Healthier Lancashire & South Cumbria

Formal Integrated Care System (ICS) Board Agenda
2 December 2020 10:00-12.00 - MS Teams Teleconference

Item	Description	Owner	Action	Format
Routine Items of Business				
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Declarations of Interest	Chair	Note	Attached
3.	Minutes of Previous Meeting and Actions	Chair	Approve	Attached
4.	Key Messages	Dr Amanda Doyle	Note	Verbal
Sustainability				
5.	Current Financial and Operational Overview	Gary Raphael/Carl Ashworth	Note	Attached
6.	Covid Vaccination Update	Dr Amanda Doyle	Note	Presentation
Building the Future System				
7.	Clinical Strategy	Andy Curran	Note	Attached
8.	ICP Core Narrative	Geoff Joliffe	Approve	To follow
9.	Strategic Assurance Framework	Gary Raphael/Emily Kruger	Note	Attached
Performance and Outcomes				
10.	Finance Report	Gary Raphael	Note	Attached
For Information				
11.	Provider Collaboration Board Update	Eileen Fairhurst/Aaron Cummins	Note	Verbal
12.	High Level Programme Summary Report	Talib Yaseen/ Emily Kruger	Note	Attached
13.	EU Exit Planning	Gary Raphael	Note	Verbal
Any Other Business				
14.	Items for the Next Board Meeting	All	Note	Verbal
15.	Any Other Business	All	Note	Verbal
Date and Time of the Next Informal ICS Board Meeting: 13 January 2021 – 10.00-12.00 noon, MS Teams Teleconference				

Healthier Lancashire & South Cumbria

Declaration of Interests for member of the ICS Board

Introduction

Managing conflicts of interest appropriately is essential for protecting the integrity of the NHS commissioning system and to protect NHS England, Clinical Commissioning Groups, GP practices together with other providers from any perceptions of wrongdoing.

It is therefore essential that declarations of interest and actions arising from declarations are recorded formally in the minutes of the ICS Board.

Process

At the beginning of each meeting, the Independent Chair will ask colleagues to indicate if they have any interests to declare.

Members are asked to indicate the type of interest they wish to declare, making reference to the table below:

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A shareholder (or similar owner interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. • A management consultant for a provider; • In secondary employment • In receipt of secondary income from a provider; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one off payments, day allowances or travel or subsistence) from a provider • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and

Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A GP with special interests e.g., in dermatology, acupuncture etc. • A member of a particular specialist professional body (although routine GP membership of the RCGP, BMA or a medical defense organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for Care Quality Commission (CQC) or National Institute for Health and Care Excellence (NICE);
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a decision (as those categories are described above). For example, this should include: • Spouse / partner; • Close relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend;

After a declaration of interest is made, the Chair will make a determination as to how the individual members should continue to participate in the meeting. This will be on a case by case basis and the decision will be explained to the ICS Board.

There are a number of options for actions that the Chair may take depending upon the particular interest identified:

- Member leaves the room for that agenda item
- Members stays in the room, can participate in the discussion and make comments but cannot vote on any decision
- Member stays in the room, can participate in discussion and can vote on the decision
- Item is deferred –agenda amended to reflect this

If the Chair is conflicted, the Deputy Chair will take the Chair's role for discussions and decision-making of the relevant part of the meeting and may use the above options for action.

The following information will be recorded in the minutes of the meeting:

- Individual declaring the interest
- At what point the interest was declared
- The nature of the interest
- The Chair's decision and resulting action taken.

In addition, any individuals retiring from and returning to meetings should be formally record in the minutes.

Minutes of the Formal ICS Board
Wednesday 4 November 2020 10:00-12:00
Microsoft Teams Teleconference

Name	Job Title	Organisation
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Dr Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
ICS Executive Directors		
Andrew Bennett	Executive Director for Commissioning	Lancashire and South Cumbria ICS
Jane Cass	Director for Performance, Assurance and Delivery	Lancashire and South Cumbria ICS
Talib Yaseen	Executive Director of Transformation	Lancashire and South Cumbria ICS
Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Carl Ashworth	Strategy and Policy Director	Lancashire and South Cumbria ICS
Gary Raphael	Executor Director of Finance	Lancashire and South Cumbria ICS
ICP Leads		
Kevin McGee	Chief Executive Officer	Blackpool Teaching Hospitals NHS Foundation Trust East Lancashire Teaching Hospitals NHS Foundation Trust
Caroline Donovan	Chief Executive Officer	Lancashire and South Cumbria NHS Foundation Trust
Roy Fisher	Chair	NHS Blackpool CCG
Denis Gizzi	Accountable Officer	NHS Chorley South Ribble & Greater Preston CCGs
Aaron Cummins	Chief Executive Officer (current Provider Collaborative Board representative)	University Hospitals of Morecambe Bay NHS Foundation Trust
Karen Partington	Chief Executive Officer	Lancashire Teaching Hospitals NHS Foundation Trust
Geoff Jolliffe	Clinical Chair	NHS Morecambe Bay CCG
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
ICS Non-Executive Lay Members		
Mike Wedgeworth	Non-Executive Director	East Lancashire Hospitals NHS Trust
Ian Cherry	Non-Executive Director	Greater Preston CCG
Isla Wilson	Vice Chair/Non-Executive Director	Lancashire and South Cumbria ICS
VCFS Representatives		
Peter Armer	VCFS Representative	VCFS
Local Authority Councillor Representatives		

ICS BOARD

Shaun Turner	Councillor Representative	Lancashire County Council
In Attendance		
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Eileen Fairhurst	Chair/Provider Collaboration Chair representative	East Lancashire Hospitals NHS Trust
Stephanie Betts	Business Affairs Lead	Lancashire and South Cumbria ICS
Jerry Hawker (on behalf of Sue Smith)	Chief Officer	University Hospitals of Morecambe Bay NHS Foundation Trust
Mark Hindle	Managing Director	Lancashire and South Cumbria Pathology Collaboration
Nicki Latham	Deputy Chief Executive	Blackpool Teaching Hospitals NHS Foundation Trust
John Bannister (on behalf of Jacqui Hanson)	Interim Regional Chief Allied Health Professions Officer, Lancashire & South Cumbria ICS	Lancashire and South Cumbria ICS
Claire Richardson	ICP Programme Director	Lancashire Teaching Hospitals NHS Foundation Trust
Professor Ebrahim Adia	Chair	Lancashire Teaching Hospitals

Item	Note	Action by
1	**Welcome, Introductions and Apologies** David Flory welcomed everyone to the meeting. Apologies for absence were received from Jacqui Hanson, Sue Smith, Neil Japp.	
2	**Declarations of Interest** It was recognised that members of the Board had a conflict of interest due to being attached to roles within partner organisations. The Chair noted how well the members of the ICS Board manage any potential conflict, not being driven nor constrained by their conflict.	
3	**Minutes from Previous Meeting and Matters Arising – 4 November 2020** The minutes of the previous meeting were reviewed and were accepted as a true record. The matters arising/action log was noted including items which are to be brought back to the December meeting. Isla asked that the Equality & Diversity assessments be placed onto the action tracker. **(NOTED)**	
4	**Key Updates/Messages** The Chair noted that the agenda for the meeting captured perfectly the challenges faced by the Lancashire & South Cumbria system - firstly to manage the ongoing response to the COVID19 pandemic whilst continuing to ensure that the needs of others are met in a safe, effective way and secondly at the same time to set the direction for the future through the system reform programme and the ICS Clinical	

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	Strategy. The oversight of all of this collaborative effort by the ICS Board will be crucial if all of these challenges are to be met. In presenting her summary of key messages, Amanda Doyle asked that the Board recognises and thanks staff who are currently working under unrelenting pressure due to COVID19, working outside their day job to support and meet the needs of key system programme delivery. The community transmission rate of C19 across Lancashire & South Cumbria is starting to see high numbers stabilising as a result of being at level 3 for 5 weeks prior to lockdown. This does not yet translate into any breathing space into the acute hospitals or across community, as we move along the pathway this will show more pressure on critical care beds. Primary care, community and the acute services are pressured and we need to recognise this. There is an increasing certainty that a vaccine will be available the very beginning of December - more detail will be brought back to the Board at the next meeting.	
Sustainability		
5	**Managing Phase 3 and Wave 2** Gary Raphael and Carl Ashworth updated the Board on the paper submitted which was in three parts: concluding the Phase 3 planning process: report on progress protecting elective care capacity: and report on progress establishing Gold Command Winter Room. Firstly, Gary presented an update on the finalisation of financial aspects for Phase 3 recovery and restoration plans, which assumed that the C19R = 1 or less as per August levels. The report provides some details on C19 claims that were made in the first half of the year when the ICS broke even. However we are currently saying that we will be £98m short in the second half of the year partly due to the way the financial envelope has been constructed and partly because we have been asked to do things we didn't do in the first half, primarily the restoration of elective services, which we have forecasted will cost £30m more than in the first. The proposed approach for the remainder of the year is to have phase 3 financial plans as a base case; to explain the variation from it in relation to our wave 2 responses; and take into account any further funding that nationally may, or may not be forthcoming to deal with the second surge of C19 demand. We do not know whether or not our exiting run rate this year will be set against a higher level of resources in 21/22 compared to published allocations that takes into account extra C19 costs, or whether we will have to revert to our previous allocations. In Spring, our system was £180m away from our negative control total of £98m and therefore just over £277m in deficit in total, about 8% of our turnover. Gary concluded that our underlying financial position remains extremely challenged and the approach to advised that planning for next year needs to be a subject of discussion at the Board in advance of any national guidance. Carl then presented on the remainder of the planning paper, providing firstly a reminder that the activity and performance plans we submitted - assuming minimal impact of COVID - saw our elective care capacity being constrained, with consequent impact on performance and patients The paper goes on to provide the Board with some assurance on how, in the face of the second Covid surge, the system has	

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	performed to date against submitted plans and the work being undertaken through the hospital cell to protect our planned elective capacity as best we can. Carl reminded the Board that that the system will be monitored against the phase 3 plans, albeit in context of our response to the current Covid response. We will need therefore to demonstrate as a system that we are focusing our efforts in a way that keeps our public and patients safe whilst delivering cost effective care Finally, the paper provides some detail on the establishment of the Gold Command Winter Room, including functions and governance arrangements. The aim of the approach is to keep the system safe, maximise the flexing of capacity in response to current and projected demand, and underpin effective mutual support across the system. Having spent a year working on plans, it is clear that what we need now is a shift towards efficient and tactically adept operational management of the system, and that is what the Winter Room will help us to deliver. **The ICS Board noted:** • **Progress in concluding the phase 3 financial planning process** • **The plans for protecting elective care performance** • **The establishment of a L&SC Gold Command Winter Room to support effective operational controls across the system in response to the second wave of Covid this winter**	
Building the Future System		
6	**Clinical Strategy** Andy Curran presented to the Board the Clinical Strategy, highlighting the importance of it being owned by all, sitting under ICS strategy. The next step will be how we implement the strategy and its priorities over the next 5-10 years. It is acknowledged that the Clinical strategy needs to enable us to work towards financial balance as well as delivering the improved care for our patients. Since being commissioned by SLE in February (just as COVID hit) there have been lessons learned and subsequently changed on how we deliver care remotely or virtually, that have been reiterated through the strategy. The strategy was co-produced with clinical and non-clinical leaders via workshops and went through a period of clinical validation over six core areas: Health and wellbeing of our communities; living well; managing illness; urgent and emergency care; end of life care including frailty and dementia; and workforce. The ICS/ICP communications teams are to turn the detailed document into a pithy summary in order to roll out for wider engagement, and we are seeking to appoint a SRO, a financial lead and clinical lead for each of the 6 core areas. Detailed work plans will need to sit under these areas but separate strategies will not be needed. Comments from Board members underlined the challenge of keeping the document at a high level whilst providing the detail on priorities for each service area – views were expressed that primary care, community services, mental health and drug and alcohol services all needed more detail to be provided. It was agreed that, as the document is taken forward for wider consultation via ICPs, the right balance of detail will be struck. Board members noted the importance of the outputs of the strategy in setting out future service models that will inform the HIP2 programme. **Resolved: The Board endorsed all the recommendations of the clinical strategy recognising that it is the overall clinical consensus, and will not align with every**	

	individual clinical priority. **The Board supported the move to the next stage of engagement via the ICPs and the request for support from members of the Board for appointment of SRO, clinical leads for each of the 6 areas and financial lead. Discussion to be had at ICS Executive Meeting, taking direction from SLE and the ICS Board.**	
7.	**System Reform: A common strategic narrative for Integrated Care Partnerships within the Lancashire and South Cumbria Integrated Care System** Geoff Joliffe presented the common strategic narrative for Integrated Care Partnerships within the Lancashire and South Cumbria ICS and asked the Board to support the three recommendations detailed in the paper. • Formal approval is now sought from the ICS Board for the common ICP strategic narrative which will complete Step 1. • Agree the two-phase approach to Step 2, noting the critical dependency on the NHS Phase 4 guidance and noting the initial proposed Step 2A / Step 2B allocation of work programmes; this step will be completed by the end of March 2021 • Agree the immediate actions in Step 2. - Cross check the proposed Step 2A / Step 2B work programmes against the ICS System Reform Plan in order to align work streams being undertaken to progress Commissioning Reform and Provider Collaboration; Finalise the Step 2A / Step 2B work programmes; Identify leads and supporting teams for Step 2A / Step 2B work programmes (including alignment of external support, e.g. NHS E/I, Innovation Agency); Develop a robust System Reform communications and engagement plan The Chair praised the work undertaken so far and suggested that further detail is now needed on the harder edge of what ICPs need to deliver. Comments from the members supported the paper in principle but proposed that as we are challenged by timescales, we should accelerate effective local placed based partnerships prior to national guidance being made available. It was noted that the ICP Advisory Group are looking at the transitional period until the funding paths are clear, on how the ICPs can give back assurance that the money being funded is being used wisely and well with value for money. **Resolved:** **In considering the recommendations in the paper, the Board does not approve the strategic narrative as it stands, approves the move to step 2, and approves that steps can be taken before Phase 4 letter is received.**	
8.	**Pathology Collaborative** Mark Hindle gave an update on the Pathology Collaborative and COVID issues within Lancashire from a pathology perspective. The Pathology Collaborative was developed following work by Lloyd Patrick Carter on efficiencies in the NHS, pathology being one area identified. The 4 Acute Trusts came together as the 4 main pathology providers to form a collaborative to look at how pathology services could be delivered efficiently going forward. Some £30m of capital was provisionally allocated from the Centre to enable the four pathology services to come together and develop. The paper presented identifies the key decision making junctures that the ICS has in front on them over the next few months.	

	• Preferred clinical model to be agreed in December - organising the Collaborative into a 'hub and spoke' model. This will make the service more financially efficient, resilient and improve quality. • Location of future service site identified as Leyland • In January financials will be considered with a view to developing an outline business case by the end of the financial year that can be considered by stakeholders in the system, which would then be made into full business case to NHSE&I for approval and receive allocation of capital to develop the clinical model The programme is now at a critical stage in the development of Pathology Collaboration with good progress being made this year and a significant year dealing with COVID. Mark asked the ICS Board to consider what they want to see within the business case as it is completed by the end of the calendar year – his recommendation is that certain components are brought to the Board for consideration as they are completed. The Board to note that the Pathology Collaboration Board is chaired by one of the Executive Directors of the Acute Trust and each organisation has a clinical and executive lead as part of the Board and its decision making. The Chair asked for more detail on the discussions on Leyland being the preferred location. Stakeholders, with over 300 people inputted into an evaluation criterion that applied to a range of locations across Lancashire & South Cumbria, all stakeholders had the opportunity to rank all locations against the criteria set. The process was independently run by Price Waterhouse Cooper which focussed on population eg majority of GPs, staff and transport links. **The ICS Board noted the paper and supported further discussion to be had at the SLE around the governance. Further components of the business case to be brought back to future Board.**	
Governance		
9.	**ICS Governance** This item was deferred to the December meeting	
Performance and Outcomes		
10.	**Finance Reports** **a) Finance** **b) Capital** Gary updated the Board that the ICS staffing budget is underspending, mainly as result of the complete confusion on development funding from national teams. Consequently, it is to expected to be underspent significantly by end of year once these issues are resolved On capital, it is projected that the ICS will be £4m underspent on £234m total capital allocation. Gary highlighted that there is a lot to spend mainly in the latter part of the year, but we do have system-wide monitoring and control arrangements in place for capital and Trusts are saying we should be able to meet position forecasted. The Capital element of report details the measures taken by Trusts to take into account where they may be slippage in some of the schemes.	
For Information		
11.	**Health Equality Project**	

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	Paper noted with option to bring back to future meeting if required.	
12.	**Provider Collaboration Board** No items to note	
13.	**High Level Programme Summary Report** Paper noted with option to bring back to future meeting if required.	
14.	**COVID-19 Cell Logs** **a. Hospital** **b. Out of Hospital** **c. Joint Cell Logs** COVID-19 logs were shared with the ICS Board for information. Papers were noted with option to bring back to future meeting if required.	
15.	**Any Other Business (AOB)** There were no other items of business. a)	

Date and Time of the Next Informal ICS Board Meeting

Wednesday 2 December 2020 – MS Teams meeting 10:00-12:00

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Healthier Lancashire & South Cumbria

ICS Board - Matters Arising Log

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
ICSB200304-02	A further report around the Strategy Delivery Plan to be provided at the next ICS Board meeting	Talib Yaseen	In progress	January 2021	A further report around the Strategy Delivery Plan to be provided at the next ICS Board meeting The strategy delivery plan needs to align with the updated draft clinical strategy and the phase 3 planning outputs to ensure cohesion. It will also need to reflect the system needs moving into phase 4 and beyond. Therefore suggested that this is reviewed and brought back to the Board in January once the ongoing impact of phase 3 is better known.
ICSB200304-04	A revised ICS Decision Making Framework to be brought to a future ICS Board meeting including findings of testing priority programme/s	Talib Yaseen	In progress	13.01.2021	In progress. – Review of Governance arrangements ongoing.
ICSB200902-01	Hospital cell to be asked to review and report on current delivery of non-evidenced interventions.	Kevin McGee	In progress	02.12.2020	In progress
ICSB2200915	Equality & Diversity Assessments – update to be provided to the ICS Board following review	Talib Yaseen	In progress	On-going	
ICSB2200916	Components of the business case for the Pathology Collaborative are to be brought to the ICS Board for approval	Mark Hindle	In progress	On-going	

ICS Board

Date of Meeting	2nd December 2020
Title of Paper	Conclusion of the phase 3 planning process
Presented By	Gary Raphael
Author	Gary Raphael
Agenda Item	5
Confidential	No

Purpose of the Paper
To apprise the Board on the discussions held at SLE in relation to concluding phase 3 planning with the allocation of system growth funding.
Executive summary
The paper reports on the conclusion of the phase 3 planning process with the allocation of system growth funding across the ICS, ensuring that CCGs are able to remain in balance while deficits are shown in providers. The rationale for this approach to allocating funding is explained in the report.
Recommendations
The ICS Board is asked to endorse and **approve** the allocation of growth funding in line with the decision of the SLE to achieve the financial positions outlined in table 1.
Governance and Reporting (List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome
FAC SLE	13/11/20 18/11/20	Approach agreed for reporting to SLE SLE endorsed the approach recommended by FAC and agreed to allocate the balance of funding (£8.2m originally held at ICS) to providers.

Conflicts of Interest Identified
None identified.
Implications

Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☒	**No**	☐	**N/A**	☐
Associated Risks	**Yes**	☒	**No**	☐	**N/A**	☒
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☒	**N/A**	☐
If Yes, Please Provide a Risk Description and Reference Number	Mark Yes, No or Not Applicable Above and Provide a Risk Description and Risk Reference Number in this Box if there are Any Associated Risks					

Conclusion of phase 3 planning process

Introduction

1. This is to report on the conclusion of the phase 3 planning process following the allocation of system growth funding across the system.

2. L&SC's updated, aggregated phase 3 financial plans, submitted on 18th November to the Regional team, have met the requirement set by SLE of a £90m shortfall against our financial envelope of £1.74bn for the second half of this year.

Organisational positions achieved across the system

3. Table 1 below reports on the final submissions made by CCGs and trusts across L&SC:

ORGANISATION	£m
Blackpool Teaching Hospital	(20.6)
East Lancashire Hospitals Trust	(17.7)
Lancashire Teaching Hospitals Trust	(19.4)
Lancashire & South Cumbria FT	(4.1)
North West Ambulance Service	(4.0)
University Hospitals of Morecambe Bay	(25.0)
Sub-total - Trusts	**(90.8)**
Blackburn with Darwen CCG	0.0
Blackpool CCG	0.0
Chorley & South Ribble CCG	0.0
East Lancashire CCG	0.0
Fylde & Wyre CCG	0.0
Greater Preston CCG	0.0
Morecambe Bay CCG	0.0
West Lancashire CCG	0.0
Sub-total - CCGs	**0.0**
TOTAL	**(90.8)**

Rationale for allocating growth such that CCGs stay in balance and deficits are shown in providers

4. On 18th November the SLE considered a paper presented by Gary Raphael on concluding phase 3 plans and specifically the Finance Advisory Committee (FAC) recommendations on the distribution of £68m growth funding.
5. SLE noted that for tactical financial reasons ensuring CCGs plans were balanced while deficits were shown in provider positions was the best option for the system,

given that CCG overspends must be recovered in the following year, while trusts are able to borrow PDC at 3.5% interest rates with no immediate requirement to repay the debt.

