08 Jun 2023
Summary of known risks of service/provider organisation	Census data collected in January 2023 as part of the national Action on Vascular Programme highlighted the following: Worcester – low IR staffing (4 consultants) SaTH – 5 surgeons and low IR staffing (3 consultants) UHB – low IR staffing (4 consultants) ULHT – 5 surgeons and low IR staffing (3 consultants) NGH – low IR staffing (3 consultants)	**Other information sources (if Applicable)**	**Appendix 5.3** Update from NHSE Trauma POC Lead Aug 23, CQUIN - critical limb ischaemia continues. CQUIN08 Revascularisation within 5 Days Objective: Revascularise patients with chronic limb-threatening ischaemia within 5 days, in line with the national standard, to reduce to length of stay, in-hospital mortality rates, readmissions and amputation rates. Target: 45% to 65% Q1 Scores - Specialised Commissioning Incentives Workspace - FutureNHS Collaboration Platform
Other Information	None identified		

6. Services currently classified as Enhanced Monitoring or Intensive Support

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Overview of the ASC Quality Highlight report

There is an agreed Quality Assurance framework in place to manage risk across the 12 organisations for 2024/25. Clinical and Quality risks are reported when they are at an Intensive Level or an Enhances level surveillance in line with the NQB guidance. During 2023/24 these have been reported to the East and West Joint Committees, which will continue in 2024/25.

There are no services currently at an Intensive Level of surveillance

There are current 3 services that are being delegated that are at an Enhanced level of surveillance. The following slides contain a copy of January's ASC Quality Highlight report. This report is presented to the Midlands Acute Specialised Commissioning Group (MASC) and the East & West Midlands Joint Committees monthly.

The Quality Highlight report details

- Which services which are subject to enhanced monitoring or intensive support
- Any information relating to the issue/concern and its impact
- Any mitigating actions which are being carried out to address the issue/concern
- Any other intelligence received by the quality team that month
- Any learning or best practice to be shared

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Acute Specialised Commissioning Highlight Report – West Midlands

Date: 18/01/2024

Key messages

Quality concerns and issues arising in Specialised Services are assessed utilising the NHSE Midlands Quality Assurance Framework and are identified as on Routine, Enhanced or Intensive Surveillance in line with NQB Guidance.

Key Messages					
#	**Concern/Issue** *New or Ongoing and Escalation Level*	**Programme of care /Speciality**	**Organisation & Integrated Care System (ICS)**	**Concern/Issue identified, Description/Impact** *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	**Proposed mitigation/Action being taken/Key Learning Points**
1	Ongoing – Enhanced Surveillance	Neonatal Services	Dudley Group of Hospitals (DGOH) BLACK COUNTRY ICB	• Baby born at Russell Hall Hospital (RHH) at 30+6 weeks gestation on 30/01/2023. Baby had been treated for suspected necrotising enterocolitis (NEC) conservatively and had progressed to enteral feeds. • On 05/03/2023 the baby deteriorated and transferred to Birmingham Women's & Childrens' Hospital (BWCH) on 06/03/2023 but died on 07/03/2023. Cause of death unascertained at present. • Concerns raised by parents regarding IPC practices • In addition, on 28/09/23 notification received regarding unrelated death where Perinatal Mortality Review had classified as Category D, different management would likely have altered the outcome	• Escalation meeting held 22/03/23 and immediate actions undertaken by the DGOH regarding IPC practices. • A number of IPC assurance visits have been completed by NHSE with ICB. Good progress being made with action plan. • Peer Review Visit undertaken 03/07/23. Full report now signed off and progress with action plan will be monitored. • Serious Incident investigation report received from DGOH and signed off under the SIF process in conjunction with ICB • Results of forensic post-mortem still awaited. • NHSE met to consider information provided by the ODN and wider quality information in relation to the service & following a meeting with the ICB & the trust on 04/10/23, • Quality Improvement Meeting held with trust on 17/11/23. Positive progress noted and a number of supportive actions agreed. Letter sent to trust by CM to confirm these and ongoing monitoring continues. • The ODN will also continue working with the Trust and a neighbouring trust to commence rotation of medical staffing across the units along with other mitigations.

