Healthier Lancashire & South Cumbria

Formal Integrated Care System (ICS) Board Agenda
3 February 2021 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	Verbal
3.	Key Messages • Covid-19 Vaccination update • Operational Priorities	Dr Amanda Doyle	Note	Verbal
4.	LSC Pathology Collaboration	Mark Hindle	Endorse	Attached
5.	ICS Response to National Consultation: Transformation of urgent and emergency care: models of care and measurement	David Bonson/Andy Curran	Approve	Attached
6.	Financial Strategy	Gary Raphael	Discuss	Attached
7.	New Hospitals Programme (HIP2)	Rebecca Malin/Talib Yaseen	Endorse	Attached
8.	System Reform	Andrew Bennett	Endorse	Attached
Any Other Business				
9.	Items for the Next Board Meeting	All	Note	Verbal
10.	Any Other Business	All	Note	Verbal
Date and Time of the Formal ICS Board Meeting: 3 March 2021 – 10.00-12.00 noon, MS Teams Teleconference				

Minutes of the Formal ICS Board
Held in Public
Wednesday 2 December 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
Jackie Hanson	Director of Nursing	Lancashire and South Cumbria ICS
Gary Raphael	Executor Director of Finance	Lancashire and South Cumbria ICS
ICP Leads		
Kevin McGee	Executive Lead	Blackpool Teaching Hospitals NHS Foundation Trust
Caroline Donovan	Executive Lead	Lancashire and South Cumbria NHS Foundation Trust
Karen Partington	Executive Lead	Lancashire Teaching Hospitals NHS Foundation Trust
Geoff Jolliffe	Clinical Chair	NHS Morecambe Bay CCG
Alex Heritage	Chief Executive	NHS Transformation Unit
Dr Stephen Hardwick	Chair	Local Medical Committee
Neil Jack	Chief Executive	Blackpool Council
Sarwar Shazad	Non-Executive Director	Lancashire and South Cumbria NHS Foundation Trust
Eileen Fairhurst	Chair/Provider Collaborative Chair representative	East Lancashire Hospitals NHS Trust
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Peter Gregory	Chair	NHS West Lancashire CCG
Denis Gizzi	Accountable Officer	NHS Chorley South Ribble and Greater Preston CCGs
Aaron Cummins	Chief Executive Officer	University Hospitals of Morecambe Bay NHS Foundation Trust
ICS Non-Executive Lay Members		
Mike Wedgeworth	Non-Executive Director	East Lancashire Hospitals NHS Trust

ICS BOARD

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		
Shaun Turner	Councillor Representative	Lancashire County Council
In Attendance		
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Lindsay Dickinson	Clinical Chair	Lancashire and South Cumbria NHS Foundation Trust
Louise Barker	Senior Communications and Engagement Manager	Lancashire and South Cumbria ICS
Vicki Ellarby	Interim Strategy Director (Fylde Coast)	Blackpool Teaching Hospitals NHS Foundation Trust
Emily Kruger	Head of Programme Management Office	Lancashire and South Cumbria Foundation Trust
Rebecca Taylor-Rossall	Digital Communications Manager	Lancashire and South Cumbria Foundation Trust
Jane Scattergood	Director of Nursing and Quality/ Covid-19 Vaccination Director	Fylde Coast CCGs/ Lancashire and South Cumbria ICS
Rebecca Higgs	Business Manager	Lancashire and South Cumbria ICS
Maria Louca	Personal Assistant to Dr Amanda Doyle	NHS Fylde and Wyre CCG/ Lancashire and South Cumbria ICS
Pam Bowling	Governing Body Secretary (minute taker)	NHS Fylde and Wyre CCG

Item	Note	Action by
1	**Welcome, Introductions and Apologies** David Flory welcomed everyone to the meeting which was being held in public for the first time – an important step for openness and transparency. Members of the public had been invited to raise questions in advance of the meeting, although none had been received. Apologies for absence were received from Roy Fisher, David Bonson, Martin Hodgson, Ebrahim Adia, Graham Urwin and Claire Heneghan.	
2	**Declarations of Interest** It was recognised that members of the Board had a conflict of interest in the agenda item on system reform.	
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 subject to the following amendments; 1) In attendance: Jerry Hawker, Chief Officer (remove – 'on behalf of Sue Smith') 2) Removal of Professor Ebrahim Adia from the attendance list The updated matters arising/action log was noted.	

4	**Key Updates/Messages** Dr Doyle reported that the NHS 111 First programme - which encouraged people to dial 111 rather than attend A&E and subsequently diverted to alternative services as appropriate - had been successfully rolled out across the patch. Initial feedback from both patients and staff had been positive. This was an initial 'soft' launch - a media campaign would be rolled out over forthcoming weeks to raise awareness to the approach. In response to a question Dr Doyle said it was too early to be able quantify the impact of the programme on A&E activity. 'Long COVID' services are being established in Lancashire and South Cumbria hosted by Lancashire and South Cumbria Foundation Trust, although a number of providers are involved in delivering support. These services assess the needs of individual post-COVID infection and signpost patients to appropriate ongoing support for management of a range of symptoms, including mental health (behavioural and organic), respiratory and neuro-muscular problems. Virtual wards are being rolled out across the patch whereby patients with COVID are managed at home, monitoring and reporting on their own oxygen levels. Dr Doyle was also pleased to report that the Safeguarding leads across Lancashire and South Cumbria, who recently attended the Board to seek support for a system wide approach to the safeguarding agenda, have won the NHS Safeguarding Initiative at the 2020 HSJ Patient Safety Awards. On 26 November 2020, NHSE/I published a document 'Integrating Care: Next Steps to building strong and effective integrated care systems across England'. Dr Doyle explained that the guidance aligns well with a lot of work that the ICS has already done. The paper seeks views on proposed options, and an ICS response will be developed to be agreed by the Board. Dr Doyle encouraged individual organisations and appropriate groups to also review and respond to the consultation.	
Sustainability		
5	**Current Financial and Operational Overview** <u>Phase 3 financial plans</u> Gary Raphael updated the Board on the conclusion of the phase 3 planning process following the allocation of system growth funding. Updated Lancashire and South Cumbria (L&SC) aggregated phase 3 financial plans were submitted to the Regional Team on 18 November 2020 and met the requirement set by the System Leadership Executive (SLE) of a £90m shortfall against the financial envelope of £1.74bn for the second half of the year. The Board was asked to endorse and approve the allocation of growth funding in line with the decision of the SLE to achieve the financial positions as outlined in table 1 of the report. Mr Raphael explained that the SLE noted that for tactical financial reasons ensuring CCG plans were balanced whilst deficits were shown in provider positions was the best option for the system, given that CCG overspends must be recovered in the following year, whilst trusts were able to borrow at 3.5% interest rate with no immediate requirement to repay the debt. On this basis, phase 3 is concluded and the Regional Team has confirmed that although the plans remain unaffordable, they are accepted as the final submission. By 4 December 2020, organisations are required to submit a revised forecast spend for the year to 31 March 2021 and the ICS finance team is working with Regional finance managers and organisational finance teams to ensure that there is a consistent	