6. Additionally, it was noted that CCGs had very little control this year over payments to be made to providers – in fact for nearly all their providers payment levels had been determined elsewhere e.g. the national team determined block payment levels to trusts. The SLE accepted that in this situation CCGs should not be asked to find ways to make savings and/or obtain funding for deficits if they had been able to exercise little control over spending plans. Furthermore, SLE noted that in a level 4 incident response decision-making responsibilities had been exercised by NHSEI in a chain of command to the cell leaders.

7. Taking this approach to allocating growth funding had led to the providers holding what effectively is a system deficit, but it was emphasised that these deficits must be considered the joint responsibility of CCGs and trusts in their ICPs to address and resolve (to the extent that they can) within the financial allocation available to the ICS.

8. On the basis of the above organisational financial plans, phase 3 is concluded and our regional team has confirmed that although our plans remain unaffordable, they are accepted as our final submission.

Adapting our plans to meet Covid wave 2 requirements

9. At its 18th November meeting the SLE noted that the scenario underpinning phase 3 plans no longer applied as we had now moved to a stage where we must respond to the second wave of Covid. Extra capacity for both physical and MH services was likely to be required.

10. Gary Raphael reported to SLE that the risk of Covid generated mental health surge demand was explicitly asked to be removed from the plans by the Regional Office and this was highlighted as a risk and acknowledged. Further work would be required in the next stage of planning to review the positon.

11. Gary Raphael had advised the SLE and was confirming the same to the ICS Board that regional and national finance directors require L&SC to hold to the £90m deficit position and if possible to reduce it, even as we assess the impact of the second wave of Covid. The guidance coming out from the national and regional teams is that systems across the country must now look to make realistic forecasts of spending in the second half of the year (in contrast to phase 3 which sought to assess the impact of a particular scenario) and must adapt their plans to meet financial constraints. This could mean scaling back restoration plans if, for instance, the response to the second wave of Covid could result in additional costs above phase 3 plans being incurred on extra capacity for Covid patients.

12. There are two other major policy areas that remain unresolved as we move into the second the half of the year:
    - First, in relation to mental health – it is acknowledged regionally that the latent pressure building in the mental health of the population requires a response from the NHS – further high level discussions will take place to ensure that across the NW there is a consistent approach to how this is being dealt with.
    - Second, specific provision has been made for extra community bed capacity (circa £8m cost). National approval for these schemes has been obtained and their cost will remain outside the current financial envelope.

13. By the 4th December organisations across the country are required to submit a revised forecast for the year to 31st March 2021. The ICS finance team is working with regional finance managers and organisational finance team to ensure that there is a consistent approach to these estimates. There is no doubt that some of the issues we suppressed in our phase 3 plans to meet the requirements of that scenario will be expressed as part of our wave 2 response, but as mentioned above, if we identify a risk of exceeding the £90m deficit position on our financial envelope, we will need to decide on what we are going to do to stay within the figure.

Underlying financial deficit

14. SLE also felt it important not to lose sight of the system's underlying deficit, which would need to be addressed as part of the 2021/22 planning round. The Board will be reminded that at the start of the year, under the old financial regime, we were facing a £180m deficit against a negative control total of £97m, which meant that overall we were £277m away from balance.

15. SLE decided that in advance of next year (and any associated guidance), we need to build our own narrative to set the financial framework for developing our plans:
    - we have key strategic pieces of work to deliver (clinical strategy and HIP2)
    - we need to allow our staff space to recover before we restore services, managing ongoing demand and meeting the backlog
    - we will need to plan for restoration of financial balance across system over a longer timescale through a whole system financial strategy – system leaders need space to develop and sign up to this

Conclusion

16. In response to recommendations from the FAC and after having discussed the rationale for allocating system growth funding to assure budgetary balance in CCGs, the SLE **endorsed** the approach to distributing growth funding and also agreed that rather than holding a small reserve at system level (£8m) the deficits in providers should be reduced to the lowest level possible, which is shown in the table above on page 2.

Recommendation

17. The ICS Board is asked to endorse and **approve** the allocation of growth funding in line with the decision of the SLE to achieve the financial positions outlined in table 1.

Gary Raphael
ICS Finance Lead
24th November 2020

ICS Board

Date of Meeting	02.12.2020
Title of Paper	Clinical Strategy - Update
Presented By	Andy Curran, ICS Exec Medical Director
Author	Andy Curran, ICS Exec Medical Director
Agenda Item	7
Confidential	No

Purpose of the Paper

For information

Executive summary

The Clinical Strategy has been developed following a process previously described to Board.

The Board on the 4th November endorsed all the recommendations of the clinical strategy recognising that it is the overall clinical consensus and will not align with every individual clinical priority.

As requested, a discussion was had at ICS Executive's Meeting to determine how to implement the strategy, using comments and recommendations from SLE and Board for direction.

This paper reports on that discussion and describes how the ICS Executive team propose to implement the clinical strategy and build it into our future planning. A series of high-level key principles are presented to guide current and future workstreams.

Recommendations

For the Board to;

1. note the progress made,
2. support the embedding of the clinical strategy into future planning processes,
3. receive future mapping of the workstreams to the 6 pillars
4. continue support of the 5 High Level Principles.

Governance and Reporting

(List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome

Conflicts of Interest Identified

Implications						
Quality Impact Assessment Completed	**Yes**	☐	**No**	☒	**N/A**	☐
Equality Impact Assessment Completed	**Yes**	☐	**No**	☒	**N/A**	☐
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☒	**N/A**	☐
Financial Impact Assessment Completed	**Yes**	☐	**No**	☒	**N/A**	☐
Associated Risks	**Yes**	☐	**No**	☒	**N/A**	☐
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☐	**N/A**	☒
If Yes, Please Provide a Risk Description and Reference Number						

Clinical Strategy Update

1 Background

1.1 At the previous Board Meeting on the 4th November the Board endorsed all the recommendations of the clinical strategy recognising that it is the overall clinical consensus, and will not align with every individual clinical priority.

1.2 Board members noted the importance of the outputs of the strategy in setting out future service models that will inform for example the HIP2 programme.

1.3 The importance of it being owned by all, sitting under the ICS strategy was acknowledged and the next step described as being how we implement the strategy and its priorities over the next 5-10 years.

1.4 Comments from Board members underlined the challenge of keeping the document at a high level whilst providing the detail on priorities for each service area – views were expressed that primary care, community services, mental health and drug and alcohol services all needed more detail to be provided.

1.5 A discussion was requested to be had at an ICS Executive's Meeting to determine how to implement the strategy, using comments from SLE and ICS Board for direction.

2 ICS Executive Proposals

2.1 The ICS executive team met to discuss the next steps and there was agreement that the Clinical Strategy does not describe a new case for change or deviate away from the Long Term Plan.

2.2 Whilst the Clinical Strategy does describe the wider strategy regards health and wellness for the whole population it also needs to explicitly describe the clinical services strategy for within our ICS.

2.3 As a stand alone piece of work the Clinical Strategy is not able to be "implemented" and crucially needs to relate to our Financial Strategy for example. The Clinical Strategy could then directly relate to the Efficiencies, Strategic and Structural elements of the financial strategy. This then would enable us to use the Clinical Strategy to develop our future ways of financial planning and indeed all elements of our future planning. This would enable our system to be clinically led as previously described.

2.4 Our current ICS Strategy has never been formally released and work done prior to the Covid-19 response has resulted in a Draft ICS Strategy. It was previously decided that formal engagement could not be carried out on the ICS Strategy until the development of the Clinical Strategy was carried out.

2.5 To ensure meaningful engagement it is important to describe the aim of the engagement and prevent unrealistic expectations. There is evidence of much engagement already done and this will be built upon as opposed to starting afresh. Agreement was made to embed the Clinical Strategy into the ICS Strategy and using this, engagement with the public to be carried out.

2.6 It had been previously agreed to use existing ICP and organisational communication and engagement routes but a discussion on resource to support the embedding of the

Clinical Strategy into a refined ICS Strategy needs to occur and will be actioned within the Executive team.

3. Reporting Structures

3.1 The Board requested that detailed work plans will need to sit under the 6 described pillars, namely Health and Well-being of our communities, Living Well, Managing Illness, Urgent and Emergency Care, End of Life Care, including frailty and dementia and lastly Workforce. It was explicitly stated that separate strategies will not be needed.

3.2 As this work has been developed with clinicians within the system it should be no surprise that there is a lot of the proposed work already ongoing. The ICS Executive team agreed to support mapping all the current work already underway to each of the above 6 described pillars. This would allow the development of an operational model for the Clinical Strategy and aid the prioritisation work already commenced. This is to be carried out by the PMO team.

3.3 Support had been requested from Board for appointment of SRO, clinical leads and financial leads for each of the 6 pillars. Whilst some leads were identifiable there was not appropriate individual for all the pillars due to their nature, eg Living Well including Self and Personalised Care, Mental health and Children's Services. It is now proposed to ensure each of the workstreams already identified and any that need to be commenced to support the Clinical Strategy all have SRO, Clinical and Financial leads nominated. This will enable a collaborative approach and a distribution of the work and responsibility.

4. High Level Principles

Discussion with ICS Executive colleagues has described how a set of high level principles would be useful for development of the workstreams. This is demonstrated for example using the HIP2 programme that the Board specifically noted must be informed by the outputs of the Clinical Strategy. Described below are the 5 key principles of the Clinical Strategy;

Principle 1 - We will be led by population need and will strive to truly understand the holistic needs of our population by embedding a population health management approach, and by targeting support and service provision from across our Integrated Care System partnerships.

Principle 2 - We will be led by our clinicians and care professionals, and by their experience and ambition, to improve the quality of care provided and to reduce variation by adopting a best practice standards approach and consistent measurements of patient outcomes.

Principle 3 - We will continue to build on the strong collaborative working and the common purpose which have been central to our response to the pandemic. These positive features have underpinned the strong response across our health and care system and our aim is to further embed them in the way we work.

Principle 4 - We will also continue to build on the 'system level' thinking we have developed in our response to the pandemic, sharing and using our collective data to inform where resources are required, providing mutual aid to ensure all of our services remain robust, and moving away from a single organisational focus. This has required

a shift in our leadership style which will increasingly need to be system, rather than organisation, based to respond to the needs of our population. Part of this shift in system thinking requires:

Better and more effective utilisation of our scarce workforce: as a system, we will think differently and consider the skills required to deliver patient centred care, rather than falling back on traditional professional and organisational boundaries. We will manage our workforce at a system level, developing a centralised recruitment function and a common identity for our L&SC staff

Understanding how we make best use of our collective estate to enable the delivery of our clinical strategy.

Principle 5 - We will galvanise the progress made on embedding digital solutions to integrate our health and care services and modernise the way we interact with our community and patients. We have made great progress, but have more to do to enable patients to self-care and live independently for longer; enable our clinical teams to work in a multidisciplinary way; and to enable the prediction and prevention of disease for our population. Digital advancements will in turn have implications for how we use our physical estate.

5. Conclusions

This paper has described the outcomes of the discussions of the ICS Executive requested by Board to allow the implementation of the previously endorsed Clinical Strategy. It recognises that it cannot stand alone as an isolated piece of work and needs to be fully embedded in the work of the ICS to ensure we achieve clinical leadership and future planning will need to reference back to the Clinical Strategy.

Engagement will be as part of the ICS Strategy work and through existing leads. Existing workstreams will also be mapped back to the Clinical Strategy and the triumvirate leadership described previously will be applied to the workstream level and not at the 6 pillars level previously recommended. The 5 High level principles are described to enable future workstreams to be guided by the Clinical Strategy and Boards is asked to continue to support these principles.

6. Recommendations

6.1 The Board is asked to

1. note the progress made,
2. support the embedding of the clinical strategy into future planning processes,
3. receive future mapping of the workstreams to the 6 pillars
4. continue support of the 5 High Level Principles.

Andy Curran

24th November 2020

ICS Board

Date of Meeting	Wednesday 2nd December 2020
Title of Paper	System Reform: A common strategic narrative for Integrated Care Partnerships (ICPs) within the Lancashire and South Cumbria Integrated Care System *ICS)
Presented By	Geoff Joliffe, Chair of the ICP Development Advisory Group (Chair, Morecambe Bay CCG, Joint Chair of Bay Health and Care Partners ICP)
Authors	ICP Programme Directors & ICS Executive Director of Commissioning Victoria Ellarby, Fylde Coast Karen Kyle, Bay Health & Care Partners Jackie Moran, West Lancashire Claire Richardson, Pennine Lancashire Sarah James, Central Lancashire Andrew Bennett, ICS
Agenda Item	8
Confidential	No

Purpose of the Paper

- To seek formal approval for the common ICP strategic narrative which has been updated to reflect feedback from the ICS Board in November 2020 and with continued extensive engagement across the ICS partnership;
- To provide an update on the actions undertaken during November 2020
- To seek approval for the continuation of Step 2 as outlined in the plan on a page, with support from NHSEI.
- To note the publication of the attached national guidance which will continue to inform the development of ICPs and the wider ICS ("Integrating care: Next steps to building strong and effective integrated care systems across England" (NHSEI) 26th November 2020.

Executive summary

In September 2020, the ICS Board agreed a two-step process for ICP development as part of the wider system reform agenda. Step 1 is the creation of a common ICP strategic narrative to set out what working in partnership means for us, what we want to do together as partners and how we will enable that change. Step 2 is the prioritisation and scoping of a number of work programmes to describe in greater detail, and subsequently deliver, the content of the strategic narrative.

The forthcoming publication of NHS Phase 4 guidance has previously been referenced as requiring consideration in relation to the development of ICPs. Whilst this guidance has not yet been formally issued, a paper entitled "Integrating care: Next steps to building strong and effective integrated care systems across England" was issued by NHSEI for discussion at the NHSEI Board meeting on 26th November 2020. This document is attached below.

There is strong alignment between this document and the common ICP strategic narrative, particularly in the following themes:

- The importance of 'place' as building block for health and care integration;
- Delivery through NHS providers, local government, primary care and the voluntary sector working together in each place, built around primary care networks (PCNs) in neighbourhoods
- Collaboration between providers (ambulance, hospital and mental health) across larger geographic footprints;
- Each place having appropriate resources, autonomy and decision-making capabilities;
- A clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management which could include places taking on delegated budgets;

- Closer working between the NHS, local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care;
- Place based leadership arrangements.

Step 1 – Common ICP Strategic Narrative
Throughout the process, it has been consistently noted that the content of the strategic narrative will not provide all the detail that is required in relation to describing how ICPs will function effectively. However, it has also been noted and agreed that the strategic narrative will be of benefit as a consistent and relatively high-level description of our ambitions for the future of ICPs within L&SC. It is important that this narrative is agreed in this spirit in order that we can move our focus to Step 2.

The ICP strategic narrative has been streamlined and updated to reflect the feedback from the ICS Board in November 2020, and further feedback from ICPs and the various sectors within the ICS. It also includes some key extracts from the document "Integrating care: Next steps to building strong and effective integrated care systems across England". As requested by the ICS Board, a separate executive summary has been created.

Formal approval is now sought from the ICS Board for the common ICP strategic narrative (Appendix A) and the executive summary (Appendix B) which will complete Step 1.

Following this approval, a more 'user-friendly' version of both documents will be created to support the next stage of the programme.

Step 2 – Agreeing and scoping the work programmes for ICP development
At the ICS Board meeting in November 2020, it was suggested that this would be approached in two phases:

- Step 2A – Work programmes that can be scoped and begin implementation prior to receipt of NHS Phase 4 guidance; and

- Step 2B – Work programmes that can only be *partially* scoped and are *unlikely to begin* implementation prior to receipt of NHS Phase 4 guidance

Feedback from the ICS Board was that this work should proceed at pace, pulling as much as possible from Step 2B into Step 2A, and accelerating this work to be completed rapidly. It was noted that there should not be a need to wait for Phase 4 guidance for this work.

During November 2020, the following actions have been completed, with oversight from the ICP Development Advisory Group:

- Priority work programmes have been agreed for step 2 as success measures for ICPs, leadership (including organisational development activities to support place-based leadership), governance and accountabilities, and financial frameworks;

- A plan on a page has been developed, outlining the priority work programmes and timescales for delivery (Appendix C);

- An initial communications and engagement plan has been drafted;

- A proposal for the development and use of an ICP maturity matrix, based on a national framework but tailored to the common ICP strategic narrative and to be 'kitemarked' by AQuA, has been agreed. This will be used to support self- and peer-assessments throughout the development timeframe;

- Discussions have been held with NHSE/I regarding a bespoke support offer for leaders across L&SC which will assist in the planning and delivery of Step 2, drawing on best practice from elsewhere and utilising national subject matter experts.

Formal approval is now sought from the ICS Board to proceed with Step 2 as outlined in the plan on a page, with support from NHSEI.

The ICP Development Advisory Group will oversee delivery of the plan, with outputs reported to the System Leadership Executive and onward to the ICS Board where required.

Recommendations

The ICS Board is asked to:

- **Approve** the common ICP strategic narrative and the executive summary, noting the amendments that have been made during November 2020 and strong alignment with the document "Integrating care: Next steps to building strong and effective integrated care systems across England" issued by NHSEI;
- **Note** the progress made with actions relating to Step 2;
- **Approve** the continuation of Step 2 as outlined in the plan on a page, with support from NHSEI.
- **Note** the publication of the attached national guidance which will continue to inform the development of ICPs and the wider ICS ("Integrating care: Next steps to building strong and effective integrated care systems across England" (NHSEI) 26th November 2020.

Governance and Reporting

(List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome
ICS Board	04.11.20	Document to be streamlined and strengthened in key areas.
System Leadership Executive	21.10.20	Agreed – recommended for approval by the ICS Board on 04.11.20
ICP Development Advisory Group	Throughout October 2020 and November 2020	Agreed – recommended for presentation to the SLE on 21.10.20 and the ICS Board on 04.11.20 Agreed – recommended for presentation to the ICS Board on 02.12.20
Various groups within individual ICPs and across sectors within the ICS	Throughout October 2020 and November 2020	Feedback provided for inclusion within version presented to the SLE on 21.10.20 Further feedback provided for inclusion with the version presented to the ICS Board on 02.12.20

Conflicts of Interest Identified

All partner organisations have an interest in the development of ICPs and the wider system reform plan.

Implications

Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Associated Risks	**Yes**	☐	**No**	☐	**N/A**	☒

Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☐	**N/A**	☒
If Yes, Please Provide a Risk Description and Reference Number	Mark Yes, No or Not Applicable Above and Provide a Risk Description and Risk Reference Number in this Box if there are Any Associated Risks					

Developing Integrated Care Partnerships in Lancashire and South Cumbria

Members of the public have a right to expect that their local public services work effectively together. Unfortunately, in recent years, it has been evident that some people experience services which are fragmented, where communication is poor and where they are left feeling that their needs and wishes are not heard or understood.

To tackle these challenges, NHS, council and community organisations have begun to improve their partnership working in local areas – with some good early results. We have called these Integrated Care Partnerships to sum up our ambitions for transforming services and helping local people to improve their own health and wellbeing. This document sets out in more detail how we want these Integrated Care Partnerships to mature in the future.

1. What do we mean by an 'Integrated Care Partnership'?

An Integrated Care Partnership (ICP) is a collaboration of planners and providers across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within a place, with a population of up to 500,000. Most people's day to day care and support needs will be met within a place and delivered in neighbourhoods of 30,000 to 50,000 people.

The document entitled "Integrating care: Next steps to building strong and effective integrated care systems across England", published by NHSEI on 26th November 2020 states that *"Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards."*

The partnership will create a feeling of belonging to a place, where all partners are valued and respected, and mutual support is offered to all partners. This will be particularly significant in challenging times. It is important to acknowledge that residents are co-partners in the continued evolution of ICPs, and that social movements in communities can increase people's ownership of their own health and wellbeing and mobilise communities to support each other.

The common purpose of an ICP is to act as an enabling collaboration that will address specific place-based challenges and deliver within each place the component parts of the Integrated Care System (ICS) strategy. The core aims of an ICP are to:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of a place-based financial allocation and resources and help the NHS to support broader social and economic development.

As a minimum, each ICP will have the following all age service provision at place level, working together to simplify and modernise care and implement service models which deliver improved outcomes:

- Public health and wider community development

- Community-based wellbeing support, including social prescribing activities, VCFSE provision and local access to green spaces, and leisure facilities
- GP and wider primary care, delivered through Primary Care Networks
- Community health care
- Community mental health care
- Urgent and emergency care, including physical and mental health (noting that some emergency services will be provided in a networked model across the ICS, e.g. stroke, trauma)
- Ongoing management of long-term conditions, including the use of skills, expertise and resources that have historically been accessed via referral to acute care services
- Local acute hospital services (noting that some services will be provided in a networked model across the ICS, and there will be tertiary services provided in some places for the ICS-wide
- population)
- Social care, education, housing, employment and training support

The providers of these services will be partners within the ICP working alongside place-based commissioning and planning teams.

Several providers will be working collaboratively at more than one level; for example, NHS Trusts who provide acute and community services will be collaborating within neighbourhoods through the provision of community services, within places through the provision of specialist expertise to support the ongoing management of long term conditions, and across the system in the networked provision of elective care.