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Acute Specialised Commissioning Highlight Report – West Midlands

Date: 18/01/2024

Key Messages					
#	**Concern/Issue** *New or Ongoing and Escalation Level*	**Programme of care /Speciality**	**Organisation & Integrated Care System (ICS)**	**Concern/Issue identified, Description/Impact** *Please include whether this requires **formal escalation** to RQG following discussion at commissioning meetings*	**Proposed mitigation/Action being taken/Key Learning Points**
2	Ongoing – Enhanced Surveillance	Deep Brain Stimulation Service	University Hospitals Birmingham (UHB) BSOL ICB	• Service is currently suspended. External review in 2021 identified a number of actions were required, including review and follow up for several patients, as a pre-condition of consideration of restarting the service. • The findings from the external review have also been the subject of media attention.	•UHB have confirmed completion of the follow up reviews for all but 7 patients, from 3 cohorts who had implantation surgery performed between 1999 and 2016. •Final Report including the outcome from completing all the reviews is being prepared by the Medical Director at UHB but is awaiting review of 3 patients by colleagues who undertook the Independent Review •A T&F Group is undertaking an option appraisal to determine the most appropriate future service model across Midlands.
3	Ongoing – Enhanced Surveillance	Adult Critical Care	University Hospitals Birmingham (UHB) BSOL ICB	• Unannounced CQC focused inspection within Critical Care services at QEH took place in August 2023. Feedback letter on concerns raised around staffing levels, leadership, meds management and equipment sent to trust 29/08/23.	Trust actions plan developed. Assurance oversight in place at the established BSOL ICB System Quality Group meetings which has NHSE representation. Update on progress received from trust at meeting on 1st November. Good progress in a number of areas but further work noted in terms of developing right culture. Further update scheduled end Jan 24.

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Acute Specialised Commissioning Highlight Report – West Midlands

INTELLIGENCE SHARING - horizon scanning, trends etc

Neonatal Unit Care
Neonatal care has been agreed as one of the joint NHSE/ICB priority areas and a paper outlining the intentions was previously presented to MASCG and the E & W Joint Commissioning Committees. Linked to the national focus on maternity and the Ockenden review at NUH, as well as in the wake of the Lucy Letby trial, there is significant media attention on neonatal care. Key challenges in neonatal care also include significant staffing challenges in a number of units, plus regional work continues in relation to high neonatal mortality rates. A number of reports have been produced over the last 6 months by N&Q, PH & Commissioning teams based on MBRRACE and local unit data, and action is in progress through the ODNs as well as through each LMNS. Oversight will continue through MASCG, the E & W JCCs as well as through the Regional Perinatal Quality Group which the ICB's also attend.
Work has also begun to develop a combined maternity and neonatal daily Sitrep across the region which will collate the operational position in each unit and system, and also then enable reports to be produced showing trends. The second phase of this work is to agree the key quality outcome metrics for neonatal care that can then be added to the Maternity Heatmap that already exists. An NHSE internal Perinatal Improvement Programme Group has also been established to coordinate actions across all involved directorates which includes specialised commissioners.

University Hospitals Birmingham Neurovascular service:
The MS service in UHB has developed a large backlog of patients requiring treatment with disease modifying drugs (approx. 550 patients affected). NHSE has met with the neurology team from UHB to discuss the recovery plan and subsequently has received a written response to some outstanding questions. Progress is slow but recruitment to new positions has commenced which should accelerate progress. NHSE is also in discussion with clinicians regarding starting a formal neurology network regionally. A discussion was also held on 10th January at BSOL SQG in relation to current issues and challenges in the neurology pathway which includes the MS but also the headaches service and potential for a standardised approach to neurosciences using a hub and spoke model. A joint CMO/CEO conversation is planned to discuss opportunities for ICS collaboration to achieve better results for the population and it will then be discussed at a future SQG meeting.

Fetal Medicine Services
There are a number of services in the WM region that have reported capacity issues particularly in the Consultant workforce. Mutual aid conversations continue and is noted on the regional Fragile Services Working Group. Commissioners have also supported a proposal from the Perinatal FM Network to provide a more sustainable model for consultant recruitment.

LEARNING AND SHARING - best practice, outcomes

Please share below any examples of positive assurance, good news stories, innovation, lessons learned, best practice, thematic work and intelligence that would be helpful to other regions

N/A

7. Fragile Services

Overview of Fragile Services database

The Fragile Services database is a list of services that the quality or commissioning team is monitoring due to information being received which suggests the service may be subject to some fragility.