approach to these estimates. Some of the issues which were suppressed in the phase 3 plans to meet the requirements of that scenario will be expressed as part of the wave 2 response - however, if there is a risk of exceeding the £90m deficit position on the financial envelope, there will need to be a decision made on what can be done to stay within that figure.

Mr Raphael added that plans for 2021/22 would need to start to be developed and reminded the Board not to lose sight of the system's underlying deficit.

Mr Raphael concluded that in response to recommendations from the Finance Advisory Committee (FAC) and after having discussed the rationale for allocating system growth funding to assure budgetary balance in CCGs, the SLE had endorsed the approach to distributing growth funding and had 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, as shown in the table on page 2 of the report.

Members discussed the content of the report and supported the approach and position reached. Comments were made about the pressures and increased demand on mental health services and gaps in funding. The Chair suggested that a report on this specific issue would assist colleagues in understanding the challenges faced.

Reference was made that the paper did not include Covid related costs for the second half of the year - therefore there was a need for the system to make strong representations in this regard and to have a clear understanding and clarity on the current gaps across the system. Dr Doyle referred to the huge piece of work around recovery and restoration, allowing staff to recover and building the workforce. There was a need to restore the system to a more balanced financial position over a period of time according to a plan which was deliverable.

The Chair thanked everyone for their contributions to the debate and stressed the importance of the decisions that are made between now and the beginning of the next financial year in order that the position is as good as it can be and individuals are geared up to succeed in terms of the huge challenges faced.

<u>Phase 4 planning</u>

Carl Ashworth set out the planning expectations for 2021/22. Phase 4 planning guidance is expected in two parts, an initial letter setting out some of the expectations from NHSE/I about how the NHS will operate in 2021/22 and then detailed planning guidance at the end of January 2021. It is expected that the guidance will set out a system oversight framework to reflect an enhanced role for systems and preparation for powers and duties set out in the transition year towards April 2022. There will be a need for a continued balance between system response to Covid and recovery and restoration, and business as usual. It is expected that financial, activity, performance and workforce plans will need to be developed by mid-March 2021.

It was proposed that the next Board meeting in January 2021 would provide an opportunity for a further conversation in advance of receipt of the detailed guidance due later in the month.

RESOLVED
That the ICS Board 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 of the paper.

6.	**Covid Vaccination Update** Jane Scattergood provided an update to the Board on the development and mobilisation of the L&SC ICS COVID vaccination programme as follows: • Pfizer/BioNTech vaccine had met regulatory approval in the last 24 hours. • During pre-regulatory phase plans were being developed for a whole adult vaccination programme and these plans can now be firmed up at pace. • The Pfizer vaccine is challenging in terms of storage and transportation. The Oxford/Astra-Zeneca vaccine is more traditional and allows greater flexibility – this is expected to be approved before the end of the year. This will be easier to dispense to primary care and to Care Homes and housebound patients. • Blackpool Teaching Hospitals and Lancashire Teaching Hospitals have ultra-low temperature freezers capable of storing the Pfizer vaccine and will receive initial supplies to begin vaccinating over 80s, high risk NHS staff and Care Home residents and staff. • Delivery of vaccine then expected to flow to other hospital sites. • Work underway to identify PCN sites to focus on vaccination of over 80s. • Across Lancashire and South Cumbria there are a number of community site vaccination centres and three large scale centres being mobilised • The system will create management oversight centre to deliver vaccine at large scale sites. • Lot of support received from provider trusts who will register venues with CQC and work as a system in terms of governance, supply chain and clinical waste management work. • Expect to vaccine over 50s by the end of February and all adults by the end of April. The Chair thanked Jane for the presentation and acknowledged the huge amount of work done by Jane and her colleagues in preparing for the Vaccination Programme. Reference was made to media attention relating to primary care about renegotiating their terms and conditions in order to deliver the vaccine and clarification was sought as to whether this was a risk to the programme. Dr Doyle advised that there had been a good response from General Practice - assurance had been given that they would not be impacted financially and that the system would work with and support them. A question was asked about the need for two doses of the vaccine and if there was a risk around the gap. In response it was confirmed that booking was being managed via a central portal for the two doses with a tracking and monitoring system. The VCFS representative offered support of mobilisation and Jane outlined the work that was already taking place in terms of capturing the volunteering response.	
Building the Future System		
7	**Clinical Strategy** Andy Curran referred to the discussion at the last meeting when the Board had endorsed all the recommendations of the Clinical Strategy and to a further discussion held at the ICS Executive meeting to determine how to implement the Strategy, using comments and recommendations from SLE and Board for direction. Mr Curran presented the report which described how the ICS Executive proposed to implement the Clinical Strategy and build it into future planning. A series of high-level key principles were presented to guide current and future workstreams. Mr Curran stressed the importance of the Clinical Strategy being a living document and recognised that it cannot stand alone as an isolated piece of work – it needs to be fully	