In the future, it is expected that the NHS will move towards organisations within each ICP receiving a financial allocation for the place, based on capitation. This, along with the potential for increased use of pooled budgets, will mean that partners within the ICP will make collective decisions on how best to invest financial resources in order to deliver neighbourhood-based, place-based, regional and national requirements and ambitions across health, care and wellbeing. Partners will need to be clear on their own role in delivery and will need to hold each other to account to ensure collective achievement of their place-based objectives.

2. What will we need to do collectively as partners within an ICP?

To achieve the common purpose of an ICP, there are several areas where collaborative working will be needed:

2.1. Place-based leadership and collaboration

Effective, collaborative leadership – with a clear, common purpose, and drawn from all parts of the system including democratic, clinical and professional teams – has been shown to be essential to developing the partnership culture needed to create and sustain system-wide improvement. ICPs will:

- Co-create a vision for the place that delivers the system and place strategies through a partnership of equals.

- Provide a 'system management' function that connects the partners within the place, as well as influencing key priorities across the ICS and connecting each place to the wider system. This function will include shaping the culture of the partnership through a population health management approach to the planning and delivery of services; holding each other to account for delivery; acting as place-based and system-wide integrators and catalysts for change; brokering challenging conversations between partners; and ensuring that decisions are made in the best

interest of the place. It will need to encompass the expertise and experience of place-based commissioning and provision.

- Use this system management approach to support a collaboration of providers across different sectors and multiple organisations to build seamless, integrated services that respond to the health and wellbeing needs of local residents.

- Promote social value in our communities by employing a workforce that is drawn from, and representative of, the population in the place; by offering fair pay and conditions of employment; by offering employability programmes that support people to acquire the skills needed to work in health and care; and by offering apprenticeship programmes which assist in providing employment now and creating the workforce of the future.

- Promote, embed and demonstrate compassionate leadership across all services within the place.

- Build a culture of rapid improvement with a shared, consistently applied methodology; a management system that aligns improvement activity to priorities and ways of working; and a set of leadership behaviours which supports an engaged and empowered workforce.

- Implement accountability frameworks that incentivise evidence-based care provision and improved outcomes for individuals and for the population as a whole, shaping priorities and decision-making.

- Support effective place-based organisational development programmes, recognising the need for increased support during large-scale and/or sustained periods of change.

- Ensure systems are in place to provide comprehensive organisational development, coaching and mentoring support for leaders to facilitate the transition from organisational to place-based leadership behaviours and decision-making.

2.2. Listening to the voice of our communities

Our residents and communities are a fundamental part of our partnerships and their voice and lived experience is vitally important in creating the culture of a social movement in our neighbourhoods and places, in ensuring that residents' needs are heard and understood, and in shaping services that meet local needs. ICPs will:

- Ensure local engagement is culturally competent, in line with the demographics of the place.

- Engage with residents to ensure co-production in health and wellbeing needs assessments, delivery plans, operating models and service redesign / transformation activities.

- Listen to feedback from patients, carers, service users and residents to ensure that services are evaluated from quantitative and qualitative perspectives, and that this feedback is used to inform future service provision.

- Engage with residents (and our workforce, many of whom are residents themselves) to encourage a social movement that fosters and enhances an increased responsibility for health and wellbeing and mobilises communities to support each other better.

- Proactively work with communities to create a greater sense of accountability to the local population for the quality of services provided and the resultant outcomes.

- Seize the short-term benefits in restoration and incentivise change to build the culture and capability for the medium and long term.

2.3. Planning integrated services

A more integrated approach to the planning of services across all sectors will support more efficient and effective use of resources. ICPs will:

- Lead the creation of a fully integrated, place-based delivery plan that is able to respond to:
  - National strategies, plans, standards/targets
  - The requirements of national and regional regulators
  - Lancashire and South Cumbria ICS strategies
  - Existing place-based strategies
  - Place and neighbourhood-based health and wellbeing/joint strategic needs assessments

- Join up population intelligence capability, and health and local authority planning, including joint commissioning, transformation and at-scale change programmes, quality improvement, service delivery and empowered communities.

- Ensure that actual and potential inequalities are identified and addressed in all aspects of service planning and provision.

2.4. Delivering integrated services

Patients, service users and our own workforce often describe their frustrations at the fragmented nature of our service provision. A key shift in the transition to significantly increased partnership working should be the removal of unnecessary boundaries between services and professions. ICPs will:

- Work with partners to ensure the delivery of high quality, safe, affordable integrated services, tailored across the differing needs within the place footprint at neighbourhood/PCN, district and place.

- Ensure that all partners work together so that services will be predominantly focused on improving health and wellbeing through a population health management approach which will include self-care, preventative action, vulnerability reduction, anticipatory care, community-based models of care and support, long term condition management using digital technology, and addressing the wider determinants of health and wellbeing with clinicians and professional groups working at the top of their licence to support complex care in the community.

- Ensure that all partners work together so there is an operating model for the place that includes standard service offers and minimum standard specifications to reduce health inequalities and unwarranted variation within the place and, where appropriate, across the places within the ICS. These service offers and standard specifications will be outcome focused in order to allow for necessary flexibility in delivery and eliminate asynchronous care. The operating model will include:

  - Primary, community, acute, mental health and social care working as self-directed teams across organisational boundaries, to deliver services to 30-50k populations, driven by data, mobilising prevention and anticipatory care. PCNs will be at the core of these teams.

- Joining up of civic and community assets, providing partnership MDTs which will include housing, Department for Work and Pensions, voluntary sector support and access to community assets to support people to maintain independence.

- Long term condition management where the focus of specialist/consultant led support is on holistic continuous condition and exacerbation management, aimed at keeping people at home.

- More intensive community support when required to keep people at home, including at times of crisis

- Elective care, urgent and emergency care, including physical and mental health, providing timely and appropriate access

- Ensure that all partners work together to provide fully integrated health and care records that are available to all staff involved in the provision of care across the place, with information governance agreements that support and enable integrated working. The ambition is to move towards records that are resident owned.

- Make best use of digital solutions that will support residents staying in their own homes wherever safe and effective, predict need and support effective mobilisation of the workforce, and promote multi-disciplinary working to deliver seamless care.

2.5. Population health management

Moving towards a preventative, proactive and holistic approach to the health and wellbeing of our residents is key to improving outcomes and reducing inequalities. ICPs will:

- Ensure plans are in place to implement a population health management infrastructure and culture.

- Ensure that the ICP uses a population health management approach to service planning, i.e. making use of holistic data from multiple sources to identify the health and wellbeing needs of the population (place and neighbourhood).

- Ensure that a risk stratification approach is used to plan how services can meet health and wellbeing needs and reduce inequalities, including addressing the wider determinants of health and wellbeing such as housing, environmental quality and access to good employment and training.

- Use population data to mobilise the workforce, working to accountability frameworks that demonstrate delivery on outcomes and incentivise prevention and anticipatory care.

- Build a collaborative decision-making process that prioritises investment in anticipatory and preventative care to reduce specific risks and vulnerabilities within the local population.

- Ensure the creation of integrated population health management units in neighbourhoods by building on existing neighbourhood working, community hubs, and PCNs, whilst also drawing in acute care specialists who focus on long term conditions and the elderly.

2.6. Improving quality of services

We know that many services in our system provide good quality care which is rated highly by patients and services users. It is important for us to build on that and learn from these teams / organisations to provide consistent, high quality care across each place. ICPs will:

- Ensure all partners work together so that actual and potential inequalities are identified and addressed in all aspects of service planning and provision
- Ensure place-based performance and assurance is focused on delivering the required improvements in population health, outcomes and inequalities.
- Ensure all partners use an evidence-based approach to care planning and provision, simplifying and standardising pathways across the place and within neighbourhoods.
- Lead the deployment of improvement science at pace and scale to support rapid cycles of change, allowing freedom to act and promoting innovation.
- Create an integrated, place-based plan for the provision of high quality services that meets the requirements of the regulators across the sectors within the partnership.
- Create and maintain an open and transparent culture that encourages incident reporting, management of serious incidents and the implementation of associated learning from incidents across all sectors within the partnership.
- Ensure there is sufficient capacity and that services are of the highest quality to meet required national standards / targets
- Design and deliver culturally competent personalised care services.

2.7. Maximising the use of resources

Resources within each place are scarce and it is therefore important that we use these wisely in order to gain the maximum benefit for our residents. It is therefore proposed that the actions set out below will accelerate the next stage of development. ICPs will:

- Use a place-based collective prioritisation and decision-making framework to agree the allocation of these financial resources within the place.
- Work with partners to create an integrated, place-based financial plan that supports population-based budgets and demonstrates best value for the 'place pound' whilst maximising impact on population health, health inequalities, quality of service provision and outcomes.
- Use contracting and payment mechanisms within the place that are based on incentives, with agreed shared risk / gain models and aligned financial processes, building on the PCN Directed Enhanced Services and local quality schemes.
- Plan and deliver local cost improvement schemes to ensure best value for money.
- Ensure local understanding of community-based physical assets and influence their collective use across partners within the place.

- Make best use of business intelligence / health informatics resources across the ICP partners, and as appropriate with wider partners across the ICS, to provide real time information for use across the place and a single suite of performance / assurance reports

- Integrate corporate teams to work across the place rather than maintaining separate teams in individual organisations.

- In time, it is anticipated that ICPs will be collectively accountable for a place-based capitated NHS budget within an agreed ICS financial framework along with any pooled budgets across the NHS and other partners within the ICP. More detailed national guidance is anticipated which will outline the expectations for ICSs and ICPs.

2.8. Valuing and developing the workforce

The partners within each ICP employ a significant number of people, many of whom are also residents within the place where they work. Partners have a duty to support their workforce and to contribute to the socioeconomic development of the place. There are a significant number of volunteers in each place who make invaluable contributions that should be supported and recognised. ICPs will:

- Recognise that key partners are anchor institutions in each place, acknowledging the fundamental role they have in advancing the welfare of the populations they serve and the way in which they can support local community wealth and development.

- Be a partnership of employers that proactively supports the employment of our local people by providing equity of access to opportunities and employing a workforce that is drawn from, and representative of, the population served by the place.

- Support fair and equitable pay and conditions of employment including paying a living wage and providing stable employment which offers fair working conditions and promotes the health and wellbeing of all staff.

- Ensure that partners develop and offer employability programmes that provide training and support to help local people acquire the skills needed to work in health and care, and work with community partners to support residents who might otherwise face barriers to work.

- Work with local Academies, schools, Further Education colleges and Higher Education institutions to offer apprenticeship programmes which assist in providing employment for the local community and in supporting the creation of the workforce of the future.

- Work with partners to create a placed-based people plan for the recruitment, retention and ongoing development of an integrated workforce.

- Integrate the workforce to support seamless service provision and minimise handovers between individuals and organisations across the partners within the place.

- Provide joint appointments and rotational posts across multiple care settings in order to make best use of, and/or further enhance, skills and experience

- Support professional development and career progression to staff at all levels and across all aspects of provision.

3. How will we need to work together as partners within an ICP?

At the current time, it is not anticipated that ICPs will be statutory organisations. It must be recognised that under current legislation, certain types of organisations are accountable to specific regulators, with ring-fenced budgets, and will be held to account for delivering certain services and/or functions. Therefore, we need to consider what can and cannot be undertaken collectively, how we will organise ourselves to manage this locally, and how we will respond to our respective regulators. This will require liaison with regional and national teams to support the shift from organisational accountabilities to place-based accountabilities. This is likely to require a new and explicit mechanism for holding ICPs to account for what is in scope of place-based, collective delivery.

Partners within an ICP will share responsibilities, risks and resources. This will require some delegation of decision-making to the place rather than organisations, clarity on which partners are delivering which services / functions within the ICP, and changes to current organisational-based leadership structures and governance arrangements.

Delegated decision making

Each ICP will require a framework that defines the scope within which decision-making happens by place-based system leaders operating within parameters agreed by the partner organisations.

This is likely to be achieved via a scheme of delegation that is explicit about what will be managed via organisations and what will be managed via the ICP. This will include decision-making across all of the functions of the ICP, and all partners within the ICP.

Supporting governance arrangements

Each ICP will require a structure where it can exercise this delegated decision-making, ensuring that partners deliver what has been agreed, and maintaining appropriate levels of lay/non-executive oversight and clinical engagement.

As part of this process each ICP will need to consider the following requirements:

- The use of formal memoranda of understanding, partnership agreements or alliances to provide clarity on the role and responsibilities of each partner organisation within the ICP

- A place where delegated decision making from the statutory bodies can be discharged, i.e. a place based ICP Board that is the decision-making group of the ICP, as outlined by a scheme of delegation and enacted by the members of the ICP Board. This may need to be supported by other place-based committees, which could function using a Committees in Common approach.

- A cross-organisational, multi-professional clinical and professional leadership body that allows senior clinicians / practitioners from across the partners within health, social care and third sector within the ICP to make decisions / recommendations on clinical practice, pathways, etc.

- Meaningful clinical, professional and democratic leadership and engagement, to ensure that there is appropriate representation and engagement across neighbourhoods, districts and the place.

- A mechanism for identifying and managing risk for the ICP, with proportionate distribution of risk across partners, and clarity on which partner within the ICP owns the risk along with which partners contribute to the mitigations

- Systems and processes for partners in the place to hold each other to account for performance and support each other where necessary. These will need to align to the accountability framework within the ICS and the approach agreed with regulators.

It should be noted that effective implementation of these governance arrangements may require changes to current organisational constitutions and Terms of Reference of existing organisational groups.

Supporting leadership arrangements

Each ICP will require a leadership team for the place that will be made up of existing executives and chairs from within the ICP. They will act as a collaborative and distributed leadership team but will continue to hold any individual organisational leadership roles and accountabilities whilst working to deliver the core aims of an ICP.

Each ICP will need to consider the following:

- An ICP Chair who will be responsible for creating productive collaborative relationships within the ICP and across the ICS, and for effective leadership of the ICP Board and its role in ensuring delivery of the core aims of the ICP

- An executive leadership team with members who have responsibilities for delivery across the place whilst but will continue to hold individual organisational leadership roles and accountabilities whilst working to deliver the core aims of an ICP.

- High levels of clinical and professional leadership and influence, where leaders are acting as a collective voice on behalf of the health and care system.

- Shared purpose and values that have been adopted by the ICP partners

- Leaders who demonstrate high levels of trust, collectively overcome challenges, celebrate shared success and drive continuous improvement to shared objectives through adaptive change and a learning culture.

- Leaders who role model values and behaviours and cascade down through their teams.

- Leaders who respect that the voice of all partners has equal weight and value.

It is suggested that there will be a need for an ‘Integration Lead’ within each ICP. It is intended that this role will work alongside the senior executives from the partners within the ICP and local communities to:

- Ensure effective integrated approaches are taken to the health needs of the local population – using population health management techniques and building on the experience and expertise within communities.

- Support the development of integration across all services (primary / community / care / hospital / VCFSE) in the place and ensuring that PCNs work effectively to support each neighbourhood of 30,000 to 50,000 residents.

- Work with health partners and local authorities to identify joint opportunities for health and care services to be transformed, building on lessons learned through the response to the Covid-19 pandemic and the potential to use new technology.

- Coordinate local contributions to health, social and economic development – set as appropriate within the context of wider system strategies

Integrated Care Partnerships in Lancashire and South Cumbria: Executive Summary

What do we mean by an 'Integrated Care Partnership'?

An Integrated Care Partnership (ICP) is a collaboration of planners and providers across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within a place.

The document entitled "Integrating care: Next steps to building strong and effective integrated care systems across England", published by NHSEI on 26th November 2020 states that *"Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards."*

An ICP will act as an enabling collaboration to address specific place-based challenges and deliver within each place the component parts of the Integrated Care System (ICS) strategy. The core aims of an ICP are to:

- Improve the health and wellbeing of the population and reduce inequalities
- Provide consistent, high quality services that remove unwarranted variation in outcomes
- Consistently achieve national standards / targets across the sectors within the partnership
- Maximise the use of a place-based financial allocation and resources and help the NHS to support broader social and economic development.

What will we need to do collectively as partners within an ICP?

To achieve the core aims of an ICP strong collaborative working will be required across a number of areas:

- **Place-based leadership and collaboration**: Effective, collaborative leadership across planning and provision will develop the partnership culture required to create and sustain system-wide improvement. ICPs will use accountability frameworks to incentivise evidence-based care provision and improved outcomes for individuals and for the population as a whole, using these to shape collective priorities and decision-making.

- **Listening to the voice of our communities**: Our residents and communities are a fundamental part of our partnerships and their voice and lived experience is vitally important in creating the culture of a social movement in our neighbourhoods and places, in ensuring that residents' needs are heard and understood, and in shaping services that meet local needs. ICPs will be expected to have a greater sense of accountability to the local population for the quality of services provided and the resultant outcomes

- **Planning integrated services**: A more integrated approach to the planning of services across all sectors will support more efficient and effective use of resources. ICPs will be accountable for developing fully integrated, place-based delivery plans that ensure actual and potential inequalities are identified and addressed.

- **Delivering integrated services**: ICP partners will ensure the delivery of high quality, safe, affordable integrated services, tailored across the differing needs within the place footprint at neighbourhood/PCN, district and place. Partners will work together to create and deliver an operating model that includes standard service offers and minimum standard specifications to reduce health inequalities and unwarranted variation within the place. The operating model will include primary, community, acute, mental health and social care to deliver services to 30-50k populations; joining up of civic and community assets; long term condition management; more intensive community support; elective care, urgent and emergency care, including physical and mental health.

- **Population health management**: ICPs will take a risk stratification approach to the wellbeing of the place-based population, including addressing wider determinants such as housing, environmental quality and access to good employment and training. Moving towards this preventative, proactive and holistic approach to the health and wellbeing of our residents is fundamental to improving outcomes and reducing inequalities.

- **Improving quality of services**: ICPs will use an evidence-based and improvement science approach to care planning and provision, simplifying and standardising pathways across the place and within neighbourhoods, and

  create an open and transparent culture that encourages incident reporting and learning from incidents across all sectors within the partnership.

- **Maximising the use of resources**: ICPs will be collectively accountable for a place-based capitated NHS budgets, along with any pooled budgets across the NHS and other partners within the ICP. Partners in the ICP will deliver a place-based financial plan that supports population-based budgets and demonstrates best value for the 'place pound' whilst maximising impact on population health, health inequalities, quality of service provision and outcomes.

- **Valuing and developing the workforce**: ICPs will have a duty to support their workforce and to contribute to the socioeconomic development of the place through being anchor institutions, supporting the employment of local people with fair pay and conditions. Partners in the ICP will be required to create a placed-based people plan for the recruitment, retention and ongoing development of an integrated workforce.

How will we need to work together as partners within an ICP?

It must be recognised that under current legislation, certain types of organisations are accountable to specific regulators, with ring-fenced budgets, and will be held to account for delivering certain services and/or functions. Therefore, we need to consider what can and cannot be undertaken collectively. Partners within an ICP will be expected to proportionately share responsibilities, risks and resources. This will require some delegation of decision-making to the place rather than organisations, clarity on which partners are delivering which services / functions within the ICP, and changes to current organisational-based leadership structures and governance arrangements. To achieve this, ICPs will need to organise and structure themselves in a clear and consistent way across Lancashire and South Cumbria:

- **Delegated decision making**: Each ICP will develop a scheme of delegation that is explicit about what will be managed via individual organisations and via the ICP. This will include decision-making across the scope of services within the ICP, and across all partners within the ICP.

- **Supporting governance arrangements**: Each ICP will develop a structure enabling it to exercise delegated decision-making (i.e. an ICP Board, which may need to be supported by other place-based committees) with appropriate levels of lay/non-executive oversight and meaningful clinical, professional and democratic participation. The use of formal memoranda of understanding, partnership agreements or alliances will provide clarity on the role and responsibilities of each partner. Partners will need a robust mechanism for identifying and managing risk for the ICP and its constituent partners, with appropriate distribution and clarity on which partner owns the risk along with which partners contribute to the mitigations. Systems and processes for partners to hold each other to account for performance and support each other where necessary will need to be aligned with an accountability framework and the approach agreed with regulators.

- **Supporting leadership arrangements**: Each ICP will require a leadership team for the place that will be made up of existing executives and chairs from within the ICP. They will act as a collaborative and distributed leadership team but will continue to hold any individual organisational leadership roles and accountabilities whilst working to deliver the core aims of an ICP. A key role within the ICP will be an 'Integration Lead' who will advocate for, and lead on, a population health management within the ICP, support the development of integration across all services, to identify joint opportunities for health and care services to be transformed and coordinate local contributions to health, social and economic development. Leaders will promote a shared purpose and values that have been adopted by ICP partners, along with high levels of clinical and professional leadership and influence, and a recognition that the voice of all partners has equal weight and value.

Integrating care

Next steps to building strong and effective integrated care systems across England

Contents

Introduction

This document builds on previous publications that set out proposals for legislative reform and is primarily focused on the operational direction of travel. It opens up a discussion with the NHS and its partners about how ICSs could be embedded in legislation or guidance. Decisions on legislation will of course then be for Government and Parliament to make.

This builds on the route map set out in the *NHS Long Term Plan*, for health and care joined up locally around people's needs. It signals a renewed ambition for how we can support **greater collaboration** between partners in health and care systems to help accelerate progress in meeting our most critical health and care challenges.

It details how systems and their constituent organisations will accelerate **collaborative ways of working** in future, considering the key components of an effective integrated care system (ICS) and reflecting what a range of local leaders have told us about their experiences during the past two years, including the immediate and long-term challenges presented by the COVID-19 pandemic.