This could be as a number of any of the following causes

- Capacity pressures
- Demand pressures
- Workforce issues
- Recruitment and retention issues
- Training and education issues
- Potential lack of provider

The Fragile Service Programme reviews the level of risk and takes appropriate mitigating actions. Whilst some fragile services can be attributed to a specific ICB, some affect whole pathways and have an impact at a regional level.

Fragile Services

The table below contains a count of the number of services across the region that have been bought to the attention of the Fragile Services Programme. These services are across ICB and Specialised Commissioned services as fragile services have the potential to affect the whole pathway.

	ICB specific						Generic	Total
Midlands Region							34	34
East Midlands	LLR	Notts	N'hants	Lincs	Derby		3	92
	21	35	8	15	10			
West Midlands	BSOL	BC	C&W	H&W	SSOT	STW	2	63
	16	8	6	15	4	12		
								189

Fragile Services in delegated Spec Comm services: Coventry & Warwickshire ICB

Specialty	Site	Reason for fragility	Detail and actions
Fetal medicine	UHCW	Lack of consultant workforce	Long term fragility due to lack of consultant workforce and difficulties recruiting. Fetal medicine network formed in 2023 and working on mitigating actions in West Midlands.
Aseptic pharmacy services	SWFT	Lack of workforce	Mutual aid being sought. Regional workshop held in November 2023. Regional board being set up.

Other C&W services on the fragility register which may impact on pathways for delegated services are:
- Breast cancer screening
- Colposcopy
- Histopathology

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8. Deep Dives

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Completed Deep Dives

As part of Joint Working on Specialised Services in 2023-24, the Midlands Acute Specialised Commissioning Team conducted a series of deep dives into priority services which were present to the East & West Midlands Joint Committees and the Clinical Collaborative Executive Forum (CCEF).

The following deep dives have been included in the appendices for information.

- **Appendix 8.1**
  Adult Critical Care
- **Appendix 8.2**
  Vascular Services
- **Appendix 8.3**
  Haemoglobinopathy
- **Appendix 8.4**
  Neonatal Services

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9. 2024-25 Priorities

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Overview of 2024-25 Priorities

As part of the 2024-25 planning round the Specialised Commissioning MDT have engaged with ICB to agree the 2024-25 priority pathways for specialised services in the Midlands.

The 9 priorities approved by ICBs and NHSE at the Midlands Acute Specialised Commissioning Group were as follows

- Neonatal Intensive Care,
- Adult Critical Care,
- Haemoglobinopathy,
- Severe Asthma,
- Oncology Review,
- Acute Aortic Dissection,
- Paediatric Critical Care,
- Multiple Sclerosis,
- Spinal Cord Injury.

Further details of each priority are included in Appendix B.

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10. Links

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Links

- NHS commissioning » Specialised services (england.nhs.uk)
- NHS England » Prescribed specialised services manual
- NHS commissioning » National Programmes of Care and Clinical Reference Groups (england.nhs.uk)
- NHS England » Service specifications
- NHS England » Commissioner assignment method 2024/25
- Prescribed Specialised Services Tools - NHS Digital
- NHS England » Directly commissioned services reporting requirements
- Integrating specialised services within Integrated Care Systems - FutureNHS Collaboration Platform

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Appendix A.
Case for change examples

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Example of how ICSs are already making a difference -Virtual e-clinics for kidney disease

- Patients with renal failure in Tower Hamlets now get more time with a specialist consultant thanks to the local ICS redesigning services around the sickest patients.
- Kidney doctors at Barts Health NHS Trust and GPs in the area set up a virtual e-clinic for GPs so they can send questions on kidney patients direct to consultants for a quick reply. The system also flags up patients that might need specialist treatment
- Since it began, waiting times for outpatients have dropped from as much as 15 weeks to just five days for advice, increasing face to face time for consultants and patients for those who most need it.
- The demand for outpatient appointments has reduced to a fifth of previous levels freeing up to time and money for reinvestment in NHS services.
- More integrated commissioning of specialised renal services would make these sorts of innovations easier as –
  - The same people and organisation would be responsible for commissioning both the specialised (eg dialysis) and non specialised (GP led) parts of the patient pathway reducing complexity and bureaucracy
  - Budgets will be pooled which creates more of an incentive to keep patients out of hospital and treat them closer to home
  - Services can be tailored around the needs of local populations helping to address health inequalities
  - Those who do need specialist services such as dialysis will still be able to access them in line with national standards and policies

"We were seeing a lot of patients who gained little from seeing a consultant, and instead are supporting GPs to help these patients. If we think a patient does need extra care then they can get in to see us far more easily, and into the right specialist clinic. Our team can now focus on those on dialysis, or with more severe kidney disease, where specialists can make the biggest difference."