	embedded into the ICS Strategy and relate to future planning and financial strategies. Engagement will be undertaken as part of the ICS Strategy work and through existing leads. Attention was drawn to the 6 pillars of the strategy, namely Health and Wellbeing of our communities, Living Well, Managing Illness, Urgent and Emergency Care, End of Life Care and Workforce - it was noted that work will be undertaken to map all the current work already underway to each of these pillars. The 5 high level principles were also described to enable future workstreams to be guided by the Clinical Strategy and the Board was asked to continue to support these principles. Members discussed the presentation and the following comments were noted. Reference was made to Principle 1 about embedding population health management and the need to include equality and diversity and remove health inequalities. Embedding digital solutions was welcomed but it was recognised that there would be a need for investment in this area. Reference was made to the first meeting of the People Board and the recognition that there will not be enough staff to deliver current service models in the future and a that there is need to change how things are done through redesign of pathways. This will require us to challenge the culture, behaviours and the way that clinicians work – an opportunity to grasp the future, do things differently and not hold on to the past by considering: • What are we going to stop doing? • What are we doing to do differently? • What are we doing to deliver in a different place? The Chair welcomed these three questions and suggested this was a helpful structure and framework for members to consider alongside the Strategy **RESOLVED:** **(1) That the Board note the progress made;** **(2) That the Board support the embedding of the clinical strategy into future planning processes;** **(3) That the Board receive future mapping of the workstreams to the 6 pillars** **(4) That the Board continue support of the 5 high Level principles.**	
8.	**System Reform: A common strategic narrative for Integrated Care Partnerships (ICPs) within the Lancashire and South Cumbria Integrated Care System (ICS)** Geoff Joliffe presented the report and asked the Board to formally approve the common ICP strategic narrative which had been updated to reflect feedback from the ICS Board at its last meeting and with continued extensive engagement across the ICS partnerships. Dr Joliffe stressed the need to move forward at pace on this element of system reform and highlighted the tight timetable moving forward. The Chair highlighted two key elements of ICP development: the importance of getting it right at 'place' level and the collaboration between providers taking a system view around many of the critical issues. Vicki Ellarby described the key changes in the common ICP strategic narrative, including key extracts from the NHSE/I Integrating Care document and the development of a separate executive summary. Following approval, a more user-friendly version of both the ICP strategic narrative and executive summary would be created to support the next stage of the programme.	

Step 2 of the work was described as agreeing and scoping the work programmes for ICP development which was to be approached in two phases: work programmes that could be scoped and begin implementation prior to receipt of NHS phase 4 guidance; and work programmes that could only be partially scoped and were unlikely to begin implementation prior to receipt of NHS Phase 4 guidance. Delivery of the plan will be overseen by the ICP DAG with outputs reported to the System Leadership Executive and onward to the ICS Board where required.

The Chair thanked Geoff and Vicki for the update and clarity on the direction and emphasised the need to move on with this programme of work. Dr Doyle added her appreciation for the work undertaken by the team and reiterated the need to understand that ICPs are not a 'son of CCGs' - they are a description of how partners in a place will work together at place to deliver shared objectives. It was noted that there was a range of maturity of PCNs but there was a strong group of PCN leads working with teams inputting into how this will work and are a key part of ICPs. There has been a lot of at scale working of PCNs which has provided confidence and they need to be allowed to continue to mature.

Jane Cass referred to the significant amount of work that had taken place since the last meeting and supported Mr Joliffe's comments about not seeing this as a binding contract but the need to liaise and respond to local partners in developing the 'place'. Jane stressed the importance of the OD piece and was pleased to see that this was a priority area with clear alignment to the NHSE/I document.

Kevin McGee referred to this being only part of the system development. There is an overall concept of what is being created across Lancashire and South Cumbria and ICP development is part of this wider piece of work. Karen Partington supported the need to get on with this work as many ICPs had already made good progress.

Graham Burgess commented on the need for primary care to move forward at the same pace as ICPs and for the ICS to hold the ring on these two pieces of work to ensure integration and co-ordination. It was also vital to get local government and voluntary sector involved in discussions at place-based level.

Dr Joliffe confirmed that the LMC would be involved at Step 2 of the process and confirmed that there would be appropriate communication across the whole system.

Dr Joliffe thanked colleagues for the comments and said he was encouraged by the response and support.

RESOLVED:
That the ICS Board:

(1) Approve the common ICP strategic narrative and the executive summary noting the amendments made during November 2020 and strong alignment within the document 'Integrating Care: Next Steps to building strong and effective integrated care systems across England' issued by NHSEI;
(2) Note the progress made with actions relating to Step 2;
(3) Approve the continuation of Step 2 as outlined in the plan on a page, with support from NHSEI;
(4) Note the publication of the 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' issued by NHSEI - 26 November 2020).