These are significant new steps towards the ambition set out in the *NHS Long Term Plan*, building on the experience of the earliest ICSs and other areas. Our challenge now is to spread their experience to every part of England. From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:

- Stronger **partnerships in local places** between the NHS, local government and others with a more central role for primary care in providing joined-up care;
- **Provider organisations** being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and
- Developing strategic **commissioning** through systems with a focus on population health outcomes;
- The use of **digital and data** to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.

This document also describes options for giving ICSs a firmer footing in **legislation** likely to take affect from April 2022 (subject to Parliamentary decision). These proposals sit alongside other recommendations aimed at removing legislative barriers to integration across health bodies and with social care, to help deliver better care and outcomes for patients through collaboration, and to join up national leadership more formally. NHS England and NHS Improvement are inviting views

on these proposed options from all interested individuals and organisations by Friday 8 January.

It builds on, and should be read alongside, the commitments and ambitions set out in the *NHS Long Term Plan* (2019), *Breaking Down Barriers to Better Health and Care (2019)* and *Designing ICSs in England* (2019), and our *recommendations to Government and Parliament for legislative change (2019)*.

1. Purpose

1.1. The NHS belongs to us all[1] and any changes to it must bring clear improvements for our health and care. Since 2018, integrated care systems (ICSs) have begun doing just this, enabling NHS organisations, local councils, frontline professionals and others to join forces to plan and provide around residents' needs as locally as possible.

1.2. By doing this, they have driven a 'bottom-up' response to the big health and care challenges that we and other countries across the world face and have made a real difference to people's lives. They have improved health, developed better and more seamless services and ensured public resources are used where they can have the greatest impact.

1.3. These achievements have happened despite persistent complexity and fragmentation. This document describes how we will simplify support to local leaders in systems, making it easier for them to achieve their ambitions. Our proposals are designed to serve four fundamental purposes:

- improving population health and healthcare;
- tackling unequal outcomes and access;
- enhancing productivity and value for money; and
- helping the NHS to support broader social and economic development.

1.4. The *NHS Long Term Plan* set out a widely supported route map to tackle our greatest health challenges, from improving cancer care to transforming mental health, from giving young people a healthy start in life to closing the gaps in health inequalities in communities, and enabling people to look after their own health and wellbeing.

1.5. The COVID-19 pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

1.6. This has all been backed up by mutual aid agreements, including with local councils, and shared learning to better understand effective response. It has

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

required openness in data sharing, commitment to collaboration in the interests of patients and communities, and agile collective decision-making.

1.7. The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. DHSC's 'Busting Bureaucracy: Empowering frontline staff by reducing excess bureaucracy in the health and care system in England' report, published on the 24th November 2020, describes in detail some of these important areas of change. The report found that there are many sources of excess bureaucracy and that these are often exacerbated by duplicative or disproportionate assurance systems and poorly integrated systems at a national, regional and local level. The report also acknowledges that the more levels of hierarchy in a system, the more likely it is that bureaucracy will exist and grow. ICS' therefore have the potential to reduce bureaucracy through increased collaboration, leaner oversight through streamlined assurance structures and smarter data-sharing agreements.

1.8. To deliver the core aims and purposes set out above, we will need to devolve more functions and resources from national and regional levels to local systems, to develop effective models for joined-up working at "place", ensure we are taking advantage of the transformative potential of digital and data, and to embed a central role for providers collaborating across bigger footprints for better and more efficient outcomes. The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing.

1.9. This reflects three important observations, building on the *NHS Long Term Plan*'s vision of health and care joined up locally around people's needs:

- **decisions taken closer to the communities** they affect are likely to lead to better outcomes;
- **collaboration between partners in a place** across health, care services, public health, and voluntary sector can overcome competing objectives and separate funding flows to help address health inequalities, improve outcomes, and deliver joined-up, efficient services for people; and
- **collaboration between providers** (ambulance, hospital and mental health) across larger geographic footprints is likely to be more effective than competition in sustaining high quality care, tackling unequal access to services, and enhancing productivity.

1.10. This takes forward what leaders from a range of systems have told us about their experiences during the past two years.

Devolution of functions and resources

1.11. Joining up delivery is not enough on its own. In many areas, we can shift national or regional resources and decision-making so that these are closer to the people they serve. For example, it will make sense to plan, commission and organise certain specialised services at ICS level, and to devolve a greater share of primary care funding and improvement resource to this more local level.

1.12. ICSs also need to be able to ensure collectively that they are addressing the right priorities for their residents and using their collective resources wisely. They will need to work together across partners to determine:

- **distribution of financial resources** to places and sectors that is targeted at areas of greatest need and tackling inequalities;
- **improvement and transformation resource** that can be used flexibly to address system priorities;
- **operational delivery** arrangements that are based on collective accountability between partners;
- **workforce planning, commissioning and development** to ensure that our people and teams are supported and able to lead fulfilling and balanced lives;
- **emergency planning and response** to join up action at times of greatest need; and
- the use of **digital and data** to drive system working and improved outcomes.

"Place": an important building block for health and care integration

1.13. For most people their day-to-day care and support needs will be expressed and met locally in the place where they live. An important building block for the future health and care system is therefore at '**place**.'

1.14. For most areas, this will mean long-established local authority boundaries (at which joint strategic needs assessments and health and wellbeing strategies are made). But the right size may vary for different areas, for example reflecting where meaningful local communities exist and what makes sense to all partners. Within each place, services are joined up through primary care networks (PCNs) integrating care in neighbourhoods.

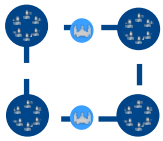
1.15. Our ambition is to create an **offer to the local population of each place**, to ensure that in that place everyone is able to:

- access clear advice on **staying well**;
- access a range of **preventative services**;
- access **simple, joined-up care and treatment** when they need it;
- access digital services (with non-digital alternatives) that put the citizen at the heart of their own care;
- access proactive support to keep as well as possible, where they are **vulnerable or at high risk**; and to
- expect the NHS, through its employment, training, procurement and volunteering activities, and as a major estate owner to play a full part in **social and economic development** and **environmental sustainability**.

1.16. This offer will be met through providers of primary care, community health and mental health services, social care and support, community diagnostics and urgent and emergency care working together with meaningful delegated budgets to join up services. It will also allow important links to be made to other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing.

1.17. Delivery will be through NHS providers, local government, primary care and the voluntary sector working together in each place in ICSs, built around primary care networks (PCNs) in neighbourhoods.

Developing provider collaboration at scale



1.18. At some times, many people will have more complex or acute needs, requiring specialist expertise which can only be planned and organised effectively over a larger area than 'place'. This may be because concentrating skills and resources in bigger sites improves quality or reduces waiting times; because it is harder to predict what smaller populations will need; or because scale working can make better use of public resources.

1.19. Because of this, some services such as hospital, specialist mental health and ambulance needs to be organised through **provider collaboration** that operates at a whole-ICS footprint – or more widely where required.

1.20. We want to create an **offer that all people served by an ICS** are able to:

- access a full range of high-quality acute hospital, mental health and ambulance services; and

- experience fair access to these services, based on need and not factors such as geography, race or socio-economic background.

1.21. We also need to harness the involvement, ownership and innovation of clinicians, working together to design more integrated patient pathways horizontally across providers and vertically within local place-based partnerships.

2. Putting this into practice

2.1. There are many good examples of recent system working that have improved outcomes and productivity, and helped to address inequalities. But COVID has made the case for a step up in scope and ambition. NHS and local government are increasingly pressing for a more driven and comprehensive roll out of system working.

2.2. So, in this section we set out a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint. The main themes are:

1. Provider collaboratives
2. Place-based partnerships
3. Clinical and professional leadership
4. Governance and accountability
5. Financial framework
6. Data and digital
7. Regulation and oversight
8. How commissioning will change

2.3. We will support preparatory work during 2021/22 with further guidance for systems and in the NHS Operational Planning Guidance for 2021/22.

Provider collaboratives

2.4. Provider organisations will play an **active and strong leadership role** in systems. Through their mandated representation in ICS leadership and decision-making, they will help to set system priorities and allocate resources.

2.5. **Providers will join up services across systems.** Many of the challenges that systems face cannot be solved by any one organisation, or by any one provider. Joining up the provision of services will happen in two main ways:

- **within places** (for example, between primary, community, local acute, and social care, or within and between primary care networks) through place-based partnerships as described above ('vertical integration'); and

- **between places** at scale where similar types of provider organisation share common goals such as reducing unwarranted variation, transforming services, providing mutual aid through a formal provider collaborative arrangement ('horizontal integration' – for example, through an alliance or a mental health provider collaborative).

2.6. **All NHS provider trusts will be expected to be part of a provider collaborative**. These will vary in scale and scope, but all providers must be able to take on responsibility for acting in the interests of the population served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

2.7. This greater co-ordination between providers at scale can support:

- higher quality and more sustainable services;
- reduction of unwarranted variation in clinical practice and outcomes;
- reduction of health inequalities, with fair and equal access across sites;
- better workforce planning; and
- more effective use of resources, including clinical support and corporate services.

2.8. For provider organisations operating across a large footprint or for those working with smaller systems, they are likely to create **provider collaboratives that span multiple systems** to provide an effective scale to carry out their role.

2.9. For ambulance trusts specifically we would expect collaboration and integration at the right scale to take place. This should operate at scale to plan resources and join up with specialist providers, and at a more local level in places where focused on the delivery and redesign with other partners of urgent and emergency care pathways.

2.10. We want to spread and build on good work of this type already under way. The partnerships that support this collaboration (such as provider alliances) often take place on a different footprint to ICS boundaries. This should continue where clinically appropriate, with NHS England and NHS Improvement helping to ensure consistent and coherent approaches across systems, especially for smaller partnerships.

2.11. Local flexibility will be important but providers in every system, through partnership or any new collaborative arrangements, must be able to:

- deliver relevant programmes on behalf of all partners in the system;
- agree proposals developed by clinical and operational networks, and implement resulting changes (such as implementing standard

operating procedures to support agreed practice; designating services to ensure their sustainability; or wider service reconfiguration);

- challenge and hold each other to account through agreed systems, processes and ways of working, e.g. an open-book approach to finances/planning;
- enact mutual aid arrangements to enhance resilience, for example by collectively managing waiting lists across the system.

2.12. In some systems, larger providers may also choose to use their scale to host functions on behalf of other system partners.

2.13. NHS England and NHS Improvement will set out further guidance in early 2021, describing a number of potential models for provider collaboratives, based on those that have been established in some parts of the country, including looser federations and more consolidated forms.

2.14. We know that providers are already making progress towards effective, collaborative working arrangements despite the constraints of relevant legislation and frameworks. Indeed, many crucial features of strong system working – such as trust between partners, good leadership and effective ways of working – cannot be legislated for.

But we recognise that these could be supported by changes to legislation, including the introduction of a 'triple aim' duty for all NHS providers to help align priorities, and the establishment of ICSs as statutory bodies with the capacity to support population-based decision-making and to direct resources to improve service provision. Our recommendations for this are set out in part 3.

2.15. Systems will continue to play an increasingly important role in developing multidisciplinary leadership and talent, coordinating approaches to recruiting, retaining and looking after staff, developing an agile workforce and making best use of individual staff skills, experience and contribution.

2.16. From April 2022, this will include:

- developing and supporting a 'one workforce' strategy in line with the NHS People Plan and the People Promise, to improve the experience of working in the NHS for everyone;
- contributing to a vibrant local labour market, with support from partner organisations and other major local employers, including the care home sector and education and skills providers.
- enabling employees to have rewarding career pathways that span the entire system, by creating employment models, workforce sharing arrangements and passporting or accreditation systems that enable

their workforce to be deployed at different sites and organisations across (and beyond) the system, and sharing practical tools to support agile and flexible working;

- valuing diversity and developing a workforce and leadership which is representative of the population it serves; and
- supporting organisational and leadership development at all levels, including talent management. This should encompass investment in, and the development of improvement expertise.

Place-based partnerships

2.17. In many places, there are already **strong and effective place-based partnerships** between sectors. Every area is different, but common characteristics of the most successful are the full involvement of all partners who contribute to the place's health and care; an important role for local councils (often through joint appointments or shared budgets); a leading role for clinical primary care leaders through primary care networks; and a clear, strategic relationship with health and wellbeing boards.

2.18. The place leader on behalf of the NHS, as set out above, will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way. They will have four main roles:

- to support and develop primary care networks (PCNs) which join up primary and community services across local neighbourhoods;
- to simplify, modernise and join up health and care (including through technology and by joining up primary and secondary care where appropriate);
- to understand and identify – using population health management techniques and other intelligence – people and families at risk of being left behind and to organise proactive support for them; and
- to coordinate the local contribution to health, social and economic development to prevent future risks to ill-health within different population groups.

2.19. Systems should ensure that each place has **appropriate resources, autonomy and decision-making capabilities** to discharge these roles effectively, within a clear but flexible accountability framework that enables collaboration around funding and financial accountability, commissioning and risk management. This could include places taking on delegated budgets.

2.20. Partnerships within local places are important. Primary care networks in neighbourhoods and thriving community networks are also provider collaboratives, and for integration to be successful we will need primary care

working with community, mental health, the voluntary sector and social care as close to where people live as possible.

2.21. The exact division of responsibilities between system and place should be based on the principle of subsidiarity – with the system taking responsibility only for things where there is a clear need to work on a larger footprint, as agreed with local places.

The NHS's offer to local government

2.22. We will work much more closely with local government and the voluntary sector at place, to ensure local priorities for improved health and care outcomes are met by the NHS becoming a more effective partner in the planning, design and delivery of care. This will ensure residents feel well supported, with their needs clearly understood; and with services designed and delivered in the most effective and efficient way for each place.

2.23. As ICSs are established and evolve, this will create opportunities to further strengthen partnership working between local government, the NHS, public health and social care. Where partnership working is truly embedded and matured, the ability to accelerate place-based arrangements for local decision-making and use of available resources, such as delegated functions and funding, maximises the collective impact that can be achieved for the benefit of residents and communities.

Clinical and professional leadership

2.24. Clinical and other frontline staff have led the way in working across professional and institutional boundaries, and they need to be supported to continue to play a significant leadership role through systems. ICSs should embed **system-wide clinical and professional leadership** through their partnership board and other governance arrangements, including **primary care network** representation.

2.25. **Primary care clinical leadership** takes place through critical leadership roles including:

- Clinical directors, general practitioners and other clinicians and professionals in primary care networks (PCNs), who build partnerships in **neighbourhoods** spanning general practice, community and mental health care, social care, pharmacy, dentistry, optometry and the voluntary sector.
- Clinical leaders representing primary care in **place-based partnerships** that bring together the primary care provider leadership role in federations and group models

- A primary care perspective at system level.

2.26. **Specialist clinical leadership** across secondary and tertiary services must also be embedded in systems. Existing **clinical networks** at system, regional and national level have important roles advising on the most appropriate models and standards of care, in particular making decisions about clinical pathways and clinically-led service change. System-wide clinical leadership at an ICS and provider collaborative footprint through clinical networks should:

- be able to carry out clinical service strategy reviews on behalf of the ICS;
- develop proposals and recommendations that can be discussed and agreed at wider decision-making forums; and
- include colleagues from different professional backgrounds and from different settings across primary care, acute, community and mental health care.

2.27. **Wider clinical and professional leadership** should also ensure a strong voice for the wide range of skills and experience across systems. From nursing to social care, from allied health professionals to high street dentists, optometrists and pharmacists, and the full range of specialisms and care settings, people should receive services designed and organised to reflect the expertise of those who provide their care.

Governance and public accountability

2.28. Systems have told us from recent experience that good partnership working must be underpinned by mutually-agreed governance arrangements, clear collective decision-making processes and transparent information-sharing.

2.29. In the *NHS Long Term Plan* and *NHS planning and contracting guidance for 2020/21*, we described a set of consistent operating arrangements that all systems should put in place by 2021/22. These included:

- system-wide governance arrangements (including a system partnership board with NHS, local councils and other partners represented) to enable a collective model of responsibility and decision-making;
- quality governance arrangements, notably a quality lead and quality group in systems, focused on assurance, planning and improvement;
- a leadership model for the system, including an ICS leader with sufficient capacity and a chair appointed in line with NHSEI guidance; and
- agreed ways of working with respect to financial governance and collaboration.

2.30. ICSs now need to put in place firmer governance and decision-making arrangements for 2021/22, to reflect their growing roles and responsibilities. With the below consistent framework, these should be flexible to match local needs.

2.31. As part of this, each system should define:

- **'place' leadership** arrangements. These should consistently involve:
    i. every locally determined 'place' in the system operating a partnership with joined-up decision-making arrangements for defined functions;
    ii. the partnership involving, at a minimum, primary care provider leadership, local authorities, including Director of Public Health and providers of community and mental health services and Healthwatch;
    iii. agreed joint decision-making arrangements with local government; and
    iv. representation on the ICS board.

  They may flexibly define:

    i. the configuration, size and boundaries of places which should reflect meaningful communities and scale for the responsibilities of the place partnership;
    ii. additional membership of each place partnership that is likely to include acute providers, ambulance trusts, the voluntary sector and other partners;
    iii. the precise governance and decision-making arrangements that exist within each place; and
    iv. their voting arrangements on the ICS board.

- **provider collaborative leadership** arrangements for providers of more specialist services in acute and mental health care. These should consistently involve:
    i. every such provider in a system operating as part of one or more agreed provider collaboratives with joined up decision-making arrangements for defined functions;
    ii. provider collaboratives represented on the appropriate ICS board(s).

  They may flexibly define:

    i. the scale and scope of provider collaboratives. For smaller systems, provider collaboratives are likely to span multiple systems and to be represented on the board of each. These arrangements should reflect a meaningful scale for their responsibilities;

ii. the precise membership of each collaborative (acute providers, specialist providers, ambulance trusts at an appropriate footprint, mental health providers);

iii. the precise governance and decision-making arrangements that exist within each collaborative; and

iv. their voting arrangements on the ICS board.

- **individual organisation** accountability within the system governance framework. This will consistently involve:

  i. the responsibility and accountability of the individual provider organisations for their current range of formal and statutory responsibilities (which are unchanged); and

  ii. the accountability relationship between the provider organisation and all place-based partnerships and provider collaboratives of which it is a member.

  It may flexibly define:

  iii. Any lead provider responsibility that the organisation holds on behalf of a place partnership or a provider collaborative.

2.32. Integrated care systems draw their strength from the effectiveness of their constituent parts. Their governance should seek to minimise levels of decision-making and should set out defined responsibilities of organisations, partnerships at place, provider collaboratives and the core ICS role. Each ICS should seek to ensure that all the relevant bodies feel ownership and involvement in the ICS.

2.33. The local test for these governance arrangements is whether they enable joined-up work around a shared purpose. Provider collaboratives and place-based partnerships should enable peer support and constructive challenge between partners delivering services and accelerate partners' collective ability to improve services in line with agreed priorities.

2.34. The greater development of working at place will in many areas provide an opportunity to align decision-making with local government, including integrated commissioning arrangements for health and social care, and local responsiveness through health and wellbeing boards. There is no one way to do this, but all systems should consider how the devolution of functions and capabilities to systems and places can be supported by robust governance arrangements.

2.35. ICS governance is currently based on voluntary arrangements and is therefore dependent on goodwill and mutual co-operation. There are also legal constraints on the ability of organisations in an ICS to make decisions jointly. We have previously made a number of recommendations for legislative change to Government and Parliament to increase flexibility in decision making by enabling decision making joint committees of both

commissioners and providers and also committees of Providers. Section 3 of this document captures these options and also describes our thinking on clarifying arrangements for an ICS.

2.36. Many systems have shown great ways to involve and take account of the views and priorities of local residents and those who use services, as a 'golden thread' running through everything they do. During 21/22, every ICS should work to develop systematic arrangements to involve lay and resident voices and the voluntary sector in its governance structures, building on the collective expertise of partners and making use of pre-existing assets and forums such as Healthwatch and citizen's panels.

2.37. In particular, governance in ICSs should involve all system partners in the development of service change proposals, and in consulting and engaging with local people and relevant parts of local government (such as with overview and scrutiny committees and wider elected members) on these. It should appropriately involve elected councillors, and other local politicians such as metro mayors where relevant, and reflect transparency in wider decision-making.

2.38. Each system should also be able to show how it uses public involvement and insight to inform decision-making, using tools such as citizens' panels, local health champions, and co-production with people with lived experience. Systems should make particular efforts to understand and talk to people who have historically been excluded.

Financial framework

2.39. In order that the collective leadership of each ICS has the best possible opportunity to invest in and deliver joined-up, more preventative care, tailored to local people's needs, we will increasingly **organise the finances of the NHS at ICS level** and put **allocative decisions in the hands of local leaders**. We are clear that we want ICSs to be key bodies for financial accountability and financial governance arrangements will need to reflect that. NHSEI will update guidance to reflect these changes.

2.40. That means that we will **create a 'single pot**,' which brings together current CCG commissioning budgets, primary care budgets, the majority of specialised commissioning spend, the budgets for certain other directly commissioned services, central support or sustainability funding and nationally-held transformation funding that is allocated to systems.

2.41. ICS leaders, working with provider collaboratives, must have the freedom – and indeed the duty – to distribute those resources in line with national rules such as the mental health, and the primary and community services investment guarantees and locally-agreed strategies for health and care, for example targeting investment in line with locally-agreed health inequalities

priorities, or responding flexibly as new, more preventative services are developed and patient journeys change.