Dr Neil Ashman, who developed the system with local GP Dr Sally Hull

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Case for change examples

Current Commissioning Arrangements	Consequences of Current Arrangements	Introduction of ICSs will…
HIV Services Commissioned nationally but Patient care delivered through HIV services via Local Authorities	Service and workforce fragmentation in some areas across England	• Enable NHSE and Local Government to collaborate on the commissioning of HIV and sexual health services strengthening pathways with domestic abuse, Sexual Assault Referral Centres and mental health services. • Help enable a joint approach to support and deliver recommendations from HIV action plan. • Help to ensure greater integration in the design of services informed by data and insight on the needs of local communities – helping to reduce inequalities. • Enable local providers of services for mental health and learning disabilities and /or autism to take control of budgets to improve outcomes by managing whole pathways of care. • Seek to avoid inpatient admissions and provide high quality alternatives to admission.
Mental Health and LDA Services Most Commissioned by CCGs. Only CYP, adult low and medium secure and adult eating disorder services are nationally commissioned.	Specialised MH services are at the end of the pathway focused on inpatient and interventionalist care leaving little incentive for upstream investment by CCGs	
Neurology Spec com funds neurology patients only at certain designated centres / in outpatients where the patient has been referred by a consultant. Neurological needs of patients not seen at a centre are met by hospitals funded by CCGs	Discourages development of local provision by CCGs at sites other than neuroscience centres – patients have to travel further. Discourages service evolution, patients not seen in the right places.	• Provide an opportunity to improve quality and access to services by moving decisions closer to communities • Enhance collaboration between partners including across larger geographical footprints • Make it easier to deliver upstream interventions in primary care around diagnosis and early treatment, to potentially prevent or delay the need for transplants further down the pathway • Potentially lead to greater investment in home dialysis with financial benefits (from reduction in travel costs) being reinvested elsewhere. • Support greater focus on prevention and provision of care closer to home.
Renal Costs of Kidney disease, dialysis and transplantation is funded via Spec com but surgery and most outpatient care is funded by CCGs. Transport is supported by CCGs and makes up 30% of elective transport in the NHS	Funding for renal medicine is complex and discourages upstream investment in prevention and earlier stages of the pathway.	

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What do we want to be different in the new model?

	Planning and Governance	Collaborative Delivery	Funding
PRESENT	Prevention, diagnosis, acute treatment, chronic management and specialised services are planned and commissioned by different organisations with plans based on different historic views resulting in misaligned priorities	Some patients have multiple touchpoints across multiple organisations for the same condition which results in limited opportunities to join up care and support innovation and technological advances	Current funding approach provides limited incentives to reduce cost through innovation which can result in specialised budgets outstripping funding available
FUTURE	All organisations across whole patient pathway working under a single planning structure with aligned incentives and plans based on a single forward view of population needs.	Fewer touchpoints which are built around the needs of the patient enabling greater innovation and collaboration and more joined up services across the patient pathway	Care funded on a population basis and with local organisations working together to set and manage budgets incentivised to innovate and save costs, leading to sustainable systems and more focus on the needs of local populations.
EXAMPLE	 Mr Wu, 68yrs Type II Diabetes End stage renal failure Needing dialysis. Can delay the need for dialysis through identification and intervention of his CKD by his GP, thereby improving his quality of life and care experience	 Mrs. Jagathesan, 74yrs Complex cardiac history awaiting a heart procedure, lives far from Cardiac centre. Can attend local hospital for pre-assessment ahead of her surgery, receive follow up care close to home in local or virtual clinics.	 Miss Jones, 19yrs Rare neurological disorder Waiting for multiple diagnostics. Gets co-ordinated diagnostics through a single point of access, reducing outpatient appointments and enabling faster diagnosis and treatment – meaning better patient experience and cost-effective care

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Case for change – examples and themes