9	**Strategic Assurance Framework** Gary Raphael presented the report which identified the need for a system assurance framework to be established to support the continued development and integration of the Lancashire and South Cumbria ICS partnership. In addition, an update was provided on the strategic risks and issues identified and plans to make improvements to the management of this aspect of assurance, recognising this as an early phase of development work. **RESOLVED:** **(1) That the ICS Board members supported and agreed to engage with the development of a system assurance framework (including strategic objectives)** **(2) That the ICS Board support the establishment of a group, including ICP representatives to progress this work on behalf of the ICS Board** **(3) That the ICS Board support the approach to the strategic risks, as the first phase of the system assurance framework.**	
Performance and Outcomes		
10.	**Finance Report** Gary Raphael reported on the month 7 financial performance for L&SC partners and ICS central functions and explained that as the ICS transitions into the new financial regime, it 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 do not take account of the new planning figures outlined later in the report. These will be included for month 8 reporting which will enable reporting on performance against the financial envelope. Mr Raphael explained that deficits will no longer be covered by top up payments as the financial envelope has been amended to include the ICS's share of system top up funding, Covid funding and growth funding. However, there were some costs that would attract national funding, such as testing, mass vaccination, hospital discharge programme and some independent sector costs. Attention was drawn to Table 5 in the report which showed how the months 7 to 12 financial envelope of £1.7b fit into the context of the overall L&SC system funding of £3.3b for 2020/21. With regard to capital, there was no significant change to the position reported at the last Board meeting. It was noted 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, a £277m deficit. It is likely that resources from 2021/22 onwards will remain constrained as the economy struggles to recover. Attention was drawn to the clinical strategy which will assist in addressing at least one aspect of the deficit, which can be analysed as generating further efficiency; Service/delivery models which are most amenable to changes signalled in the clinical strategy; and structural change. **RESOLVED:** **That the Board note the updates to the financial position and look forward to involvement in articulating the ICS's ambitions for the forthcoming short and medium term planning rounds.**	

For Information		
11.	**Provider Collaboration Board Update** Eileen Fairhurst reported that the last meeting of the PCB was held on 27 November 2020 and focussed on a number of strategic issues relevant to the whole population. The NHSE/I publication on System Reform was welcomed by the Board for the benefit of the whole ICS. A presentation was received on HIP2 and the strategic importance of this for the whole of the Lancashire and South Cumbria population was recognised. The Board also received positive assurance on the CAMHS services and endorsed key recommendations relating to system transformation work programmes including stroke, vascular and diagnostic radiology. The PCB will maintain oversight of these programmes. The Board is also very focussed on making sure there is increased alignment between the work of the Provider Collaborative Board and ICPs. **RESOLVED:** **That the contents of the report were noted.**	
12.	**High Level Programme Summary Report** The monthly updated summary position of the progress with delivery of ICS programmes was received. **RESOLVED:** **That the contents of the report were noted.**	
13.	**EU Exit Planning** Gary Raphael advised that there were no formal requirements relating to EU Exit placed on the ICS and provided an update on system actions. There is a very strong procurement team in Lancashire and South Cumbria who are focussing on the continuation of supplies in the NHS. Operationally 160 supply lines have been secured which represents 70% of supplies – for the other 30%, the procurement team are ensuring that business continuity plans are in place. There is a move towards a situation where a 'just in time' approach is being replaced with a position of contingency stock to take account of any delay. Staff that need to be registered to work in the NHS in England are being supported to ensure that they can remain. Detailed update reports are being provided to the SLE. The Chair asked that an updated report be provided at the next formal meeting in public in February.	
14.	**Agenda items for the next meeting** None noted.	
15.	**Any Other Business (AOB)** There being no futher items of business, the Chair commented that he was encouraged by today's meeting, in particular the positive way that people contributed and supported each other and constructively challenged. This support would essential to help get through the next period of significant change, subject to changes in legislation.	

Date and Time of the Next Informal ICS Board Meeting
Wednesday 13 January 2021 – MS Teams meeting 10:00-12:00

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	15.02.2021	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	31.03.2021	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
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	
ICSB201202	Paper and analysis on the impact of the financial allocation of funding to be brought back to future Board meeting	Gary Raphael	In progress		

Title of Paper	L&SC Pathology Collaboration Outline Business Case CIAM Briefing Paper		
Date of Meeting	3 February 2021	Agenda Item	4

Lead Author	Mark Hindle, Managing Director, L&SC Pathology Collaboration		
Contributors			
Purpose of the Report	Please tick as appropriate		
	For Information	✓	
	For Discussion	✓	
	For Decision		
Executive Summary	The purpose of the paper is to present to the Board a summary of the inputs and outputs of the Comprehensive Investment Appraisal Model (CIAM) which has been produced to compare the shortlist of options previously approved by the Pathology Collaboration Board. The model is used to identify a preferred option based on a best value analysis in order to complete the Outline Business Case (OBC) in support of the PDC capital.		
Recommendations	Note report		
Next Steps	Request to see and approve Outline business case in March/April 2021		
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Not Applicable
Risk Identified	Yes		No
If Yes : Risk			
Report Authorised by:			

1. Introduction

1.1 This paper serves to update the Board on the significant progress that has been made over the last 6 months to set the strategic direction for the future delivery of pathology services across Lancashire and South Cumbria. Two significant decisions have been made:

1.2 The framework that will be used for the delivery of services, which is a hub and spoke model. The hub will deliver non urgent/routine work and each acute site will have an essential services laboratory (ESL) for urgent/emergency work

1.3 The location for the hub in Central Lancashire following a robust selection process with the involvement of key stakeholders.

1.4 Specifically, this paper serves to provide further detail and assurance to Board members about the process undertaken to agree the Comprehensive Investment Appraisal Model (CIAM), which in turn determines the hub and spoke delivery framework. This is a major step forward for the collaboration and means that work and engagement can now focus on the detailed design of the future service and how it will be operationalised.

2. Background/Context

2.1 It is mandatory for NHS organisations to use the CIAM model to develop business cases. It compares options to identify the one which represents the best value for money and that will achieve the best return on investment. Agreeing the CIAM is the step before delivering the outline business case and it is essential to demonstrate the best value in analysis in order to access the available capital, which in this case is £31 million.