2.42. ICS leaders will also have a duty to ensure that they deploy the resources available to them in order to protect the future sustainability of local services, and to ensure that their health and care system consumes their fair share of resources allocated to it.

2.43. It also means that ICS leaders will be expected to use new freedoms to delegate significant budgets to 'place' level, which might include resources for general practice, other primary care, community services, and continuing healthcare. Similarly, through active involvement at place level, providers will have a greater say in how transformation funding is deployed. Decisions about the use of all of these budgets will usually be made at the lowest possible level, closest to those communities they serve and in partnership with their local authority. New powers will make it easier to form joint budgets with the local authority, including for public health functions.

2.44. Providers will through their role in ICS leadership have the opportunity to shape the strategic health and care priorities for the populations they serve, and new opportunities – whether through lead provider models at place level or through fully-fledged integrated care provider contractual models – to determine how services are funded and delivered, and how different bodies involved in providing joined-up care work together.

2.45. We will deliver on the commitment set out in the Long Term Plan to mostly move away from episodic or activity-based payment, rolling out the blended payment model for secondary care services. This will ensure that provider collaboratives have greater certainty about the resources available to them to run certain groups of services and meet the needs of particular patient groups. Any variable payments will be funded within the ICS financial envelope, targeted to support the delivery of locally-identified priorities and increasingly linked to quality and outcomes metrics. Each ICS will be expected to agree and codify how financial risk will be managed across places and between provider collaboratives.

2.46. These changes will reduce the administrative, transactional costs of the current approach to commissioning and paying for care, and release resources for the front line - including preventative measures - that can be invested in services that are planned, designed and delivered in a more strategic way at ICS level. This is just one way in which we will ensure that each ICS has to capacity and capability to take advantage of the opportunities that these new approaches offer.

2.47. Finally, we will further embed reforms to the capital regime introduced in 2019/20 and 2020/21, bringing together at ICS level responsibility for allocating capital envelopes with responsibility for allocating the revenue

budgets which fund day-to-day services. This will ensure that capital investment strategies:

- are not only coordinated between different NHS providers, but also aligned with local authorities' management of their estates and wider assets;
- reflect local judgments about the balance between competing priorities for capital expenditure; and
- give priority to those investments which support the future sustainability of local services for future generations.

2.48. We will set out in the 2021/22 planning guidance how we will support ICSs to begin operating more collective financial governance in 2021/22 and to prepare for the powers and duties set out above.

Data and Digital

2.49. Data and digital technology have played a vital role helping the NHS and care respond to the pandemic. They will be at the heart of creating effective local systems, helping local partners in health and social care work together. They can help improve productivity and patient outcomes, reduce bureaucracy, drive service transformation and stimulate improvement and research.

2.50. But digital maturity and data quality is variable across the health and care. Data has too often been held in siloes, meaning that clinicians and care professionals do not have easy access to all of the information that could be useful in caring for their patients and service users.

2.51. To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

(1) build smart digital and data foundations
(2) connect health and care services
(3) use digital and data to transform care
(4) put the citizen at the centre of their care

Build smart digital and data foundations

- Have clear **board accountability** for data and digital, including a member of the ICS Partnership Board being a named SRO.
- Have a system-wide **digital transformation plan.** This should outline the three year journey to digitally-driven, citizen-centred care, and the benefits that digital and data will realise for the system and its citizens.

- Build the **digital and data literacy** of the whole workforce as well as specific digital skills such as user research and service design.

- Invest in the **infrastructure** needed to deliver on the transformation plan. This will include **shared contracts and platforms** to increase resiliency, digitise operational services and create efficiencies, from shared data centres to common EPRs.

Connect health and care services

- Develop or join a **shared care record** joining data safely across all health and social care settings, both to improve direct care for individual patients and service users, and to underpin population health and effective system management.
- Build the tools to allow **collaborative working** and frictionless movement of staff across organisational boundaries, including shared booking and referral management, task sharing, radiology reporting and pathology networks.
- Follow **nationally defined standards** for digital and data to enable integration and interoperability, including in the data architecture and design.

Use digital and data to transform care

- Use digital technology to **reimagine care pathways**, joining up care across boundaries and improving outcomes.

- Develop shared **cross-system intelligence and analytical functions** that use information to improve decision-making at every level, including:

    - actionable insight for frontline teams;
    - near-real time actionable intelligence and robust data (financial, performance, quality, outcomes);
    - system-wide workforce, finance, quality and performance planning;
    - the capacity and skills needed for population health management.
- Ensure **transparency of information** about interventions and the outcomes they produce, to drive more responsive coordination of services, better decision-making and improved research.

Put the citizen at the centre of their care

- Develop a road map for **citizen-centred digital channels** and services, including access to personalised advice on staying well, access to their own data, and triage to appropriate health and care services.

- Roll out **remote monitoring** to allow citizens to stay safe at home for longer, using digital tools to help them manage long-term conditions.

- We want to build on the experience of data sharing during COVID so that data is shared, wherever it can and should be. This will inform the upcoming Department of Health and Social Care Data Strategy. While this will be mainly about embedding a culture of sharing data with appropriate safeguards, we would support legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Regulation and oversight

2.52. We have consistently heard that regulation needs to adapt, with more support from national regulators for systems as well as the individual organisations within them, and a shift in emphasis to reflect the importance of partnership working to improve population health.

2.53. Regulation best supports our ambitions where it enables systems and the organisations within them to make change happen. This means a focus on how effective local arrangements are at implementing better pathways, maximising use of collective capacity and resources, and acting in partnership to achieve joint financial and performance standards.

2.54. We have already taken steps to bring together NHS England and NHS Improvement to provide a single, clear voice to the system and our legislative proposals haven't changed – this merger should be formalised in future legislation.

2.55. As a formally merged body, NHS England will of course remain answerable to Parliament and to the Secretary of State for Health and Social Care for NHS performance, finance and healthcare transformation. There will need to be appropriate mechanisms in law to ensure that the newly merged body is responsive and accountable. We envisage Parliament using the legislation to specify the Secretary of State's legal powers of direction in respect of NHS England in a transparent way that nevertheless protects clinical and operational independence.

2.56. There are a further practical steps that we can take to support systems:

- working with the CQC to seek to embed a requirement for strong participation in ICS and provider collaborative arrangements in the "Well Led" assessment;
- issuing guidance under the NHS provider licence that good governance for NHS providers includes a duty to collaborate; and
- ensuring foundation trust directors' and governors' duties to the public support system working.

2.57. We expect to see greater adoption of system- and place- level measurements, which might include reporting some performance data such as patient treatment lists at system level. Next year, we will introduce new measures and metrics to support this, including an 'integration index' for use by all systems.

2.58. The future **System Oversight Framework** will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

2.59. This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSEI will intervene in cases where there are serious problems or risks.

The proposed future Intensive Recovery Support Programme will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

2.60. Greater collaboration will help us to be more effective at designing and distributing services across a local system, in line with agreed health and care priorities and within the resources available. However there remains an important role for patient choice, including choice between qualified providers, providers outside the geographic bounds of the system and choice of the way in which services need to be joined up around the individual person as a resident or patient including through personal health budgets.

2.61. Our previous recommendations to government for legislation include rebalancing the focus on competition between NHS organisations by reducing the Competition and Market Authority's role in the NHS and

abolishing Monitor's role and functions in relation to enforcing competition. We also recommended regulations made under section 75 of the *Health and Social Care Act 2012* should be revoked and that the powers in primary legislation under which they are made should be repealed, and that NHS services be removed from the scope of the *Public Contracts Regulations 2015*. We have committed to engage openly on how the future procurement regime will operate subject to legislation being brought before Parliament.

How commissioning will change

2.62. Local leaders have repeatedly told us that the commissioning functions currently carried out by CCGs need to become more strategic, with a clearer focus on **population-level health outcomes** and a marked reduction in transactional and contractual exchanges within a system. This significant change of emphasis for commissioning functions means that the organisational form of CCGs will need to evolve.

2.63. The activities, capacity and resources for commissioning will change in three significant ways in the future, building on the experience of the most mature systems:

- Ensuring a single, system-wide approach to undertake **strategic commissioning**. This will discharge core ICS functions, which include:
    - assessing population health needs and planning and modelling demographic, service use and workforce changes over time;
    - planning and prioritising how to address those needs, improving all residents' health and tackling inequalities; and
    - ensuring that these priorities are funded to provide good value and health outcomes.
- Service transformation and pathway redesign need to be done differently. Provider organisations and others, through partnerships at place and in provider collaboratives, become a principal engine of transformation and should agree the future service model and structure of provision jointly through ICS governance (involving transparency and public accountability). Clinical leadership will remain a crucial part of this at all footprints.
- The greater focus on population health and outcomes in contracts and the collective system ownership of the financial envelope is a chance to apply capacity and skills in transactional commissioning and contracting with a new focus. Analytical skills within systems should be applied to better understanding how best to use resources to

improving outcomes, rather than managing contract performance between organisations.

2.64. Many commissioning functions are now **coterminous with ICS boundaries**, and this will need to be consistent across the country before April 2022. Under the legislative provisions recommended in section 3 current CCG functions would subsequently be absorbed to become core ICS business.

2.65. However, with the spread of place-based partnerships backed by devolved funding, simplified accountability, and an approach to governance appropriate to local circumstances along with further devolution of specialised commissioning activity, there will be flexibility for local areas to make full use of the local relationships and expertise currently residing in CCGs.

2.66. Systems should also agree whether individual functions are best delivered at system or at place, balancing subsidiarity with the benefits of scale working. Commissioners may, for example, work at place to complete service and outcomes reviews, allocate resources and undertake needs assessments alongside local authorities. But larger ICSs may prefer to carry out a wider range of functions in their larger places, and smaller ones to do more across the whole system.

2.67. Commissioning support units (CSUs) operate within the NHS family across England, providing services that have been independently evaluated for quality and value for money. We expect that CSUs will continue to develop as trusted delivery partners to ICSs, providing economies of scale which may include joining up with provider back office functions where appropriate and helping to shape services through a customer board arrangement.

Specialised commissioning

2.68. Specialised services are particularly important for the public and patients, with the NHS often working at the limits of science to bring the highest levels of human knowledge and skill to save lives and improve health.

2.69. The national commissioning arrangements that have been in place for these services since 2013 have played a vital role in supporting **consistent, equitable, and fast access for patients** to an ever-expanding catalogue of cutting edge technologies - genomic testing, CAR-T therapy, mechanical thrombectomy, Proton Beam Therapy and CFTR modulator therapies for patients with cystic fibrosis to name just a few.

2.70. But these national commissioning arrangements can sometime mean fragmented care pathways, misaligned incentives and missed opportunities for **upstream investment and preventative intervention**. For example, the split in commissioning responsibilities for mental health services has

potentially slowed the ambition to reduce the number of children admitted for inpatient treatment and, where they are admitted, making sure they are as close to home as possible. Bringing together the commissioning of mental health services has aligned incentives and enabled resources to be moved into upstream services, reducing over-reliance on geographically distant inpatient care.

2.71. Integrated care systems provide an opportunity to further **align the design, development and provision of specialised services with linked care** pathways, where it supports patient care, while maintaining consistent national standards and access policies across the board.

2.72. The following principles will underpin the detailed development of the proposed arrangements:

- ***Principle One: All specialised services, as prescribed in regulations, will continue to be subject to consistent national service specifications and evidence-based policies determining treatment eligibility.*** NHS England will continue to have responsibility for developing and setting these standards nationally and whoever is designated as the strategic commissioner will be expected to follow them. Over time, service specifications will need to become more outcomes focused to ensure that innovative and flexible solutions to unique system circumstances and/or opportunities can be easily adopted. But policies determining eligibility criteria for specific treatments across all specialised services will remain precise and consistently applied across the country.

- ***Principle Two: Strategic commissioning, decision making and accountability for specialised services will be led and integrated at the appropriate population level: ICS, multi-ICS or national.*** For certain specialised services, it will make sense to plan, organise and commission these at ICS level. For others, ICSs will need to come together across a larger geographic footprint to jointly plan and take joint commissioning decisions. And many services, such as those in the highly specialised services portfolio, will continue to be planned and commissioned on a national footprint. Importantly, whichever level strategic commissioning occurs the national standards will apply.

- ***Principle Three: Clinical networks and provider collaborations will drive quality improvement, service change and transformation across specialised services and non-specialised services.*** Clinical networks have long been a feature of the NHS. But, during the COVID pandemic they have become critical in supporting innovation and system wide collaboration. Looking ahead they will be supported to drive clinically-led change and service improvement with even greater

accountability for tackling inequalities and for improving population health.

- ***Principle Four: Funding of specialised services will shift from provider-based allocations to population-based budgets, supporting the connection of services back to 'place'.*** We are considering from April 2021 allocating budgets on a population basis at regional level and are considering the best basis for allocating funding and will provide further information in due course. In this first year, adjustments will then be made to neutralise any changes in financial flows and ensure stability. We intend to publish a needs-based allocation formula, before using it to inform allocations against an agreed pace of change in future years. A needs-based allocations formula will further strengthen the focus on tackling inequalities and unwarranted variation.

3. Legislative proposals

3.1. The detailed policy work described above will be necessary to deliver our vision but will not by itself be sufficient. While legislation is only part of the answer, the existing legislation (*the National Health Service Act 2006 and the Health and Social Care Act 2012* does not present a sufficiently firm foundation for system working.

3.2. In September 2019, NHSEI made a number of recommendations for an NHS Bill[2]. These aimed to remove current legislative barriers to integration across health and social care bodies, foster collaboration, and more formally join up national leadership in support of the ambitions outlined above.

3.3. Recommendations included:

- rebalancing the focus on **competition** between NHS organisations by reducing the Competition and Markets Authority's role in the NHS and abolishing Monitor's role and functions in relation to enforcing competition;
- simplifying **procurement** rules by scrapping section 75 of the 2012 Act and remove the commissioning of NHS healthcare services from the jurisdiction of the Public Contracts Regulations 2015;
- providing increased flexibilities on **tariff**;
- reintroducing the ability to establish **new NHS trusts** to support the creation of integrated care providers;
- ensuring a more coordinated approach to planning **capital investment**, through the possibility of introducing FT capital spend limits;
- the ability to establish decision-making **joint committees** of commissioners and NHS providers and between NHS providers;
- enabling **collaborative commissioning** between NHS bodies – it is currently easier in legislative terms for NHS bodies and local authorities to work together than NHS bodies;
- a new "**triple aim**" duty for all NHS organisations of 'better health for the whole population, better quality care for all patients and financially sustainable services for the taxpayer; and

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875711/The_government_s_2020-2021_mandate_to_NHS_England_and_NHS_Improvement.pdf

- **merging NHS England and NHS Improvement** – formalising the work already done to bring the organisations together.

3.4. These recommendations were strongly supported and backed across the health and social care sector[3]. We believe these proposals still stand.

3.5. One of the key considerations in our recommendations was how, and to what extent, ICSs should be put on a statutory footing. Responses to our engagement were ultimately mixed – balancing the relatively early stage of development of some ICSs against a desire to enable further progress and to put ICSs on a firmer footing.

3.6. At the time, we proposed a new statutory underpinning to establish ICS boards through voluntary joint committees, an entity through which members could delegate their organisational functions to its members to take a collective decision. This approach ensured support to those systems working collectively already and a future approach to those systems at an earlier stage of development.

3.7. Many respondents to our engagement and specifically Parliament's Health and Social Care Select Committee raised a number of questions as to whether a voluntary approach would be effective in driving system working. There was particular focus on those areas at an earlier stage of their development and whether a voluntary model offered sufficient clarity of accountability for health outcomes and financial balance both to parliament and more directly to the public.

3.8. The response of the NHS and its partners to COVID-19 and a further year of ICS development has increased the appetite for statutory "clarity" for ICSs and the organisations within them. With an NHS Bill included in the last Queen's Speech, we believe the opportunity is now to achieve clarity and establish a "future-proofed" legislative basis for ICSs that accelerates their ability to deliver our vision for integrated care.

3.9. We believe there are two possible options for enshrining ICSs in legislation, without triggering a distracting top-down re-organisation:

Option 1: a statutory committee model with an Accountable Officer that binds together current statutory organisations.

Option 2: a statutory corporate NHS body model that additionally brings CCG statutory functions into the ICS.

[3] https://www.aomrc.org.uk/wp-content/uploads/2019/09/190926_Support_letter_NHS_legislation_-proposals.pdf

3.10. Both models share a number of features – broad membership and joint decision-making (including, as a minimum, representatives from commissioners; acute, community and primary care providers; and local authorities); responsibility for owning and driving forward the system plan; operating within and in accordance with the triple aim duty; and a lead role in relating to the centre.

Option 1 – a statutory ICS Board/ Joint Committee with an Accountable Officer

3.11. This option is closer to our original proposal. It would establish a mandatory, rather than voluntary, statutory ICS Board through the mechanism of a joint committee and enable NHS commissioners, providers and local authorities to take decisions collectively.

3.12. Unlike previously proposed versions of this model it would have a system Accountable Officer, chosen from the CEOs/AOs of the Board's mandatory members. This Accountable Officer would not replace individual organisation AOs/CEOs but would be recognised in legislation and would have duties in relation to delivery of the Board's functions. There would be a duty for the Board to agree and deliver a system plan and all members would have an explicit duty to comply with it.

3.13. In accordance with our stated ambition, there would be one aligned CCG only per ICS footprint under this model, and new powers would allow that CCGs are able to delegate many of its population health functions to providers.

3.14. This option retains individual organisational duties and autonomy and relies upon collective responsibility. Intervention against individual NHS organisations (not working in the best interests of the system) would continue to be enhanced through the new triple aim duty and a new duty to comply with the ICS plan.

3.15. The new Accountable Officer role would have duties to seek to agree the system plan and seek to ensure it is delivered and to some extent offer clarity of leadership. However, current accountability structures for CCG and providers would remain.

3.16. There remain potential downsides to this model. In effect, many of the questions raised through our engagement in 2019 about accountability and clarity of leadership would remain. While the addition of an Accountable Officer strengthens this model, there remains less obvious responsibility for patient outcomes or financial matters. Having an ICS Accountable Officer alongside a CCG Accountable Officer may in some cases confuse rather than clarify accountability. The CCG governing body and GP membership is

also retained, and it is questionable whether these are sufficiently diverse arrangements to fulfil the different role required of CCGs in ICSs.

3.17. Furthermore, many may not consider this model to be the "end state" for ICSs and opportunities for primary legislative change are relatively rare. There are therefore strong arguments to go further when considering how the health and care system might evolve over the next ten years and more.

Option 2 – a statutory ICS body

3.18. In this option, ICSs would be established as NHS bodies partly by "re-purposing" CCGs and would – among other duties – take on the commissioning functions of CCGs. Additional functions would be conferred and existing functions modified to produce a new framework of duties and powers.

3.19. The CCG governing body and GP membership model would be replaced by a board consisting of representatives from the system partners. As a minimum it would include representatives of NHS providers, primary care and local government alongside a Chair, a Chief Executive and a Chief Financial Officer. The ICS body should be able to appoint such other members as it deems appropriate allowing for maximum flexibility for systems to shape their membership to suit the needs of their populations. The power of individual organisational veto would be removed. The ICS Chief Executive would be a full-time Accounting Officer role, which would help strengthen lines of accountability and be a key leadership role in ensuring the system delivers.

3.20. The ICS's primary duty would be to secure the effective provision of health services to meet the needs of the system population, working in collaboration with partner organisations. It would have the flexibility to make arrangements with providers through contracts or by delegating responsibility for arranging specified services to one or more providers.

3.21. This model would deliver a clearer structure for an ICS and avoids the risk of complicated workarounds to deliver our vision for ICSs. Although there would be a representative for primary care on the Board, there would no longer be a conflict of interests with the current GP-led CCG model (created by the 2012 Act) and it could be possible to allocate combined population-level primary care, community health services and specialised services population budgets to ICS.

3.22. Many commissioning functions for which NHSE is currently responsible could, for the most part, be transferred or delegated to the ICS body, but with the ability to form joint committees as proposed through our original recommendations, with NHSE, if and where appropriate.

3.23. Through greater provider involvement, it could also reduce some of the transactional burdens of the current contracting processes. There would be powers for the ICS to delegate responsibility for arranging some services to providers, to create much greater scope for provider collaboration to use whole-population budgets to drive care pathway transformation.

Our approach

3.24. Either model would be sufficiently permissive in legislation to allow different systems to shape how they operate and how best and most appropriately deliver patient care and outcomes support at place.

3.25. Under either model we would want local government to be an integral, key player in the ICS. Both models offer a basis for planning and shaping services across healthcare, social care, prevention and the wider determinants of health. Both would allow for the delegation of functions and money to place-based statutory committees involving NHS bodies and local government. Both would enable NHS and local government to exploit existing flexibilities to pool functions and funds.

3.26. While both models would drive increased system collaboration and achieve our vision and our aims for ICSs in the immediate term, we believe Option 2 is a model that offers greater long term clarity in terms of system leadership and accountability. It also provides a clearer statutory vehicle for deepening integration across health and local government over time. It also provides enhanced flexibility for systems to decide who and how best to deliver services by both taking on additional commissioning functions from NHS England but also deciding with system colleagues (providers and local councils) where and how best service provision should take place.

3.27. Should these proposals be developed further and proposed by Government as future legislation, we would expect a full assessment of the impact of these proposals on equalities and public and parliamentary engagement and scrutiny as is appropriate.

Questions

Q. Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?

Q. Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?

Q. Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?

Q. Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?