Current Arrangements	Consequences	Integration Opportunities
Sickle Cell Spec comm funds haematology services. ICBs funds the upstream pathway – from genetic screening, pre-conception care, newborn screening, primary care, urgent and emergency care.	Lack of joined up care meant that significant service quality issues went unchecked for years. Opportunities to support patients through core ICB offerings (e.g. community nursing) were missed – haematology didn't have sight of the offering and ICBs didn't have sight of the service.	Single commissioner will have a view of the entire end-to-end pathway and will have the mechanism to identify and address issues. One accountable group for ensuring quality services. Integrating specialised haematology services in and end-to-end pathway can improve connectivity with ICB core services (maternity, primary care, community support, urgent and emergency care access) for people with Sickle Cell disease.
Fragmented funding and pathways	**Disincentives to improve outcomes and £**	**"steps to the left" and end-to-end pathways**
Neurology Only funded at certain Neurosciences centres – even if the specialist consultant works at multiple hospitals. Neurological needs of patients not seen at a centre are met by hospitals funded by ICBs.	Discourages development of local services outside the neuroscience centre (investment from ICBs) – patients have to travel further. Inconsistent provision leading to inequities. Discourages service evolution, with no common approach to pathway development.	Introduce a consistent approach to commissioning neurology services – enabling improved quality and access, and services closer to home. Enhance collaboration between partners including across larger geographical footprints. Create streamlined pathways leading to faster diagnosis and more cost effective care.

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HIV Pilot - Ensuring Comprehensive HIV Screening in Emergency Departments (EDs) Across South London

Almost all hospitals in South London in high or extremely high prevalence areas offer opt-out HIV ED testing.

Cases identified in South London EDs:
- At KCH, the oldest patient identified through ED testing was 95.
- At GSTT, a significant number of patients testing positive in ED have primary infection (20%) with very high viral loads.
- At SGUH, an HIV diagnosis was suspected in only 11 (22%) of the subsequently 50 positive cases.
- At Croydon, newly diagnosed HIV-positive patients now need shorter hospital stays, from an average of 34.9 days down to only 2.4.

2. Opt-out HIV tests are offered to those who need blood tests (c.300,000 people).

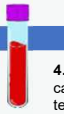
5. If a test is reactive, the patient is invited for further tests by the sexual health service.

7. On appropriate treatment, patients with HIV can expect to live as long as someone without HIV. Those with undetectable viral loads cannot pass HIV onto anyone else, even in unprotected sex. Clinicians try to re-engage patients lost to follow-up.

The process of HIV screening in EDs | What happens next | Uptake

1. Over 1 million people attend Emergency Departments* in South London every year.

3. The level of uptake of HIV tests varies across South London, from 34% - 98%.



4. One sample and blood bottle can be used for both the blood tests and the HIV test, meaning the additional costs are largely lab-associated.

6. Newly diagnosed patients are brought into care and put on treatment. Early detection is vital to reduce HIV/AIDS related complications.

This variation across South London means that not all patients who have HIV are being identified. This is due to key factors such as the age of those tested, the length of time before re-testing repeat ED attendees, and general operationalisation of the screening strategy.

This pilot aims to address this through 'levelling up' across south London, supported by a minimum service specification.

There is variation in lab costs across South London, with costs ranging from £2.50 to £5.55 per test. Some trusts use 2 blood bottles.

~150 patients are newly diagnosed with HIV in EDs in South London every year. Each person living with HIV newly linked to care could avoid NHS costs of over £200,000.

"Making a diagnosis of HIV today does mean spending money on the treatment tomorrow; missing a diagnosis today means greater treatment costs in years to come (and not just for one patient, but for anyone else before or after them in the chain of transmission)."

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Home based immunoglobulin therapy (IVIg) in Neurology in South London

1. Home based Immunoglobulin therapy for people with autoimmune neuropathies is safe and effective and less costly than hospital-administered intravenous immunoglobulin (IVIg)

3. This is highly disruptive to quality of life. Patients frequently require time off work which makes maintaining employment challenging and costs them greatly through loss of income and travel.

5. In addition to being more convenient, this method offers clinical benefits as lower drug doses can be used more frequently. This is better tolerated by patients (reduces adverse reactions), avoids fluctuations in condition between treatment and reduces risk of stroke and other blood related issues related to large doses.