3. CIAM Economic Summary

3.1 The main outputs are derived from the Economic Summary within the CIAM, as summarised below.

	Option 0 **Do Minimum**	**Option 1** **Multiple single discipline hubs and spoke**	**Option 2** **Single multidisciplinary hub and spoke**
Incremental costs - £	Comparable option	-£31m	-£16m
Incremental benefits - £		£99m	£135m
Risk-adjusted Net Present Social Value (NPSV)		£68m	£119m
Benefit-cost ratio		3.18	8.32

This demonstrates that Option 2 is the preferred option

4. Chronology of Engagement Pre-Decision

- Detailed inputs and assumptions to the CIAM shared with the Pathology Collaboration Finance group on 8 December 2020
- Figures and data included in the model endorsed on 16 December 2020.
- Pathology Collaboration Board on 18 December held in a workshop format to share detailed information and provide the opportunity for Q&As
- Focus groups with senior clinicians and BMS colleagues took place w/c 4 January 2021
- Presentation circulated to all Board members with sensitivity analysis on the CIAM
- Individual trust/ICS boards updated on progress

5. Key Matters Arising from Board Discussion

- A key issue raised is the need for the future model to be flexible and responsive to the different requirements for services in a geography as diverse as Lancashire and South Cumbria.
- Therefore, the future model **will not be a one size fits all** and there will be a bespoke approach to designing ESLs to respond to geographical factors and to meet the clinical requirements and specialties of specific acute sites.
- A Quality Committee is to be convened with an independent Chair to ensure all issues raised are considered as the future model is designed, using a risk management approach.

6. Conclusion and Recommendation

6.1 Board members are asked to note this update.

Mark Hindle
Managing Director

Lancashire & South Cumbria Pathology Collaboration

3 February 2021

Healthier Lancashire & South Cumbria

NHS
Lancashire & South Cumbria Pathology Collaboration

Pathology Collaboration Update

Mark Hindle, Managing Director
3 February, 2021

Progress to Date

- Strategic Outline Case agreed
- Project infrastructure in place to deliver OBC
- Significant clinical engagement, variable clinical agreement
- Location for Hub identified
- Workforce models being identified
- Governance arrangements being upgraded to reflect current progress
- LIMs specification agreed – out to tender
- Significant and effective collaborative working through Covid 19
- CIAM and delivery framework agreed – hub & spoke

About the CIAM

- Comprehensive Investment Appraisal Model/economic model
- The CIAM compares options to identify the one which represents the best value for money and that will achieve the best return on investment
- Mandatory for the NHS to use this model to develop business cases
- Agreeing the CIAM is the step before delivering the outline business case
- It is a major milestone and is significant because it also determines the framework for delivering pathology services across Lancashire & South Cumbria in the future.

CIAM Continued

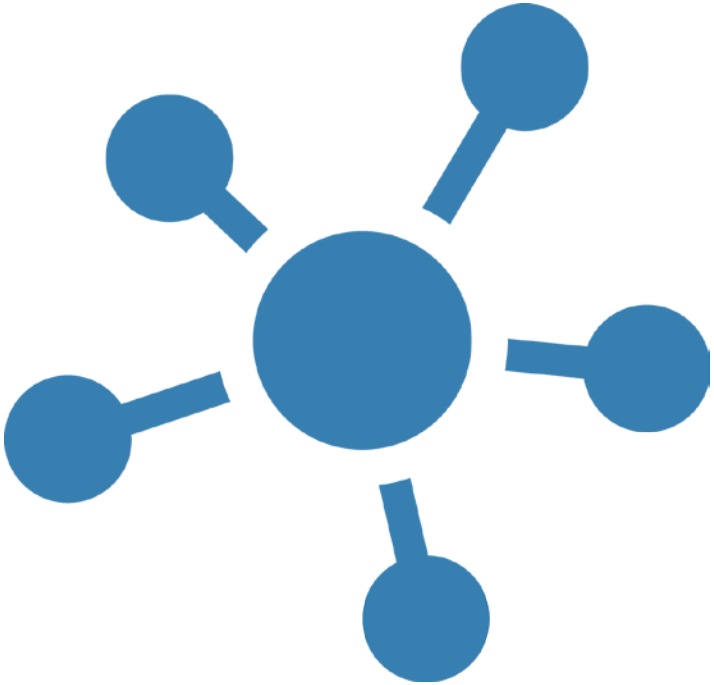
	Option 0 Do Minimum	Option 1 Multiple single discipline hubs and spoke	Option 2 Single multidisciplinary hub and spoke
Incremental costs - £	Comparable option	-£31m	-£16m
Incremental benefits - £		£99m	£135m
Risk-adjusted Net Present Social Value (NPSV)		£68m	£119m
Benefit-cost ratio		3.18	8.32

The outputs of the CIAM demonstrated that Option 2 provides the best value for money option when compared to the do minimum and should therefore be recommended as the preferred service option for the Pathology Collaboration.

Engagement Pre-Decision

- Detailed inputs and assumptions to the CIAM shared with the Pathology Collaboration Finance group on 8 December 2020
- Figures and data included in the model endorsed by this group on 16 December
- Pathology Collaboration Board on 18 December held in a workshop format to share detailed information and provide the opportunity for Q&As
- Focus groups with senior clinicians and BMS colleagues took place w/c 4 January 2021
- Presentation circulated to all Board members with sensitivity analysis on the CIAM

Option 2: Hub & Spoke



- All routine work is undertaken in the central hub which will be located in the Leyland area
- Emergency/urgent work will be undertaken in the Essential Services Laboratory (ESL) on each acute site
- Key concern expressed is the different requirements for services in a geography as diverse as Lancashire and South Cumbria
- Therefore, the future model **will not be a one size fits all** and there will be a bespoke approach to designing ESLs to respond to geographical factors and to meet the clinical requirements and specialties of specific acute sites
- A Quality Committee is to be convened with an independent Chair to ensure all issues raised are considered as the future model is designed.