4. Implications and next steps

4.1. The ambitious changes set out here are founded on the conviction that collaboration will be a more effective mechanism for transformation against long term population health priorities and also for driving sustainable operational performance against the immediate challenges on quality, access, finance and delivery of outcomes that make difference to people's experience of services today.

4.2. International evidence points to this being the case as across the world health systems change to pursue integration as the means of meeting health needs and improving health outcomes. We have seen this reinforced through our experiences in tackling COVID-19.

4.3. The rapid changes in digital technology adoption, mutual cooperation and capacity management, provision of joined up support to the most vulnerable that have been essential in the immediate response to the pandemic have only been possible through partners working together to implement rapid change as they focus on a shared purpose.

4.4. As we embed the ways of working set out above, partners in every system will be able to take more effective, immediate operational action on:

- managing acute healthcare performance challenges and marshalling collective resource around clear priorities, through provider collaboratives;
- tackling unwarranted variation in service quality, access and performance through transparent data with peer review and support arrangements organised by provider collaboratives;
- using data to understand capacity utilisation across provider collaboratives, equalising access (tackling inequality across the system footprint) and equalising pressures on individual organisations.

The NHS England and NHS Improvement's operating model

4.5. NHSEI will support systems to adopt improvement and learning methodologies and approaches which will enable them to improve services for patients, tackle unwarranted variation and develop cultures of continuous improvement.

4.6. This will be underpinned by a comprehensive support offer which includes:

- access to our national transformation programmes for outpatients and diagnostics;
- support to tackle unwarranted variation and increase productivity (in partnership with the Getting it Right First Time programme);
- the data they need to drive improvement, accessed through the 'model health system';
- the resources and guidance that they need to build improvement capability; and
- assistance from our emergency and electivity intensive support teams (dependent on need).

4.7. Much of this support offer will be made available to systems through regional improvement hubs, which will ensure that improvement resource supports local capacity- and capability-building. Systems will then able to flexibly and rapidly deploy the support into place partnerships and provider collaboratives.

4.8. NHSEI developed a joint operating model during 2019, with input from senior NHS leaders including those in systems and regions, as well as frontline staff and other stakeholders. This resulted in a description of the different ways NHSEI will operate in future, underpinned by a set of principles including subsidiarity, and a set of 'levers of value' that NHSEI can use at national and regional level to support systems.

4.9. NHSEI will continue to develop this operating model to support the vision set out above, and any legislative changes. This will include further evolving how we interact with systems nationally and regionally; and ensuring that its functions are arranged in a way that support and embed system working to deliver our priorities.

4.10. The new operating environment will mean:

- increased freedoms and responsibilities for ICSs, including greater responsibility for system development and performance, as well as greater autonomy regarding assurance.
- the primary interaction between NHSEI and systems will be between regions and the collective ICS leadership, with limited cause for national functions to directly intervene with individual providers within systems.
- as systems take on whole population budgets they will increasingly determine how resource is to be used to 'move the dial' on outcomes, inequalities, productivity and wider social and economic development

against their specific health challenges and population health priorities.

- NHSEI regional teams will become ‘thinner’ as we move direct commissioning responsibility out to systems (individually and collectively). They will increasingly continue to enable systems to take on greater autonomy, working with them to identify their individual development priorities and support needs.

Transition

4.11. The experience of the earliest ICSs shows that great leadership is critical to success and can come from any part of the health and care system. But, to be effective, it must be felt right across, and draw on the talents of leaders from every part of, a system.

4.12. These systems have developed a new style of behaviour, which makes the most of the leadership teams of all constituent organisations and empowers frontline leaders. System leaders have impact through a collaborative and distributive leadership style that operates across boundaries, leading for communities.

4.13. This shared approach to leadership is based on qualities such as openness and transparency, honesty and integrity, a genuine belief in common goals and an ability to build consensus.

4.14. ICSs need to be of sufficient size to carry out their ‘at scale’ activities effectively, while having sufficiently strong links into local communities at a much more local level in places and neighbourhoods.

4.15. Pragmatically we are supporting ICSs through to April 2022 at their current size and scale, but we recognise that smaller systems will need to join up functions, particularly for provider collaboration. We will support the ability for ICSs to more formally combine as they take on new roles where this is supported locally.

4.16. We will work with systems to ensure that they have arrangements in place to take on enhanced roles from April 2022. We will set out a roadmap for this transition that gives assurance over system readiness for new functions as these become statutory.

4.17. We know that under either legislative proposal we need to ensure that we support our staff during organisational change by minimising uncertainty and limiting employment changes. We are therefore seeking to provide stability of employment while enabling a rapid development of role functions and purpose for all our teams, particularly in CCGs directly impacted by legislative Option 2.

4.18. We want to take a different approach to this transition; one that is characterised by care for our people and no distraction from the 'day job': the critical challenges of recovery and tackling population health.

4.19. **Stable employment:** As CCG functions move into new bodies we will make a 'continued employment promise' for staff carrying out commissioning functions. We will preserve terms and conditions to the new organisations (even if not required by law) to help provide stability and to remove uncertainty.

4.20. **New roles and functions:** For many commissioning functions the work will move to a new organisation and will then evolve over time to focus on system priorities and ways of working. The priority will be the continuation of the good work being carried out by the current group of staff and we will promote best practice in engaging, consulting and supporting the workforce during a carefully planned transition, minimising disruption to staff.

4.21. Other functions will be more directly impacted, principally the most senior leaders in CCGs (chief officers and other governing body / board members). ICSs need to have the right talent in roles leading in systems.

4.22. Our commitment is:

- not to make significant changes to roles below the most senior leadership roles;
- to minimise impact of organisational change on current staff during both phases (in paragraphs 4.19 and 4.20 above) by focusing on continuation of existing good work through the transition and not amending terms and conditions; and
- offer opportunities for continued employment up to March 2022 for all those who wish to play a part in the future.

Next steps

4.23. We expect that every system will be ready to operate as an ICS from April 2021, in line with the timetable set out in the *NHS Long Term Plan*. To prepare for this, we expect that each system will, by this time, agree with its region the functions or activities it must prioritise (such as in service transformation or population health management) to effectively discharge its core roles in 2021/22 as set out in this paper.

4.24. All ICSs should also agree a sustainable model for resourcing these collective functions or activities in the long term across their constituent organisations.

4.25. To support all of the above, all systems should agree development plans with their NHSEI regional director that clearly set out:

- **By April 2021:** how they continue to meet the current consistent operating arrangements for ICSs and further planning requirements for the next phase of the COVID-19 response
- **By September 2021:** implementation plans for their future roles as outlined above, that will need to adapt to take into account legislative developments.

4.26. Throughout the rest of 2020, the Department of Health and Social Care and NHSEI will continue to lead conversations with different types of health and care organisations, local councils, people who use and work in services, and those who represent them, to understand their priorities for further policy and legislative change.

4.27. The legislative proposals set out in this document takes us beyond our original legislative recommendations to the government. We are therefore **keen to seek views on these proposed options from all interested individuals and organisations**. These views will help inform our future system design work and that of government should they take forward our recommendations in a future Bill.

4.28. Please contact england.legislation@nhs.net or write with any feedback to NHS England, PO Box 16738, Redditch, B97 9PT by Friday 8 January.

4.29. For more information about how health and care is changing, please visit: www.england.nhs.uk/integratedcare and sign up to our regular e-bulletin at: www.england.nhs.uk/email-bulletins/integrated-care-bulletin

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ICS Board

Date of Meeting	December 2020
Title of Paper	Lancashire & South Cumbria ICS System Assurance Framework & Strategic Risk Management Update
Presented By	Gary Raphael
Author	Emily Kruger Collier
Contributor/s	Ann Highton
Agenda Item	9
Confidential	Yes

Purpose of the Paper
For discussion and endorsement
Executive summary
This paper identifies the need for a system assurance framework to be established to support the continued development and integration of the Lancashire & South Cumbria ICS partnership. In addition, the paper provides an update on the strategic risks and issues identified and plans over the coming months to make improvements to the management of this aspect of assurance, recognising this as an early phase of the development work.
Recommendations
1. For the ICS Board to support and engage with the development of a system assurance framework (including strategic objectives) (section 4) 2. To support the establishment of a group, including ICP representatives, to progress this work on behalf of the ICS Board. (section 4) 3. To support the approach to the strategic risks, as the first phase of the system assurance framework (section 5)
Governance and Reporting (List Other Forums that have Discussed this Paper)

Meeting	**Date**	**Outcome**
ICS Executive Team	09/11/20	Paper endorsed with recommendations to be included for SLE.

Conflicts of Interest Identified
NA

Implications						
Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Associated Risks	**Yes**	☐	**No**	☐	**N/A**	☒
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☒	**N/A**	☐
If Yes, Please Provide a Risk Description and Reference Number	Mark Yes, No or Not Applicable Above and Provide a Risk Description and Risk Reference Number in this Box if there are Any Associated Risks					

Lancashire & South Cumbria ICS System Assurance Framework & Strategic Risk Management Update

1. Introduction

This paper identifies the need for a system assurance framework to be established to support the continued development and integration of the Lancashire & South Cumbria ICS partnership. In addition, the paper provides an update on the strategic risks and issues identified and plans over the coming months to make improvements to the management of this aspect of assurance, recognising this as an early phase of the development work. ICS board members are invited to help shape the development of the strategic objectives, risks, information sources and assurance process (the latter is not included in this report).

2. Background

The work to develop strategic risks, and the approach to manage these, is underway and arose from some of the challenges in identifying and responding to risks as part of the response to the covid-19 pandemic. A gap for strategic management, alignment and the associated mitigation plans in relation to risks across the partnership, was highlighted. Focus was largely operational which was leading to duplication of practice already embedded within individual organisations thus triggering the need to explore an alternative and more effective approach to risk management at system level. The improvement work around strategic risk and issue management emphasised a requirement for ownership, oversight and assurance at Board level across the partnership that is not currently structured. Whilst recognising that the ICS Board is not of a statutory nature, it is important that there is structured oversight, alignment to ICS strategic objectives and assurance across partners. It is therefore deemed necessary to establish a robust System Assurance Framework, and the associated processes, to underpin the ICS Board and manage the risks which may compromise the strategic direction.

3. System Assurance Framework (SAF)

Assurance is; "...an objective examination of evidence for the purpose of providing an independent assessment on governance, risk management, and control processes for the organisation." An assurance framework will provide a structured means of identifying and mapping the main sources of assurance across the partnership and oversee the mitigation. Therefore, a System Assurance Framework is expected to take a similar form to a traditional Trust 'Board Assurance Framework', although will be broader in scope and therefore developed to be appropriate for application across the Lancashire & South Cumbria partnership. It is anticipated that the SAF will improve connectivity and alignment across partners, supporting system reform and Integrated Care Partnership (ICP) development plans. As well as organising and responding to various National assurance asks, for example health inequality assurance.

The support of the ICS Board is vital to the inauguration and embedment of a SAF. A SAF will also strengthen and provide clarity to the Boards role as arbiter of our developing strategic aims and objectives. The SAF, once developed, can be used as a tool to aid, measure, evidence and challenge impediments to progress and assess any threats to achieving objectives. It is anticipated that the structure of the SAF will cover key elements of assurance including;

- Achieving objectives, such as health improvement
- Strategic risk management
- Finance
- Safety, Quality & performance

A small group with representation from each ICP, covering a range of expertise, will be established to further scope and support the development of the SAF by 2021/22, and using the strategic risk element, outlined in the following section of the paper, as a first phase, and a firm foundation on which to test and further develop the SAF.

4. The First Phase: Lancashire & South Cumbria Strategic Risks & Issues

Recognising the work completed to date to improve strategic risk management it seems sensible and appropriate to use this work as the first phase of the SAF development.

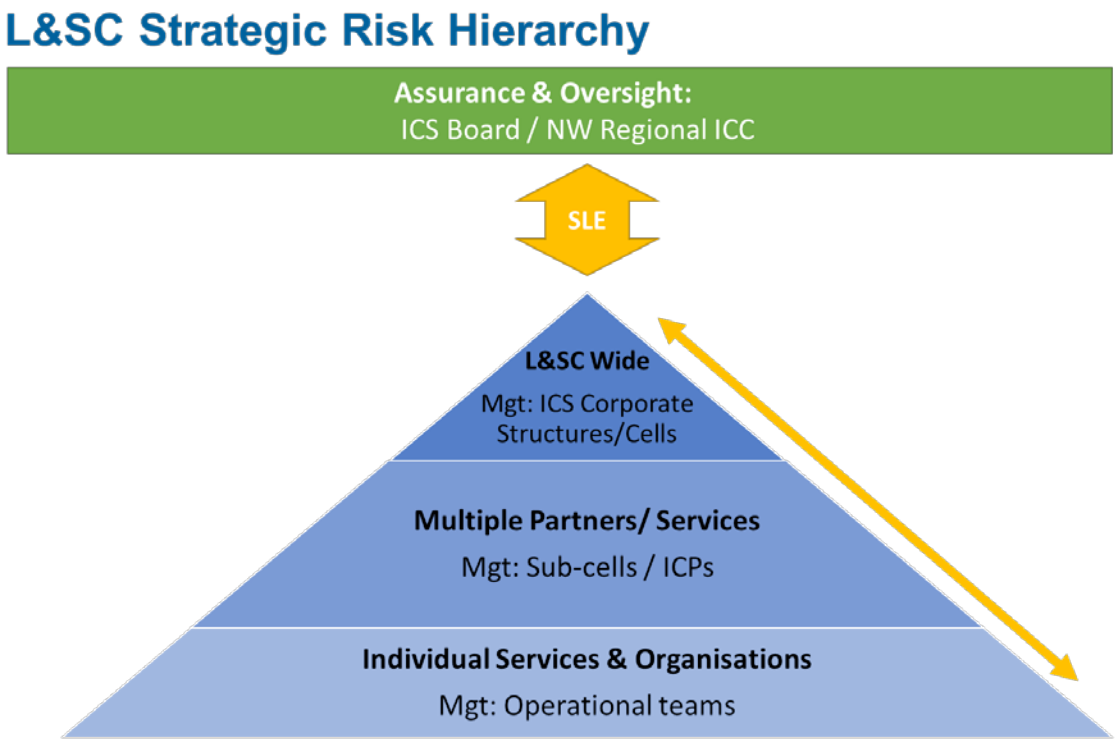
Strategic risks are defined as unforeseen events, that affect the achievement of strategic objectives. This proposal relates directly to system wide strategic risks i.e. affecting the population and partners across Lancashire & South Cumbria. This proposal does not seek to replace Board Assurance Frameworks within individual organisations, nor operational management of risks.

The command and control structure groups have provided a useful forum, with a range of clinical and non-clinical representatives across regional partners, to engage, and help identify the strategic risks across Lancashire & South Cumbria. The current strategic risks identified are presented in appendix 1. It is important to note that these may change over time, particularly when the Covid-19 pandemic and the increased level of threat that it poses, is reduced or removed. Due to capacity constraints the work to date around strategic risk management has been focused on the cell and sub-cell structures, with plans, as part of the SAF, development to expand and achieve alignment with ICPs.

The main benefit to the development of a strategic risk management approach is that it will offer clarity of the system wide issues which impact the ability to achieve strategic objectives, thus enabling more proactive planning. Additionally, this in turn offers greater transparency to identify, monitor and take action to remove or reduce any threats, particularly those directly affecting the Lancashire & South Cumbria population.

5. Strategic Risk Roles and Responsibilities (to be developed with board members)

The structure below illustrates; the proposed management, the groups responsible for, expected at each level. Whilst in the midst of the covid-19 pandemic, the structure also reflects the command and control hierarchy as part of the process. This creates an escalation framework and weaves a golden thread through controls to reduce or mitigate risk. The strategic risks identified, need to be considered and assessed at each level of the hierarchy.



As the hierarchy demonstrates, the ICS Board takes the role in assurance and oversight of risks and must ensure that delivery of strategic objectives are not threatened, or that mitigation plans in place are both appropriate and sufficient. SLE is asked to undertake a pivotal role in risk management to

provide sponsorship across each of the strategic risks, which involves directing and supporting the management of the associated risks and plans throughout the structure, as agreed by the ICS Board. SLE will be required to request a more detailed explanation report where a risk is not being adequately mitigated As the SAF develops it is expected that there will be greater alignment, and links with wider groups within the corporate structure.

At each level of the hierarchy an appropriate risk owner, will be identified based upon who is most appropriate to deal with each risk.

The strategic risks will now be linked to the development of the SAF and alignment of the ICS partners. The roll out of strategic risks will continue and progress will be reported back to the ICS Board.

6. What is the board being asked to do?

As board members will appreciate, the appendix shows strategic objectives, risks and potential data sources (metrics) at a very early stage of development, enabling us to shape them further before moving on to develop a robust approach to assurance. Board members who are so inclined are invited to comment on the current work to guide the development of the proposed SAF. It would be particularly helpful to ascertain whether or not:

- The strategic objectives are broadly right for the system
- The strategic risks are articulated properly or need more work

Moreover, the examples provided on potential data sources are just suggestions – through discussion it should be possible to focus more precisely on what data the board would ideally like to have (without duplicating what happens in ICPs/organisations) some of which may be available while others may require development.

7. Recommendations

- For the ICS Board members to support and engage with the development of a system assurance framework (including strategic objectives).

- To support the establishment of a group, including ICP representatives, to progress this work on behalf of the ICS Board.

- To support the approach to the strategic risks, as the first phase of the system assurance framework.

Gary Raphael

ICS Finance Lead

19th November 2020

Appendix 1

Strategic Objective	Risk Description	Impact	Example source of information/for discussion
Improve population health and well-being and reduction in inequalities	Inequalities worsen across communities and/or between different groups - whether from decline in the economic circumstances of different groups, from the unforeseen impacts of health policy implementation. Or new risks like Covid which may cause; • Greater social isolation • Impediments to access to services whether from fear of Covid 19, lack of service capacity or interruptions to pathway progression • Delays in diagnosis and/or treatment • Inadequate proactive preventative interventions	There may be a negative impact on the health and outcomes for the population and/or deterioration of conditions	• Evidence of worsening inequalities • Proportionate spend on prevention/population health management • Suicides
Securing good staff health and well-being	The resilience of staff is tested beyond endurance exacerbated by: • Increases and shifts in activity across settings • Covering for absent colleagues • More agency staff on more shifts • changes in responsibilities • new policy and guidelines	Potentially reducing services' collective ability to meet current challenges and improve provision in the longer term, which could also impact on the wellbeing of those staff. The winter of 2020/21 could be the point at which serious disruption to services arises from staff absences,	• Staff survey results • Use of staff resilience hub • One off surveys
Delivery of safe, effective services	There is a risk that CQC and other regulatory requirements are not met. The configuration of local services limits the ability to meet Royal College and other guidelines. During Covid there is an increased risk of lack of effective compliance with Infection Prevention	As a result, this could increase nosocomial infections and create a downward trend in service quality and ability to deliver integrated services. This may also impact upon the reputation and the confidence of patients to attend and utilise these services. This may also lead	• Nosocomial infection rates • Safety siren reports • Programme to ensure compliance with guidelines

	Control procedures and/or lack of sufficient Personal Protective Equipment.	to patient and staff harm as well as poor outcomes for patients. This could also lead to lack of accreditation and loss of sustainable provision.	
Manging capacity to meet demand for urgent and elective services	There is risk that service capacity is insufficient to deal with increased demand, capacity is lost or reduced because of staff absences or IPC compliance impacts.	The consequential reduction in productivity adversely impacts on services' ability to diagnose, treat and care for patients and their carers, leading to deterioration in population heath.	• Effectiveness of patient prioritisation processes linked to a common waiting list • Level of success of the mutual support process • Confidence in emerging plans to create capacity and increase productivity
A common approach to learning and innovation – to drive improvements in service delivery and outcomes for patients	The risk is that our innovations and solutions are not implemented consistently across L&SC.	Leading to growing inequalities in service access and patient outcomes and/or that we are not innovating fast enough, so that we do not resolve the problems that require solutions.	• What innovations have taken place? • Impact on health, service and financial outcomes?
To achieve a high level of cost effectiveness, ensuring delivery of best value for the public purse	The cost of services in their current configuration and taking account of existing clinical and managerial practice, exceeds the amount of money that is available to the system and the difference cannot be explained in comparison to our peers across England.		• Affordability of current services • Unexplained variation
A sustainable workforce model for public services across L&SC	There is insufficient workforce to be able to appropriately staff and deliver the required health, wellbeing, and care services for the population.	Compromising provision, continuity, and quality of services.	• Clinical sustainability assessments (making) services attractive places to work • Growing our own workforce

ICS Board

Date of Meeting	2 December 2020
Title of Paper	ICS Finance Report
Presented By	Gary Raphael, ICS Executive Lead for Finance
Author	Elaine Collier, ICS Head of Finance
Agenda Item	10
Confidential	No

Purpose of the Paper
For noting.
Executive summary
This paper reports on month 7 financial performance for the L&SC system. It covers the revenue and capital positions of all L&SC partners and the position on ICS central functions. This paper also updates on the final submission of our phase 3 financial plans and looks forward to the 2021/22 planning round.
Recommendations
The Board is asked to **note** the updates to the financial position and to look forward to involvement in articulating our ambitions for the forthcoming short and medium term planning rounds.
Governance and Reporting (List other forums that have discussed the issues in this paper)

Meeting	Date	Outcome
None		

Conflicts of Interest Identified
Not applicable

Implications						
Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment Completed	**Yes**	☒	**No**	☐	**N/A**	☐
Associated Risks	**Yes**	☒	**No**	☐	**N/A**	☐
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☒	**N/A**	☐
If Yes, Please Provide a Risk Description and Reference Number	They are detailed in this report					

Financial Report

Introduction

1. This paper reports on month 7 financial performance for L&SC partners and ICS central functions. It also updates on the final submission of our phase 3 financial plans and looks forward to the 2021/22 planning round.