7. The model has been in place at Kings College Hospital for several years. We are proposing to support the Neurosciences centre to establish a service, using learnings from Kings as well as learnings in home care from the OPAT pilot.

2. Some patients are required to come into hospital (day case units) for recurrent infusions every 3-6 weeks, which may takes place over two to five successive days. Each episode of treatment costs £4k.

4. Alternatively, many patients are suitable for home therapies – including a subcutaneous injection they can deliver themselves. This can transform the patient experience, and patients report high levels of satisfaction with this option.

6. This contributes to improved use of hospital estates (freeing capacity in day case units for other activity), reduces drug costs through VAT savings and is cheaper for patients (reduced travel and lost income). Additionally, it offers greater environmental sustainability (reduced travel).

8. Funding is available to recruit a CNS to support patients on this pathway. Project management support is available from SLOSS for implementation. **Trust and system support is required to manage and plan for day case activity and income changes.**

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Appendix B.
2024-25 priorities – detailed slides

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Midlands Oncology Service Review: Fragile		Lead: Laura Morris	Ref: C1
Delegation Status: Green (HCD retained)	**ICB:** All	**National Priorities: Recovery:** Cancer, Use of Resources. **LTP:** Workforce, Inequalities. **DCG**	
What is the problem in summary? Oncology is identified as a fragile service across the Midlands. Performance challenged, with 8/11 systems in tiered support. Inequity of timely access at Trust and tumour site level. Oncologist vacancy rate is 15% , expected to rise to 25% in 2027 with 20% forecast to retire over 5 years. Midlands has the lowest WTE per population in England. There are also workforce challenges in chemo nurses; therapeutic radiographers and medical physics. Across the Midlands, we spend £522 million on SACT per year (activity, drugs and support costs), plus Radiotherapy spending.		**What are we looking to achieve?** Reduce variation in waiting times; increase productivity and share best practice through the development of new models of care, workforce strategies and shared resource. **Scope:** Workforce; capacity; service models **Specific Partners:** Cancer Alliance (EAG/ECAG); EMAP (priority area); ICB cancer leads	
Planned Deliverables: - Mutual aid framework (Q1). - Develop plans for managing agency/locum costs (Q1). - Review and appraise variety of current financial spends and service models for oncology services (Q2). - Produce Virtual Ward criteria (Q2). - Confirm transformation plans in place at system for virtual or community clinics (Q4)		**How will we know if things have improved (KPI)?** - Reduced and consistent waiting times across systems. - Reduced vacancy rates. - Unit cost reduction. - Consistent approach to managing mutual aid.	

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Acute Aortic Dissection		**Lead:** Jon Gulliver	**Ref:** IM1
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Acute aortic dissection (AAD) is rare and immediately fatal for 48%. For Type A making it to cardiac surgery, mortality is 25%. Surgery is time critical. All cardiac surgery centres have at least one AAD specialist surgeon but with no coordinated regional on-call rota presenting challenges to accessing intervention. There is consensus that coordination will improve outcomes for patients and reduce waits but there is resistance to change.		**What are we looking to achieve?** Reduce variation in access to emergency surgery and improved outcomes through the introduction of coordinated East and West on call rotas. **Scope:** Workforce; capacity; service models **Specific Partners:** Cardiac Transformation Programme, Cardiac Networks.	
Planned Deliverables: - Approved SOP(Q1). - SPOC testing and training(Q1). - Recruit MDT coordinator (Q1). - Establish regional MDT(s) (Q2). - Agree process for collecting and reporting KPI (Q1). - Service go live (Q1 WM, Q2 EM).		**How will we know if things have improved (KPI)?** - In hospital mortality with/without intervention; 1 year mortality. - LOS. - Referral numbers. - Intervention/no intervention. - Time from referral to intervention. - Deaths between diagnosis and intervention Type A. - Deaths between diagnosis and place of safety Type B. - Patient satisfaction.	