Next Steps and Timescales

- **March 2021:** OBC completed and Trust Board approvals
- **Q1 2021:** Hosted Pathology Entity formed
- **Q1 2021:** Automation procurement starts
- **Mid 2021:** NHSi approval
- **Q3 2021:** FBC completion
- **2021/22:** LIMS implementation
- **Q1 2022:** Allocation of capital
- **Q1 2022:** New build commences
- **End 2022:** Completion
- **April 2023:** New service commences

Pathology Collaboration

Healthier Lancashire & South Cumbria

Questions?

ICS Board

Title of Paper	Transformation of Urgent and Emergency Care: Models of Care and Measurement		
Date of Meeting	3 February 2021	Agenda Item	5

Lead Author	David Bonson	
Contributors	Urgent and Emergency Care Network	
Purpose of the Report	Please tick as appropriate	
	For Information	
	For Discussion	✓
	For Decision	✓
Executive Summary	The 'Transformation of Emergency Care: Models of Care and Measurement' report, issued by NHS England and NHS Improvement on 15 December 2020, sets out the final recommendations on the urgent and emergency care standards from the 'Clinically-led Review of NHS Standards' and gives an opportunity for wide consultation on the findings. The report also describes in detail how the proposed measures align with the strategy for transformation of urgent and emergency care services, building on experiences through COVID-19 and developing the long-standing vision for urgent care services. This report provides a summary of the paper to brief the Integrated Care System (ICS) Board, to advise of the implications and actions required locally. It also proposes an ICS response to the consultation.	
Recommendations	The ICS Board is asked to:- - Note the future models for urgent and emergency care being proposed - Note that a delivery plan will be prepared by the Urgent and Emergency Care Network for approval at a future ICS Board - Note the proposed changes to the measures of performance in the transformed urgent care system - Note that work has commenced to understand current performance against the proposed measures at an ICP and ICS level - Comment on and approve the proposed ICS response to the national consultation.	

Next Steps	A delivery plan for 2020/21 will be developed by the Urgent and Emergency Care Network and will be presented to a future ICS Board meeting.		
Equality Impact & Risk Assessment Completed			Not Applicable
Patient and Public Engagement Completed	In process		
Financial Implications			Not Applicable
Risk Identified			No
If Yes : Risk	-		
Report Authorised by:	David Bonson		

ICS Board

Transformation of Urgent and Emergency Care: Models of Care and Measurement

1. Introduction

1.1 The Transformation and Emergency Care: Models of Care and Measurement report (the full document is available at https://www.england.nhs.uk/wp-content/uploads/2020/12/Transformation-of-urgent-and-emergency-care_-models-of-care-and-measurement-report_Final.pdf) was issued by NHS England and NHS Improvement on 15 December 2020 and sets out the final recommendations on the urgent and emergency care standards from the 'Clinically-led Review of NHS Standards' (CRS) and gives an opportunity for wide consultation on these findings. Importantly, the report also describes in detail how the proposed measures align with the strategy for transformation of urgent and emergency care services, building on experiences through COVID-19 and developing the long-standing vision for urgent care services.

1.2 This report provides a summary of the paper to brief to the Integrated Care System (ICS) Board, to advise of the implications and actions required locally. It also proposes an ICS response to the consultation.

2. Background and Context

2.1 The "Keogh" Urgent and Emergency Care Review was published in 2013 and set out a vision of:-

- Providing highly responsive urgent care services close to home, and
- For those with more serious or life-threatening emergency care needs, centres with the very best expertise and facilities to maximise the changes of survival and a good recovery.

2.2 There is a golden thread from the objectives of the "Keogh" Review to the current transformation programme of urgent and emergency care services:-

- The adoption of technology that led to the introduction of NHS 111 online
- The development of NHS 111 as the key point of access to urgent care
- The introduction of a consistent model for primary and community based urgent treatment centres
- Maximising the ability of the ambulance service to treat patients at source and reduce avoidable conveyance to emergency departments
- Developing a networked approach to urgent and emergency care so that no decision need be taken in isolation.

2.3 The Clinically-Led Review of Access Standards has considered not only the current models of care but also the transformation that is well underway. The proposals for future service models build on the key principles of the original vision for urgent and emergency care and further develop the core principles first set out in 2013:-

- **People with urgent care needs should get the right advice in the right place, first time**, whether through advice to self-care from NHS 111 online, from a call to NHS 111, from a call to general practice, or through referral to the most appropriate service after calling NHS 111, whether that may be pharmacy, general practice, community services, urgent dental care, mental health services, an urgent treatment centre or an emergency department. Patients should be able to access care as close to home as possible.
- **We must provide highly responsive, bookable, urgent care services that support reduced avoidable attendance at, or time in an emergency department, and resultant admissions.** Wherever possible bookable time slots available to the public through referral from NHS 111, should be offered for all services within the wider urgent and emergency care system. This will ensure that patients spend as little time as possible queuing in order to access care and also that clinicians will already have immediate access to relevant information about patients when they see them.
- **Ambulance services are increasingly able to offer care for patients by telephone or at scene without the need to convey to an emergency department and we have committed to developing urgent community response services and rapid access to reablement services.** Alongside the increasing availability of same day emergency care services, these services remain integral parts of reducing avoidable and unnecessary emergency department attendance and admission.
- **General practice also has a key role in ensuring patients can access the services they need in a timely manner.** The move to the 'Total Triage' model ensures a safe approach and patients need to understand that if they telephone their general practice, they can speak to a clinician and if required get a face-to-face appointment.
- **We must ensure that those people with more serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise to maximise chances of survival and a good recovery.** Through capital investment we will provide the capacity and capability of our emergency departments, improving flow through hospitals, eliminating ambulance handover delays and treating all patients who need to be there in a timely manner. Crucially, through introducing new 'critical time standards' we aim to improve the quality of care for life-threatening conditions, with the aim of saving more lives and reducing avoidable morbidity.
- **We must ensure that no patient stays in the emergency department or in hospital longer than is clinically necessary** and that hospital capacity is only used by patients who need it. Ensuring the right capacity is available is reliant both on in-hospital processes that safely reduce the length of time that patients stay in the emergency department and acute hospital bed, and on 'discharge processes' which support the timely discharge of patients back home where possible or into rehabilitation or residential settings, when necessary.