Financial Performance

2. We are now transitioning into the new finance regime where we will be monitored against a fixed financial envelope. The work on phase 3 financial planning spanned the period of reporting for month 7 and as such the month 7 tables set out below do not yet take account of the new planning figures outlined later in this report. These will be included for month 8 reporting which will enable us to report on our performance against the financial envelope.

3. Unlike the regime for months 1 to 6, deficits will no longer be covered by top up payments. Instead, our financial envelope has been amended to include our share of system top up funding, Covid funding and growth funding. However, there are still some costs that we expect to attract additional national funding, for example, testing, mass vaccination, hospital discharge programme and some independent sector costs. We are working to clarify how these should be reported to ensure we show a true picture of the position and also secure the available funding.

4. Table 1 below shows the summary financial position for the L&SC system at the end of month 7, October 2020. It is difficult to draw any conclusions at this stage due to the month 7 reporting falling between different versions of the planning process, which led some organisations to make different assumptions about how they should report against the ongoing work.

5. However, we must draw you attention to a potential risk. The figures below assume that all retrospective top up and Covid claims for months 1 to 6 will be paid, and this has also been assumed in the phase 3 planning. At this stage, £28.9m of CCG claims and £8.9m of trust claims are yet to be validated. It is likely to be the end of November or early December before organisations are notified of the outcome of the validation work. Should these claims not be covered, they will be an additional charge against our financial envelope.

Table 1 – L&SC summary financial position as at the end of month 7, October 2020:

L&SC - M07						
	Year-to-date			Forecast Outturn		
	Plan	Actual	Under/(over) spend	Plan	FOT	Under/(over) spend
	£m	£m	£m	£m	£m	£m
CCG financial position	(86.6)	(121.2)	(34.6)	(94.9)	(131.3)	(36.4)
CCG Retrospective Top Up - M1-6	85.0	113.9	28.9	85.0	113.9	28.9
COVID-19 Reimbursement - M7-12	0.0	8.0	8.0	0.0	8.0	8.0
Commissioner Total	**(1.6)**	**0.8**	**2.4**	**(9.9)**	**(9.3)**	**0.6**
Trust Income excl Top Up	1,533.0	1,522.1	(10.9)	2,795.6	2,788.0	(7.6)
Pay	(1,214.4)	(1,210.3)	4.1	(2,145.2)	(2,136.2)	9.0
Non Pay	(552.2)	(554.5)	(2.3)	(976.5)	(971.6)	4.9
Non Operating Items	(24.4)	(23.7)	0.7	(41.2)	(39.9)	1.3
Trust Top Up - M1-6	247.5	256.4	8.9	247.5	256.4	8.9
COVID-19 Reimbursement - M7-12	0.0	1.2	1.2	0.0	1.2	1.2
Provider Total	**(10.5)**	**(8.7)**	**1.8**	**(119.7)**	**(102.1)**	**17.6**
L&SC Total	**(12.1)**	**(7.9)**	**4.2**	**(129.6)**	**(111.4)**	**18.2**

6. Tables 2 and 3 have been included to show the financial position by commissioner and provider sector which we will build on in future reporting. Again these positions are distorted by the use of forecasts that were made prior to the conclusion of the phase 3 planning process (before it was agreed that all CCGs should breakeven and return any unused growth for distribution to the trust sector). The trust table shows how trust performance can fluctuate due to both increasing expenditure and loss of income. The Covid response has had a particular impact on trusts being able to achieve previous income levels and whilst some of this has been reflected in the financial envelope, there is an expectation that they will recover their income levels during months 7 to 12.

7. The ICS report has to use the figures reported by organisations to their Governing Bodies and Boards, which is why I have not amended them to take into account the very latest estimates made for the phase 3 plans.

Table 2 – CCG summary of year-to-date expenditure and forecast outturn positions:

L&SC - CCG Overview M07							
Net Expenditure	Year-to-date			Trend	Forecast Outturn		
	Plan	Actual	Under/(over) spend		Plan	FOT	Under/(over) spend
	£m	£m	£m		£m	£m	£m
Blackburn with Darwen CCG	164.6	164.6	(0.1)	↓	286.0	286.1	(0.1)
Blackpool CCG	239.2	238.8	0.4	↑	584.9	584.9	(0.0)
Chorley & South Ribble CCG	184.7	184.3	0.4	↑	314.2	314.2	(0.0)
East Lancashire CCG	399.5	399.4	0.0	↔	682.1	682.1	0.0
Fylde & Wyre CCG	200.7	200.2	0.5	↑	336.7	336.7	(0.0)
Greater Preston CCG	207.3	206.3	1.0	↑	350.9	350.9	(0.0)
Morecambe Bay CCG	363.3	363.3	0.0	↔	619.8	619.8	0.0
West Lancashire CCG	114.0	113.9	0.1	↑	192.8	192.2	0.7
Total CCG Net Expenditure	**1,873.2**	**1,870.8**	**2.4**	↑	**3,367.4**	**3,366.9**	**0.6**

NOTE

Plan and forecast outturn figures may reflect previous versions of the plan, as phase 3 planning spanned M7 close down

CCG plan figures assume that the outstanding retrospective top ups will be paid. To be confirmed early December.

Table 3 – Trust summary of year-to-date income and expenditure and forecast outturn positions:

L&SC - Trust Overview M07								
Income & Expenditure		Year-to-date			Trend	Forecast Outturn		
		Plan	Actual	Under/(over) spend		Plan	FOT	Under/(over) spend
		£m	£m	£m		£m	£m	£m
Blackpool Teaching Hospital	Income	266.9	266.8	(0.1)	↓	479.7	479.7	0.0
	Expenditure	312.0	313.2	(1.3)	↓	550.2	545.4	4.8
East Lancashire Hospitals Trust	Income	311.8	311.4	(0.4)	↓	560.0	560.0	0.0
	Expenditure	354.3	353.4	0.9	↑	624.0	623.5	0.5
Lancashire Teaching Hospitals Trust	Income	307.8	297.1	(10.7)	↓	575.1	568.5	(6.6)
	Expenditure	371.2	370.4	0.9	↑	661.4	660.3	1.2
Lancashire & South Cumbria FT	Income	219.3	218.9	(0.4)	↓	399.0	398.0	(1.0)
	Expenditure	246.4	245.7	0.7	↑	434.0	430.1	3.9
North West Ambulance Service	Income	215.9	216.3	0.4	↑	386.9	386.9	0.0
	Expenditure	233.0	233.2	(0.2)	↓	408.9	408.9	0.0
Univ Hospitals of Morecambe Bay	Income	211.2	211.6	0.3	↑	394.9	394.9	(0.0)
	Expenditure	274.1	272.6	1.5	↑	484.3	479.4	4.9
Total Trust Income		**1,533.0**	**1,522.1**	**(10.9)**	↓	**2,795.6**	**2,788.0**	**(7.6)**
Total Trust Expenditure		**1,791.0**	**1,788.5**	**2.5**	↑	**3,162.9**	**3,147.6**	**15.3**

NOTE

Plan and forecast outturn figures may reflect previous versions of the plan, as phase 3 planning spanned M7 close down.

Trust plan figures assume that the outstanding retrospective top ups will be paid. To be confirmed early December.

We have been notified of an error on the Lancashire Teaching Hospital income actuals, this will be corrected at month 8.

Phase 3 Planning

8. The phase 3 planning process has now concluded, with L&SC reporting a financial gap of £90.8m against its financial envelope. This is the position after all the system funding for top up, Covid and growth has been distributed and adopts the tactical approach agreed by SLE to balance CCG positions and show the deficits in trusts. This ensures that funding is available for CCGs to satisfy their commitments including trust block payments, on the basis that the majority of these commitments were determined nationally. This approach should also protect the system against having to repay CCG deficits from future year allocations.

9. Taking this approach has led to the providers holding what effectively is a system deficit, but this is on agreement that these deficits must be considered the joint responsibility of CCGs and trusts in their ICPs.

Table 4 – L&SC summary of final Phase 3 financial plans:

SUMMARY OF FINANCIAL GAP	18/11/20 PLAN £m
Blackpool Teaching Hospital	(20.6)
East Lancashire Hospitals Trust	(17.7)
Lancashire Teaching Hospitals Trust	(19.4)
Lancashire & South Cumbria FT	(4.1)
North West Ambulance Service	(4.0)
University Hospitals of Morecambe Bay	(25.0)
Trusts	(90.8)
CCG's	0.0
L&SC SYSTEM FINANCIAL GAP	**(90.8)**

Financial Envelope

10. We have previously reported on the financial envelope and thought it would be helpful to demonstrate how this fits with the current reporting. The total funding available to the L&SC system for 2020/21 is £3.3b and is made up of CCG allocations. The table below shows how the M7-12 financial envelope of £1.7b fits into this overall funding.

Table 5 – Financial envelope for months 7 to 12, in the context of overall system funding:

L&SC - Financial envelope	M1-6 £m	M7-12 £m	Full Year £m
CCG allocations	1,477.4	1,461.9	2,939.3
Top up funding	50.9	119.9	170.8
Covid funding	63.0	90.5	153.5
Growth funding		67.6	67.6
FINANCIAL ENVELOPE	**1,591.3**	**1,739.9**	**3,331.2**
Service Development Funding (SDF)		27.3	27.3
Other funding - Hospital Discharge Programme		8.9	8.9
TOTAL FUNDING AVAILABLE TO CCGs	**1,591.3**	**1,776.1**	**3,367.4**

Plan forecast outturn - Table 2

Capital

11. There is no significant change to the position reported at the last board meeting. The ICS has a capital envelope of £138.7m for 2020/21 for our pre-Covid business as usual plans and we have worked with trust partners during the start of the year to refine these plans to ensure we are able to remain within this envelope. During the year a series of additional capital allocations have become available resulting in a total available resource of £234.3m.

12. Trusts continue to forecast achievement of these plans with the exception of £4m at LTH as reported last month. There are however a number of risks to this position.

13. There remains approximately £80m of awaited allocations. Whilst Trusts have received informal confirmation that the resource is available, and some memoranda of understanding have been signed, Trusts have been told that they can proceed at risk but there is understandable nervousness at committing large scale expenditure without this formal notification. This is putting significant risk into the system with the potential to cause underspends against the programme. Further risks include allocations relating to phase 1 Covid capital expenditure still not being received and some allocations that have been received being less than anticipated.

14. These issues are being raised with Regional colleagues in order to mitigate the risk.

15. ICS and Trust colleagues will undertake a further detailed review of expenditure plans in December and report risks and mitigations at the Board meeting in January.

ICS Central Functions

16. The table below provides an update on the financial position for central functions. The focus on the Covid response earlier in the year and the delay in some national funding being confirmed, has meant a slow start to some workstreams, resulting in a year-to-date underspend. However, we are expecting a refocus on this work and are forecasting to achieve a breakeven position at year-end.

Table 6 – Central Functions budgets as at the end of month 7, October 2020:

ICS Central Functions	Year-to-date			Full Year Forecast		
	Budget	Actual	Under/(over) spend	Annual Budget	Forecast Outturn	Under/(over) spend
	£000	£000	£000	£000	£000	£000
ICS Core Budgets						
Clinical Portfolios	294	282	12	462	462	0
Enabling Functions	768	776	(8)	1,313	1,313	0
Executive Functions	1,247	1,000	247	2,140	2,140	0
Other Support Functions	166	166	(0)	284	284	0
	2,474	2,224	250	4,199	4,199	0
Nationally Funded Budgets	3,524	1,596	1,928	6,048	6,048	0
System Funded Budgets	256	249	7	437	437	0
TOTAL	**6,253**	**4,069**	**2,184**	**10,684**	**10,684**	**0**

Underlying deficit

17. The Board may recall that at the start of the year, before Covid struck, the system was reporting that it was just under £180m adrift of its control total of minus £97m, meaning that we were £277m (8%) in deficit. If anything, our experience during 2020 is that expenditure trends have not

improved and it is likely that the resources we will have from 2021/22 onwards, post Covid, will remain constrained as the economy struggles to recover.

18. All our providers, except LSCFT, were forecasting significant deficits and some CCGs were also in deficit.

19. Whether it is providers and/or CCGs in deficit, as a system it doesn't matter, the deficit requires action. In recent years the focus has been on meeting control totals set by the Northwest Region. Although we have had some success in achieving tactical solutions as a system, we have failed to halt the deterioration in our underlying position. Clearly, as a system we must ensure that we address the position and agree solutions. The SLE has signalled its intent to outline expectations for the forthcoming 2021/22 planning round and the ICS Board too will wish to be explicit on its views on the level of ambition over a specified timescale.

20. There is a major difference between previous years and this – which is that we now have a clinical strategy that forms the bedrock of all related strategies, whether in relation to finance, estates, digital and/or workforce. The clinical strategy will assist in addressing at least one aspect of our deficit (which can be analysed as follows):
    - Efficiency
    - Service/delivery models – most amenable to changes signalled in the clinical strategy
    - Structural

21. This will be a system in recovery and the expectation should be that substantial steps are taken each year on the road to financial recovery. How that may happen over time will be the subject of the planning round and I will work with Non-Executive Directors and other members of the Board to ensure that the benchmarking information we have at our disposal is mined to gain insights into the areas where better value for money could be achieved and more affordable, clinically sustainable services delivered for the benefit of our patients and population.

Recommendation

22. The Board is asked to **note** the updates to the financial position and to look forward to involvement in articulating our ambitions for the forthcoming short and medium term planning rounds.

Gary Raphael
ICS Executive Lead for Finance
24th November 2020

ICS Board

Date of Meeting	2nd December 2020
Title of Paper	ICS Programme Executive Summary Report
Presented By	Talib Yaseen – ICS Executive Director of Transformation
Author	Emily Kruger Collier – Head of ICS PMO / Denise Wyn-Jones – PMO Programme Manager / Tracy Ashworth – PMO Programme Manager / Jenny Wright – Programme Co-ordinator / ICS Programme Teams
Agenda Item	12
Confidential	Yes

Purpose of the Paper

To provide a monthly updated summary position of the progress with delivery of ICS programmes.

Executive summary

The report provides a monthly programme update and summary of the status, key activities, progress and upcoming plans for each of the Lancashire & South Cumbria wide programmes. Programme resource is increasingly being utilised to support the Covid wave 2 response and continued restoration and recovery efforts. ICS Programmes have re-prioritised their work accordingly.

Discussions are underway with SLE and the Provider Collaborative Board about when we will be in a position to restart system programmes and how these will be resourced and led. Current priorities around restoration are likely to run through the whole of 21/22.

Recommendations

None but to note the current position.

Governance and Reporting

(List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome
SLE	Nov-2020	For Information & Recommendation

Conflicts of Interest Identified

Implications

Quality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Equality Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Privacy Impact Assessment Completed	**Yes**	☐	**No**	☐	**N/A**	☒
Financial Impact Assessment	**Yes**	☐	**No**	☐	**N/A**	☒

Completed						
Associated Risks	**Yes**	☐	**No**	☐	**N/A**	☒
Are Associated Risk Detailed on the ICS Risk Register?	**Yes**	☐	**No**	☐	**N/A**	☒
If Yes, Please Provide a Risk Description and Reference Number	Mark Yes, No or Not Applicable Above and Provide a Risk Description and Risk Reference Number in this Box if there are Any Associated Risks					

Monthly Lancashire & South Cumbria ICS Programme Executive Summary Report: November 2020

Purpose: To provide a summary of the status, key monthly activities, progress and upcoming plans of each of the Lancashire & South Cumbria wide programmes.

This report is to;

- confirm the current status
- offer assurance of progress.
- escalate significant issues and risks to programme delivery.
- support advanced planning and decision-making at the relevant programme stages and gateways.
- recommend where action or support from system leaders is required.

Please note: On the 23rd March, the decision was taken by the ICS Executive Team to stand down the ICS transformational programmes, except where the planned work would contribute to the response and action required to manage the Covid-19 pandemic. The released capacity from the ICS team, as a result of this decision, has been reallocated to support the ongoing co-ordination role in response to the Covid-19 pandemic across Lancashire & South Cumbria.

A condensed programme report has been produced to offer an overview of continued programme activity, and the schedule of associated programme products.

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Contents

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Section A: Recommendations for Executives

This section will provide any key highlights, to bring to the attention of the System Leaders Executive, that may require focus, action, guidance or recommendation from members.

Programme	Recommendation	Page Ref
All	Programme resource is ever increasingly being utilised to support the Covid wave 2 response and continued restoration and recovery efforts. Programmes have started to re-prioritise their work accordingly.	-
Highlights		
1.5 Integrated Learning Disabilities and Autism Service Strategy - Transforming Care	The programme has agreed a shadow pooled budget from April 2021, between Lancashire County Council, Blackburn with Darwen Council, Blackpool Council and all CCGs.	7
2.3 Strategic Workforce Planning	Over the last month, all 5 LSC Trusts are now registered on the Staff Digital Passport scheme and trials are underway. This makes LSC only the second ICS in the country to achieve this.	8
3.6 Digitally Enabled Care	The WeLLPres-LPRES integration went Live successfully on the 30th September 2020, including the completion of the testing on the production environment and signage of acceptance criteria document.	9
4.3 Cancer	The Targeted Lung Health Check continues to be hampered due to local lockdown; competing digital priorities and workforce issues and as a result the delivery timeline is being reviewed.	10
4.4 Stroke Services	**AI For Stroke:** Funding has been approved by the ICS Investment Committee.	10

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Section B: Programme Product Schedule

The ICS Programme Product Schedule presents the planned products for each of the programmes, the meeting, and purpose they are intended for. The aim is to support advanced planning for decision-making and meeting agendas. The product schedule covers a 5-month rolling period of products. The product schedule is a live document and the table below presents the position **at the 6th November**.

B.1 Programme Products - Outcome table: **details the outcomes of products presented in the previous 2 months and table**

Programme	Product	Product details	Meeting	Purpose	Date of meeting	Outcome	Outcome details
1.6 CYPEWMH	Programme Evaluation Report	CAMHS Redesign Evaluation Final Report	CCB	Review or comment	13/10/20	Reviewed & comments provided	The paper was fully supported with a number of recommendations including to agree a develop and provide updates against a delivery plan, as well as sharing the associated financial modelling .
	Programme Evaluation Report	CAMHS Redesign Evaluation Final Report	JCCCG	Approval	05/11/20	Approval	Financial plan to be sent back to future JCCCG
2.5 Medicines Management	Update Paper	Policy Recommendation and update	JCCCG	Endorsement	05/11/20	Endorsed	
3.4 Collaborative Services	Opportunities Long List	Various Collaborative Opportunities	FIG	Endorsement	11/09/20	Endorsed	Endorsed and agreed to develop short list
	Opportunities Short List	Various Collaborative Opportunities	FIG	Review or comment	09/10/20	Reviewed & comments provided	Approved four options with further review suggested
3.5 Primary & Community Care & Wellbeing Framework	Programme Brief		PDB	Review or comment	08/10/20	Reviewed & comments provided	A draft of the programme brief was reviewed by the board and comments provided.
4.5 Palliative & End of Life Care	Programme Brief		PDB	Endorsement	/08/10/20/	Endorsed	Brief updated with feedback
4.6 Planned Care	Exception Report	The paper requested an extension to the current community dermatology contracts throughout L&SC until Oct 2022 to allow focus on restoring services and optimising referral pathways by the use of technology.	CCB	Approval	13/10/20	Approved	The delay was agreed

Programme	Product	Product details	Meeting	Purpose	Date of meeting	Outcome	Outcome details
4.10 Respiratory	Clinical Model Implementation Plan	An update on plans to implement a new pathway from October 2020	SLE	For information	16/09/20	To note	
Long Term Conditions (LTC) esp. BAME &IMD groups	Clinical Model Implementation Plan	To update on plans to implement new pathway from October 2020	SLE	For information	16/09/20	To note	

B.2 Upcoming Programme Products Schedule: details the products due at ICS corporate meetings in the upcoming 3 months.

Programme	Product	Product details	Planned Month for Completion	Meeting	Purpose	Date of meeting
1.5 Integrated LD & Autism Service Strategy	Strategic Plan		December 2020	JCCCG	Approval	03/12/20
	Joint Funding Options Appraisal		December 2020	CCB	Approval	08/12/20
	PID	PIDs for National Exemplar sites	December 2020	PDB	For information	10/12/20
	PID	PIDs for National Exemplar sites	December 2020	SLE	For information	16/12/20
2.4 Children & Young People's IPA	Proposal	Paper detailing proposal for CYP IPA pilot	November 2020	CCB	Approval	10/11/20
3.1 HIP2 Development	Other	Introductory presentation with HIP2 Q3 Board Report; will include alignment of the key milestones/decisions required to meeting dates.	December 2020	JCCCG	For information	03/12/20
3.4 Collaborative Services	Update Paper – for information only	Transport & workforce	November 2020	SLE	For Information	18/11/20
	PID	Estates, IM&T, Referrals, and PTS	December 2020	PDB	Review & comment	10/12/20
	PID	Estates, IM&T, Referrals, and PTS	December 2020	SLE	Approval	16/12/20
3.4 Collaborative Services	Update Paper – for information only	Programme Update - Agency Market Management - Temporary Workforce	January 2021	PDB	For information	14/01/21
4.1 Adult Mental Health	Update paper	Rehab Progress Report & Interim evaluation	December 2020	CCB	For information	08/12/20
	Proposal	Governance Proposal paper	January 2021	JCCCG	Approval	14/01/21
4.6 Planned Care	Policy	Spinal Injections for Backpain Policy	January 2021	JCCCG	Approval	14/01/21

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Section C: Programme Executive Summary

The executive summary provides a narrative to reflect highlights and key programme activities undertaken during the previous month and planned over the next 2 months. Updates are triangulated with programme plans, risks, benefits, and scheduled products.