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Severe Asthma		**Lead:** Jon Gulliver	**Ref:** IM2
Delegation Status: Green	**ICB:** All	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Health Inequalities.	
What is the problem in summary? Severe asthma (SA) is a debilitating, chronic disease with an average of 4 asthma attacks and 4x more A&E visits pa, patients with SA account for ~50% of all asthma-related healthcare costs. Biologic treatment has the potential to improve lives and reduce the use of healthcare/social resource. Access is variable and ~80% of eligible patients are currently not prescribed a biologic.		**What are we looking to achieve?** Increase access to biologics for patients with SA to improve outcomes for patients and reduce the use of other healthcare resource. **Scope:** All patients with severe asthma. **Specific partners:** Respiratory Network	
Planned deliverables: - Review of current treatment and patient pathways for the management of asthma across primary and secondary care including case finding for biologics, diagnosis and treatment optimisation. - Review of the data to understand the inequalities that are present in accessing biologics treatment, based on underlying service and/or patient factors. - Share with respiratory networks and specialist asthma centres to inform options appraisal.		**How will we know if things have improved (KPI)?** - Number of new initiations per ICB - Increase in percentage bio penetration per ICB - Reduction of variation in bio penetration by ICB	

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Multiple Sclerosis Service Review: Risk Register		**Lead:** Dom Tolley	**Ref:** T1
Delegation Status: Green	**ICB: BSol; H+W; Black Country**	**National Priorities: Recovery:** Elective, Use of Resources. **LTP:** Workforce, Health Inequalities.	
What is the problem in summary? A review of the MS tertiary service provided by University Hospitals Birmingham to a number of ICBs has found significant waiting times and increasing numbers of patients to be seen for initial consultations to access to Drug Modifying Therapies (DMTs) and lack of structure for the ongoing management of this patient group. There is a lack of good governance with regards to the prescribing and monitoring of these patients, which has a potential of harm.		**What are we looking to achieve?** Improve access of eligible MS patients to DMTs and ongoing care of those already on treatment outside of BSol ICB. **Scope:** All patients eligible MS patients who should fall under the care of UHB. **Specific partners:** None	
Planned deliverables: - Review of West Midlands regional MS DMT pathways and governance and current financial spend for MS DMT patients and produce options appraisal for MASG and JCs, to include the development of Neurology ODNs (Q2) - Develop and implement a revised MS DMT clinical pathway, including shared care agreements (Q4).		**How will we know if things have improved (KPI)?** - Reduction in waiting list and waiting times for MS patients on DMT clinical pathway by the end of 2024/25	

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Spinal Cord Injury Services		**Lead:** Dom Tolly	**Ref:** T2
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands region only has one commissioned Spinal Cord Injury (SCI) rehabilitation unit (RJAH), which has the second longest waiting times for admission in England. The unit cannot manage high cervical spinal injuries, due to lack of ACC, resulting in out of region transfers. The East Midlands does not have a SCI rehabilitation centre. Patients are managed in Sheffield or Stoke Mandeville where there are long waits. This delay in rehabilitation treatment means poorer outcomes (increased rates of HCAI and pressure sores), potential harm and DTOC.		**What are we looking to achieve?** Improved access to SCI and outcomes. Reduction in harm and DTOC resulting into lower use of healthcare resource. **Scope:** All patients presenting with a SCI and requiring rehabilitation. **Specific partners:** None	
Planned deliverables: - Complete a demand and capacity analysis for SCI rehab, including patient acuity and complexity (Q1-Q2). -Review current financial spend for SCI patients and review potential options costs for SCI services (Q1-Q2) - Present review and options papers to MASG and JCs, including QIA and 13Q (Q3), including weaning and ventilated patient services for high c-spine injured patients.		**How will we know if things have improved (KPI)?** - Reduction in LOS SCI patients. - Reduction in DTOC both from Acute beds base and to CHC services - Reducing periods of bed rest. - Reduction in complications.	

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Adult Critical Care (ACC) Rehabilitation & Digital Enablement		**Lead:** Dom Tolly	**Ref:** T3
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** UEC, Elective, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The Midlands ACC Strategy has continued to develop a more diverse, resilient and holistic model of ACC care across the 29 ACC units. The major quality, clinical and operational improvement drive in the next 3 years of the strategy is to develop consistent 7-day services for ACC rehabilitation in line with national guidance. In doing so this potentially will reduce in LOS for ACC patients by up to 1.5 days, improve patient outcomes, reduce costs for patient episodes.		**What are we looking to achieve?** Digital enablement will provide clinical support, improved decision making through a networked approach to care through virtual ward rounds. Digital critical care platform will reduce clinical errors in transfers of care between providers, by allowing shared care records. **Scope:** All ACC units. **Specific partners:** EM and WM ACC ODNs.	
Planned deliverables: - Complete digital services review paper (Q1). - Complete ACC rehab gap analysis by provider/ICB (Q2). - Review of current spend for ACC rehab and review potential options costs for services (Q2). - Present review and options papers to MASG and JCs, including QIA (Q3).		**How will we know if things have improved (KPI)?** - Reduction in length of stays for ACC patients. - Reduction in pharmacy and parental nutritional spends.	