2.4 Lancashire and South Cumbria ICS has an existing Urgent and Emergency Care Strategy which was approved by the Joint Committee of CCGs in September 2019. This strategy has been incorporated into the overarching Clinical Services Strategy (Pillar 4), which has recently been approved by the ICS Board. Excellent progress has been made across Lancashire and South Cumbria in implementing the local

response to the national strategy and providing more integrated urgent care services, however, it is recognised that there is still more to do, particularly in light of the response to COVID. This "refresh" of the national approach presents an ideal opportunity to review and strengthen our local delivery plans. A delivery plan for 2021/22 will be developed by the Urgent and Emergency Care Network and will be presented to a future ICS Board meeting.

3. Models of Care

3.1 The COVID-19 pandemic has had a profound effect on the delivery of NHS services and the ways in which people access healthcare services. The social distancing requirements saw a sharp reduction in emergency department attendances and a requirement to urgently increase capacity within NHS 111 services to meet the need for remote access to urgent care services. Subsequently, attendances at emergency departments are almost back to pre-COVID levels. In the wake of COVID-19, it is important that patients receive urgent care in the right place and at the right time, to provide a better patient experience and to ensure fewer patients attend emergency departments and social distancing is maintained.

3.2 The models of care described follow the patient journey:-

i) <u>Transforming access to urgent and emergency care services – developing the NHS 111 model</u>

- Investment in call handling capacity
- Investment in local Clinical Assessment Services
- Improved profiling of services within the Directory of Services
- Establishing NHS111 direct booking into emergency departments
- Developing processes to stream patients to more alternative non-emergency department settings
- Local communications to encourage greater use of NHS 111 and change patient behaviour.

ii) <u>999 Ambulance Services: Optimising performance and reducing winter service pressures</u>

- Build on the existing Ambulance Response Programme operating model
- Increase proportion of calls without conveyance to hospital ('Hear and Treat' and 'See and Treat').

iii) <u>Urgent Treatment Centres: Improving access, capacity and capability</u>

- Increase capacity for booked appointments through NHS 111
- Increase ambulance conveyances to urgent treatment centres where clinically appropriate
- Maximise video consultation technology
- Establish referral pathways to secondary care services for video consultation.

iv) Improving flow through hospitals emergency departments and same day emergency care

- Reduce delays in ambulances handing over patients to emergency departments
- Increase rapid clinical assessment of the needs of patients including streaming to other services where appropriate, eg, urgent treatment centres
- Adopt a consistent, expanded model of same day emergency care in all sites to avoid admissions, where appropriate
- Manage flow out of emergency departments into beds for admitted patients
- Manage investment in increasing capacity.

v) Managing Hospital Occupancy

- Reduce length of stay and bed occupancy
- "Forensic" focus on processes to support discharges
- Develop urgent community response services to respond within 2 hours to deteriorating patients, to support recovery and prevent admission.

4. Measuring Performance in a Transformed System

4.1 As well as describing the future priorities for urgent and emergency care, the report also sets out how the proposed measures align to and support the delivery of the models of integrated urgent and emergency care in the national strategy.

4.2 In June 2018, the NHS National Medical Director was asked by the Prime Minister to review NHS access standards to ensure they measure what matters to patients and are clinically appropriate and supported. To support this, a Clinical Oversight Group was established, made up of patient, clinical and healthcare provider representatives and national charities.

4.3 The National Medical Director, supported by the Clinical Oversight Group recommends this more sophisticated and patient centred set of metrics should replace the simple "4-hour A&E measure".

4.4 The intention is to enable a new national focus on measuring what is both important to the public, but also clinically meaningful. These indicators have been developed through extensive field testing with 14 acute NHS Trusts and through consultation with an extensive group of clinical and patient representative stakeholders. It has been concluded that these indicators are critical to understanding and driving

improvements in urgent and emergency care and taken together, provide a system wide view of performance.

4.5 The recommended measures provide a more sophisticated and patient centred set of metrics to replace the existing single NHS constitution measure of:-

"A maximum four-hour wait in A&E from arrival to admission, transfer or discharge".

4.6 This four-hour standard was introduced in 2004 to support improvements in patient flow within acute hospitals. However, since then there have been major changes in the delivery of urgent and emergency care meaning increasingly that this single standard is no longer driving the right improvements. Some of the issues with the single standard are:-

- The target does not measure total waiting times
- The target does not take account of patient condition
- The target does not measure whole system performance
- The target does not consider clinical advances in care, including same day emergency care
- The target is not well understood by the public
- There is significant variation in the proportion of admitted patients across the country.

4.7 The proposed new measures are supported by a wide range of clinical and patient stakeholders, including the Academy of Medical Royal Collages, Royal College of Emergency medicine, Royal College of Surgeons and Healthwatch.

Proposed New Bundle of Standards by the Clinically-Led Review of Standards

Service	Measure
Pre-hospital	Response times for ambulances
	Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances
	Proportion of contacts via NHS 111 that receive clinical input
A&E	Percentage of Ambulance Handovers within 15 minutes
	Time to Initial Assessment – percentage within 15 minutes
	Average (mean) time in Department – non-admitted patients
Hospital	Average (mean) time in Department – admitted patients
	Clinically Ready to Proceed
Whole System	Patients spending more than 12 hours in A&E
	Critical Time Standards

4.8 The different measures can be utilised by different audiences for monitoring and reporting performance, providing accountability, setting expectations for individual patient care or for operational management. The bundle is designed so that no measure should be viewed in isolation but in the context of a whole system against all the other measures.