1. Transformation of Services

Lancashire & South Cumbria wide programmes aimed to significantly change the form, structure and/or develop the way in which services are delivered.

1.1 Intermediate Care – Advancing Integration

The programme restarted in October and which is now part of a wider programme governance structure; which is yet to be confirmed. There has also been a transfer of Executive Sponsorship from Julie Higgins to Jerry Hawker. The team are currently developing the vision document for the programme with the initial metrics and stakeholder management plan, the draft of which is expected to be available for feedback and comments during December.

1.2 Acute Paediatric Services

Until priorities are agreed, the programme is unable to make any progress in terms of ICS stages and gateways; although much provider engagement work is underway promote system working.

1.3 Diagnostics Collaborative

Pathology – Digital: A paper was taken to Diagnostics Programme Board on the 29th October to agree the prioritisation of the pathology digital workstreams. The prioritisation was approved with the recommendation that timescales for delivery are required. It was agreed that a number of other 'must do' projects are priority for completion by end of 2020/2021 including the roll out of LAMP Covid testing for staff; establishing the centralised image sharing/viewing platform and central storage architecture; deploy HiPRES application; Deploy Brainomics AI for Stroke; Integrate NPEX to ICS Data Hub. These priorities will cause delays to other work including implement a single instance Digital Pathology system along with support to Radiology and Endoscopy specialties.

Radiology: Funding has been identified to secure programme resource for the data/analytics and workforce. The programme will now review and agree the high impact interventions which will be progressed locally/collaboratively to support recovery and restoration.

Interventional Radiology: On hold due to Covid. Key priority for the coming months is to define the future service model when programme recommences.

1.4 Urgent and Emergency Care

East Lancashire Hospital Trust has now gone live with 111 First. The programme is developing a set of deliverables for the winter plan and the ICS plan on page priorities which more detailed plans produced during November. The Network is also supporting the development of the Winter Co-ordination Hub and the mobilisation of winter ICP plans.

1.5 Integrated Learning Disabilities and Autism Service Strategy - Transforming Care

The programme has now established the Joint Funding Working Group, working with Blackpool and Blackburn with Darwen to create an options appraisal for LD&A which will be taken to CCB in December 2020 for review. The programme has also agreed a shadow pooled budget from April 2021, between Lancashire County Council, Blackburn with Darwen Council, Blackpool Council and all CCGs. The Local Authorities have commissioned the Local Government Association to support the process.

A Patient Needs Assessment has been completed which has identified areas that require commissioning new accommodation and Community Services. Work is also ongoing in relation to a

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pathway which will track inpatients and provide solutions to enable discharging back into the community. This work will be supported by a community discharge grant, with allocations across all authorities, and a process for accessing the funding.

The Whalley periphery houses group has been re-established, and now has a five-year plan provided by Mersey Care Foundation Trust and will be supported by the LD&A programme.

The programme has also been successful for four National exemplar sites, with PIDs completed for those being led by the LD&A Programme, and Expression of Interest documentation for those being led the East Lancashire CCG. These have been signed off by the relevant CCGs and Acute Trusts.

L&SC are also in the process of completing the National requirements for LeDeR which will be submitted by the 31st December 2020.

1.6 Children and Young Peoples Emotional Wellbeing and Mental Health

CAMHS Thrive Redesign: The outcome of the Thrive evaluation was presented to CCB, and JCCCG in November. JCCCG praised the work completed and the approach taken and agreed that the proposed model meets the Thrive mandate. Members also advised that an implementation plan and associated financial model need be developed for January 2021.

2. Delivering Sustainable Services

Lancashire & South Cumbria wide programmes aimed to stabilise services that are constrained and require action.

2.1 Head & Neck Services

The Programme has been paused due to Covid-19, and currently awaiting a decision regarding re-starting of the priority programmes in line with the Clinical Strategy.

2.2 Vascular Services

The Programme has been paused due to Covid-19, and currently awaiting a decision regarding re-starting of the priority programmes in line with the Clinical Strategy.

2.3 Strategic Workforce Planning

Over the last month, all 5 LSC Trusts are now registered on the Staff Digital Passport scheme and trials are underway. This makes LSC only the second ICS in the country to achieve this.

For careers, an initial application for Kickstart programme funding has been made to offer 41 roles in LSC, with job descriptions and person specifications completed for advertisement upon confirmation of funding. The Careers Insights Week showcasing the numerous career pathways for students was extremely successful. Feedback survey results are being used to inform future events and activity. The team continue to develop their virtual support offer for other, wider employability programmes and placement opportunities.

Workforce continue to support the volunteer agenda and have collaborated with Maggie Asquith, to deliver an inaugural 'Pathways into Health and Social Care through Volunteering' online event. This workshop will inform further work to develop a suitable scheme.

Regulated Care collaboration: The virtual Social Care Workforce Forum held on 7th October was aimed at care managers responsible for recruitment and retention where they could engage with partners from Lancashire Skills and Employment Hub, CQC, Skills for Care, local authorities, education, health and care providers. This identified a number of focus areas of support offers which includes the establishment of an ICS Social Care BAME Network and a Leadership Development Group; both are to commence in December.

A Social Care Training and Development task and finish group is co-ordinating requests for

Continual Professional Development from care providers and RESTORE2 training (which assesses deterioration in people) is being delivered across the ICS in conjunction with the distribution of pulse oximeters.

The clinical placement expansion plan for Regulated Care is in development. This is aimed at increasing the number of student nurses in care homes and delivering a rotational student placement package in the community which links into social, primary and community care. It is being developed in collaboration with the EELE project, with oversight from the ICS Collaborative Education Forum.

2.4 Integrated Children & Young People's Health

Children and Young People's Individual Patient Activity: A paper detailing the plans and resource requirements for continuing the successful pilot was taken to CCB on the 10th November with the outcome that Jerry Hawker is now taking it to the wider IPA group to progress.

2.5 Medicines Management

A Medicines Management policy recommendation and update paper was taken to JCCCG on 5th November 2020, and all of the recommendations were ratified by JCCCG.

3. Building the Future System

Lancashire & South Cumbria wide programmes aimed to structurally improve and integrate services through reform to structure, form, functions and operating models.

3.1 HIP2 Development

The programme governance has been expanded to include Blackpool Teaching Hospital and East Lancashire Hospitals. Recruitment is underway for programme clinical leadership. A draft communications plan is developed, and key stakeholder engagement has commenced with focus over the coming months, to include engagement with the external comms provider to support political engagement. In December 2020, an introductory presentation will be delivered to JCCCG.

3.2 Strategic Estates Infrastructure

Digitalisation of Lloyd George (LG) Medical Records in GP Practices: A communication plan and a full programme schedule have been developed, the latter of which takes into consideration those practices and CCGs/ICPs with immediate/urgent needs for implementation. In addition, a new Covid-19 risk assessment has been produced to ensure that packing teams can work safely in GP practices. The collection and scanning of records has commenced in first 5 priority practices. The contract and payment schedule will be signed off by December.

3.3 Population Health

The VCFE Alliance and the ICS have successfully bid for organisational development support from NHSE/I to increase ICPs capacity to work on health inequalities. Focus has also been on delivering a Primary Care Network live data set to enable risk stratification of Covid vulnerable groups with all but one District Council now contributing data. Covid testing results will be added to the tool and linked to the virtual ward. The team is working with the LRF to enable social support for people in the Covid virtual ward allowing them to remain at home while better managing their risk factors. Work is underway to agree a financial envelope and supporting resources so that Covid-specific population health management work progresses over the next few months, with plans to scope a wider programme in the new financial year.

3.4 Corporate/ Shared Services Collaborative

The Temporary Workforce programme has identified that the scale of cost mitigation opportunity for the agency market management and a common rate card is in the region of £8m. The programme

will finalise the project plan during December 2020.

The non-patient transport workstream objectives and opportunities will be developed by the end of December 2020 and taken for sign-off to the Estates and Infrastructure Group during January 2021.

FIG agreed in October Estates, IM&T, Referrals, and PTS as further areas to assess for efficiencies. By January PIDs including resource requirements will be drawn up.

3.5 Primary, Community Care & Wellbeing

The Primary Care Sub-Cell is focussing on 'operational' work in response to the Covid-19 second wave, and requires significant resource for vaccination planning and the roll out of virtual wards. Meanwhile, there is a review of GP quality contracts and the approach to assessing GP demand and capacity. This work is expected to continue during November and in addition the team will be progressing; the QOF population stratification approach, launching the revised Primary Care SitRep, and PCN development including recruitment of five ICP/ PCN leads; with a coordinated approach across Dental, Pharmacy and Eye Health.

3.6 Digitally Enabled Care

Population Health Management Data Architecture: Recruitment of the development support team has taken place, and the team are commencing the programme design work. Focus is on the flow of patient information from Health and Social Care, during and beyond COVID 19, and associated IG issues. The control of patient information (COPI notice) has been extended to March 2021 which sets a deadline for completion of this work.

WeLLPres-LPRES: The WeLLPres-LPRES integration went Live successfully on the 30th September 2020, including the completion of the testing on the production environment and signage of acceptance criteria document. Support has been provided for users to manage the change with a self-service portal created to mitigate the number of calls. Work is currently underway in relation to the delivery of the Prostate Managed Care Pathway, and delivery of the Patient Portal during the course of November 2020.

4. Improving Performance & Outcomes

Lancashire & South Cumbria wide programmes to reduce variability and improve performance and outcomes across public services.

4.1 Adult Mental Health

Rehab: An Assurance Group has been established to oversee the implementation of the redesign of the rehab pathway, and the associated impact on performance, activity, finance and quality. A progress update and interim evaluation is planned to be presented to CCB in December 2020.

Psychology Workforce Project: The L&SC job advert was published on the 21st October 2020 and 210 applications were received with interviews taking place week commencing 9th November 2020. We are on target to achieve the number of 50 posts.

The Mental Health Advice Line (MHAL): The Mental Health Advice Line is currently expanding its professional access to NWAS paramedics as well as police officers. Roll out has been completed in all areas except for Pennine Lancashire which is planned for November.

Early Intervention to Psychosis (EIP): Individual Placement and Support (IPS) employment support has been fully integrated into the EIP pathway. There are some really positive news stories from the team in regard to referrals and job starts. The IPS team have exceeded their projected

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targets and it is hoped that this continues throughout the quarter. The programme will receive a full IPS quarterly data set report in December 2020.

Mental Health Performance Reporting: A plan has been put in place to have a version of the dashboard that can be circulated by the end of December 2020 with the automation of the Aristotle dashboard due to be completed by April 2021.

Mental Health Directory: There has been some delays to the launch of the mobile app, due to app approval, however, the app will now launch in self-care week which is 16th November 2020.

A general update paper for Mental Health will be taken to JCCCG in January 2021, including key services areas such as rehab, winter pressure bids, and National KLOEs.

4.2 Better Births and Maternity

An Outcomes Framework is in development to ensure service focus is on positive outcomes for women and their families; which will form part of the programme's MOU/ Maternity Alliance Agreement.

The Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme was relaunched on 1st October and declaration forms are to be completed by each Trust regarding 10 Safety standards that maternity must meet to get a significant "discount" on the insurance premium.

On 13th October, a letter from Ruth May; Chief Nursing Officer, regarding continuity of carer data and surveys completion. The letter has caused national concern due to the potential adverse impact on the achievement of the March 2021 target. To address this, from November, key local stakeholders will meet to get baseline data and develop robust local collection/ reporting mechanisms, together with a plan review to demonstrate assurance across LSC.

In Digital, following the Clevermed award for Badgernet maternity, each Trust is currently formalising local contracts and identifying project teams. The LTH implementation plans will be developed from November.

For Workforce & Education Transformation, the CLiP (Collaborative Learning in Practice) project has successfully bid for additional monies to deliver phase 2 from March 2021. A clinical lead is now in post to support the Maternity Support Worker project with future plans for further resource. From 2nd November, a Project Training & Development Lead commenced in post for the Maternity Essential Training project which will be launched in November.

4.3 Cancer

During October, capital allocations were received to support endoscopy recovery. Q2 assurance was completed satisfactorily with the regional team and the work programme for the remainder of 2020/2021 was agreed. Significantly, the Targeted Lung Health Check continues to be hampered due to local lockdown; competing digital priorities and workforce issues and as a result the delivery timeline is being reviewed. Future priorities for Q3 involve supporting the delivery of cancer services through the Covid-19 second wave, contributing to the clinical prioritisation of surgical cases, developing protocols to support pathways, and investing in key workforce roles to deliver endoscopy activity.

4.4 Intensive & Hyper Acute Stroke Services (ISDN)

Patient and Carer Assurance Group: The Chair position has been recruited to with wo representatives per ICP that will sit on the Local Stroke Strategy Groups linking in with the regional meeting. The first meeting is set for 13th November 2020. One of their first priorities will be to refresh and agree the L&SC Integrated Service Specification.

Life After Stroke: a workshop was held on 22nd October 2020, with excellent attendance from all

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disciplines across the stroke pathway, plus all newly recruited patients and carers. The workshop identified national and local workstream priorities. A further meeting will set up, to coordinate Rehabilitation priorities, patient and carer priorities and Life after stroke cross cutting priorities, with an aim of working collaboratively to achieve priorities – date to be scheduled.

AI For Stroke: Funding has been approved by the Investment Committee. All Trusts are going through a procurement for installation of Nodes on CT Scanners, with a view to go live week commencing 14th December 2020. Ongoing training and installation for AI will be carried out during the course of October/November 2020. An update paper will be presented at the HIP2 meeting 12th November, and PBC for 27th November.

Engagement: L&SC Patient representative Jean Sherrington has been asked to speak at the Westminster Health Forum policy conference, in relation to; Stroke prevention, care and treatment in England - next steps for Integrated Stroke Delivery Networks, training, and local delivery. Jean Sherrington and Elaine Day, have also been invited by the National GIRFT to do a video presentation at the UK Stroke Forum on 7th December 2020.

4.5 Palliative & End of Life Care

The Electronic Palliative Care Coordinating System (EPaCCS) project steering group membership has been agreed with project management support, project clinical leadership and governance now in place. The system essentially allows electronic transfer of information to support communication on end of life care.

Due to staffing absences, the wider programme are experiencing capacity issues at present, which is delaying progress for some areas of work. From November, the team plan to develop and agree a project brief for bereavement scoping across LSC and Compassionate Communities Education.

4.6 Planned Care Services

Dermatology: During the last month approval has been given via CCB to extend current community dermatology contracts and delay the community procurement until October 2022. In addition, the 4 ICP dermatology working groups within L&SC have met to discuss new ways of working and what can be done within the next few months to optimise pathways to help manage the backlog of patients and new patient referrals by the use of technology. ICPs throughout November will develop local delivery plans detailing key milestone and timelines in relation to delivering the projects.

Ophthalmology: The standards, outcomes and measures will be shared for agreement and sign-off by the Clinical Leads across the ICS by the end of December 2020. The plan on a page is also being drafted for the ICS Priorities, and the Hospital Cell Elective Care Recovery Group to be shared 24th November 2020.

Adapt and Adopt Programme/Outpatients: The programme continues to share best practice and update on plans in relation to video consults, validation and stratification, advice and guidance and patient-initiated follow-ups. All Trusts have either commenced or completed the validation requirements and work on a specification for future video consultations is underway across the system. The UHMB Advice and Guidance roll out is almost complete across the system and phase to of the project is in planning. Involvement in the Ophthalmology road map development continues, and the system outlining the support requirements for MSK, and other task and finish groups.

4.7 Prevention Strategies

Diabetes Prevention: The team are working through referral recovery plans; devised via the National Diabetes Prevention Programme (NDPP) Steering Group with CCGs; to bolster referral into the programme. MyDiabetes MyWay is working with GP practices across ICS footprint to set up the full integrated patient platform. Practice awareness sessions continue in parallel to digital teams

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working on enabling bulk accesses to speed up entry to the full platform.

The full year 2020/2021 national transformation funding is imminent; however, the team has identified a new risk concerning the potential difficulty of getting these funds to the right place due to the temporary CCG-Trust Block Contract arrangement.

4.8 Universal Personalised Care

The Personalised Care programme funding has now been confirmed. A meeting was held with NHSE to review programme deliverables, where potential priorities were agreed to March 2021 and the programme now need to agree their level of support to the individual programmes, which will necessitate a revised Programme Plan being approved by NHSE and ICS SLE.

4.9 Individual Patient Activity (IPA)

The programme now includes Covid-19 recovery but the increased cases and subsequent impact on hospitals and care providers has put the agreed timeframes at risk and the trajectory (for completing the recovery programme for patients with Covid packages requiring a further assessment) has been submitted to NHSE where it will be monitored and reported fortnightly. A more collaborative approach between Health and Local Authorities is in place for recovery planning and the recruitment of additional relevant staff with recruitment/training to be completed in November to enable required assessments to start by 1st December. Any impact will be reviewed in line with the Business Case.

4.10 Respiratory

Blackpool was confirmed as an NHSE early implementer site for the smoking in pregnancy work stream and the NHSE MOU is expected to be completed in November. For vaccination, Fylde Coast GPs received praise for their high rates - attributed to innovative promotion and ways of working - and a weekly vaccination rate dashboard for each GP practice is nearing completion, which enables tracking of high risk groups.

The bespoke searches (test of change) and collation of baseline register data, at practice population level for those at risk of COPD and Asthma, will be completed by December. Nexus Intelligence is being used to replicate the West Lancs 'population vulnerability management' approach, enabling the identification of COPD at-risk patients this winter and for long term improved health inequality management.

In addition, the CSU is linking into the 111 First and Same Day Emergency Care (SDEC) schemes by supporting Unscheduled Care to formulate pathways that stipulate length of stay (LoS) and timings of clinical interventions for acute admissions according to an 'ideal' clinical scenario, and then audit them to enable exception reporting to inform how resources/ inputs may be managed to optimise LoS.

A winter scheme has launched to increase the number of patients seen with COPD, Community Acquired Pneumonia and Lower Respiratory Tract Infection without COPD via SDEC to reduce avoidable prolonged admissions and reducing Emergency Department overcrowding. The directory of services has also been amended to permit direct streaming SDEC for Ambulatory Emergency Care (AEC) for these patients and this is also supported by a proposal to increase the Respiratory Assessment Unit (RAU) from 5 to 7 days.

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5. Business as Usual

Lancashire & South Cumbria wide updates relating to progress, challenges or information updates on an ad hoc basis. These programmes are not actively monitored but reported by exception.

5.1 Leadership & Organisational Development

Following engagement with UHMBT Inclusion Leads Collaborative and supporting the facilitation of their Inclusive and Compassionate Leadership Masterclass workshops with Eden Charles, the team recently presented a proposal for an ICS Inclusion Approach to the ICS Executive and following their feedback, the paper will be refined and returned for approval. During November, assessor training workshops are scheduled, entailing regular applicant liaison, to verify completion of all assessment processes to ensure system readiness for the February 2021 assessment centres.

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Healthier Lancashire & South Cumbria

Annex 1: Glossary of Terms

BAME	Black, Asian and Minority Ethnic
CAMHS	Children & Adolescent Mental Health Services
CCB	Collaborative Commissioning Board
CCG	Clinical Commissioning Group
CNST	Clinical Negligent Scheme for Trusts
COPI	Control Of Patient Information
CQC	Care Quality Commission
CYP	Children & Young People
CYPEWMH	Children & Young People Emotional Wellbeing & Mental Health
DARS	Data Access Request System
DISN	Diabetes Inpatient Specialist Nurse
EELE	Enabling Effective Learning Environment
ELHT	East Lancashire Hospital Trust
EPaCCS	Electronic Palliative Care Co-ordination System
FIG	Finance Investment Group
GIRFT	Getting It Right First Time
HEE	Health Education England
HIP2	Health Infrastructure Plan
ICP	Integrated Care Partnership
ICS	Integrated Care System
IM&T	Information & Technology
IPA	Individual Patient Activity
ISDN	Integrated Stroke Delivery Network
JCCCG	Joint Committee Clinical Commissioning Groups
L&SC	Lancashire & South Cumbria
LD&A	Learning Disabilities & Autism
LeDeR	Learning Disabilities Mortality Review
LPRES	Lancashire Person Record exchange Service
LRF	Local Resilience Forum
LSC	Lancashire & South Cumbria
LSCFT	Lancashire & South Cumbria Foundation Trust
MBCCG	Morecambe Bay Clinical Commissioning Group
MDMW	MyDiabetes MyWay
NDPP	National Diabetes Prevention Programme
NHSEI	NHS England / Improvement
NWAS	North West Ambulance Service
PCN	Primary Care Network
PDB	Programme Delivery Board
PHM	Population Health Management
SitRep	Situation Report
SLE	System Leadership Executive
VCFE	Voluntary, Community & Faith Sector

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