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Haemoglobinopathies		**Lead:** Nick Hey	**Ref:** BI1
Delegation Status: Amber	**ICB: All**	**National Priorities: Recovery:** UEC, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? The APPG on Sickle Cell and Thalassaemia conducted a review of services and experiences of patients and produced 'No one's listening.' This report revealed many years of sub-standard care, stigmatisation and lack of prioritisation and patients losing trust in the NHS system. A regional review demonstrated wide variance in the level of service on offer to patients and numerous areas for improvement, in particular in improved training and knowledge at non-specialist trusts and A&Es.		**What are we looking to achieve?** Improve outcomes for patients and reduce unnecessary admissions for patients by improving networks of care. **Scope:** All haemoglobinopathy services. **Specific partners:** EM and WM HCCs.	
Planned deliverables: • Med Tech Funding (Spectra Optia) business cases . Potential for approval of additional national funding to support red blood cell exchange services - (Q2). • Review of SCD prevalence, activity and provision (Q1). • Review position against APPG report (Q1). • Review of Specialist Haemoglobinopathy Team provision – Service provision review and re-commissioning (Q4).		**How will we know if things have improved (KPI)?** - Updated review of regional position against No one's listening recommendations demonstrating improvement, especially in non-specialist centres. - Increased access and activity for red blood cell exchange.	

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Neonatal Critical Care: Risk Register		**Lead:** Sumana Bassinder	**Ref:** WC1
Delegation Status: Green	**ICB: All**	**National Priorities: Recovery:** Maternity, Use of Resources. **LTP:** Workforce, Health Inequalities. **DCG**	
What is the problem in summary? Neonatal Critical Care remains an area of significant national and regional scrutiny. The Midlands also has one of the highest neonatal mortality rates in the country. There is significant work to do to implement the requirements of the NCCR including configuration, patient pathways, increase cot capacity, workforce strategy, neonatal transport review to support the revised neonatal networks. All against a backdrop of high-profile scrutiny (Ockenden, Thirlwall, Letby, Kirkup).		**What are we looking to achieve?** Improved outcomes for babies and a reduction in mortality rates. **Scope:** All NIC services. **Specific partners:** EM and WM ODNs. Perinatal Programme. LMNS	
Planned deliverables: • Review of WM capacity and configuration (Q1). • Describing patient pathways. • Financial impact of compliance (Q1) • Production of workforce strategy. • Review of neonatal transport. • Ongoing capacity monitoring and compliance review. • Perinatal dashboard (Q1) • Review of PMRT process.		**How will we know if things have improved (KPI)?** - Reduction in mortality rates. - Reduction in babies being transferred out of region for neonatal care. - Reduction in the number of cots closed due to staffing challenges.	

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Paediatric Critical Care (PCC)		**Lead:** Sumana Bassinder	**Ref:** WC2
Delegation Status: Green	**ICB: All**	**National Priorities: DCG**	
What is the problem in summary? PCC capacity is an area of concern regionally and nationally for both Level 2 (High Dependency) and Level 3 (Intensive Care). National funding was received in 23/24 to increase Level 2 capacity outside of Level 3 centres but so far only a partial implementation has been achieved. Further work required to identify, increase and progress additional capacity.		**What are we looking to achieve?** Right capacity in the right place. **Scope:** All PIC services. **Specific partners:** EM and WM ODNs.	
Planned deliverables: - Monitoring of delivery of WM plans. - Plan for increase of resilient L2 capacity in the EM in line with GIRFT (Q1) - Demand, capacity and financial review of L2 and L3 provision and production of options appraisal (Q4)		**How will we know if things have improved (KPI)?** - Reduction in OPEL status levels from 23/24 surge baseline during 24/25 surge periods. - Reduction in patients transferring out of area for paediatric critical care. - Improved cot utilisation, closer to home and outside of tertiary centres.	

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