4.9 A holistic assessment of performance is being proposed to develop a single composite measure to provide “at a glance” assurance of relative performance of any individual system which can be scaled up to an aggregate Integrated Care System footprint.

5 A New Offer to the Public

The new offer to the public of the service model and measurement standards is described as:-

Right care, right place, right time: the full NHS offer to patients
1. In an emergency, 999 ambulance services will get the right vehicle to you quickly.
2. Wherever possible, ambulance staff will give or help arrange the care you need in your own home, avoiding an unnecessary trip to hospital.
3. If they need to take you to an emergency department, the handover between clinicians should take no longer than 15 minutes.
4. When it’s not an emergency, the NHS 111 ‘phone and online service will support you to get the right care in the right place, putting you in touch with doctors, nurses and other healthcare professionals, where appropriate.
5. If you need it, the NHS 111 service will also be able to book you an appointment at a convenient time with a GP, pharmacist or local urgent care service – and if it’s more serious, they can arrange an ambulance response or give you a timed slot to go to an emergency department.
6. You will be assessed within 15 minutes of arriving in a hospital emergency department.
7. If you are critically ill, you will be treated as a priority and get the right tests and treatments fast.
8. For all patients, staff will work to ensure you do not spend longer in A&E than necessary.
9. The NHS will work to eliminate long waits of 12 hours or more as measured from the time of your arrival rather than the point at which a decision is made to admit you.
10. Where possible and the right thing clinically, you will get any tests, treatment and prescriptions you need to allow you to go home the same day.
11. Where your clinicians think you need to stay in hospital after your initial care, you will be moved to an appropriate bed within one hour.

6 Consultation

6.1 The report launches a wide national consultation on the proposed new standards with an online consultation accessed from the NHS England website, https://www.england.nhs.uk/clinically-led-review-nhs-access-standards, or by email to England.reviewofstandard@nhs.net), which runs until 12 February 2021. Individuals and organisations have been encouraged to respond in their own right

and a Lancashire and South Cumbria response is proposed. This response has been drawn together through the Urgent and Emergency Care Network and includes inputs from a wide range of organisations and individuals across the system.

6.2 The Urgent and Emergency Care Network comprises members from:-

- Acute Trusts
- North West Ambulance Service
- Upper Tier Local Authorities
- Clinical Commissioning Groups
- Lancashire and South Cumbria Foundation Trust
- NHS England/Improvement
- ICS.

6.3 The response to the consultation is required to be submitted via an online questionnaire and the proposed ICS response is detailed at Appendix A. It is proposed that the ICS response is positive and supportive of the recommended new measures and includes the following overarching summary:-

The Lancashire and South Cumbria ICS has received the document, "Transformation of Urgent and Emergency Care: Models of Care and Measurement", through its Urgent and Emergency Care Network and the ICS Board. We welcome the clarity in describing the models of integrated urgent care and the ambition to implement a number of key changes across the entire pathway, including the expanded role of the NHS 111, optimising the role of the ambulance services and improving access and patient flow to emergency treatment.

We believe that the standards proposed give clear and transparent measures of the whole urgent and emergency care pathway indicating how well patients are able to move between the different elements of services.

We welcome the level of clinical and potential engagement in the process of designing and developing these proposals and in the subsequent testing across the hospital systems.

We agree that the existing 4-hour target, whilst useful when introduced some 15 years ago, does not provide a clear, consistent or helpful measure of system performance and should not form part of the new bundle of measures for the future. We welcome the focus the new standards propose on reducing avoidable conveyance by ambulance to emergency departments and recognise the need to reduce avoidable attendances to improve patient flow and help reduce nosocomial transmission risk.

We are mindful, however, that the proposed new measures and changes to models of care will mean some significant changes across our systems at a period when the NHS is under significant pressure managing the response to COVID-19, delivering the vaccination programme and ultimately merging the restoration of services.

We welcome the ability to separately monitor each measure in the bundle to understand constraints on performance both within the system as a whole (at ICS level), and also within each place. We also believe it is helpful to be able to aggregate the measures into a single composite implicatory of overall performance. We look forward to understanding the thresholds to be set for the proposed measures and to receiving technical guidance at an early stage to prepare to collect the data in a consistent manner.

7. Conclusion and Recommendation

This report provides a summary of the national report, 'Transformation of Urgent and Emergency Care: Models of Care and measurement' and the implications for services. It also provides details of the proposed new set of 10 measures to replace the single "4 hour A&E" standard and a proposed response from the ICS.

The ICS Board is asked to:-

- Note the future models for urgent and emergency care being proposed
- Note that a delivery plan will be prepared by the Urgent and Emergency Care Network for approval at a future ICS Board
- Note the proposed changes to the measures of performance in the transformed urgent care system
- Note that work has commenced to understand current performance against the proposed measures at an ICP and ICS level
- Comment on and approve the proposed ICS response to the national consultation.

David Bonson
Director of Urgent and Emergency Care

27 January 2021

Clinical Review of Standards Consultation

Are you aware of the existing Accident and Emergency four-hour standard?

- ✓ Yes
- ❑ No

If yes, what do you understand the existing four-hour standard to mean?

- 95% of patients to be seen and discharged or admitted within 4 hours of arrival at A&E

Which would help you understand how well urgent or emergency care is doing: A single measure or a wider range of measures across your urgent or emergency care journey?

- ❑ Single measure
- ✓ Bundle of measures

Please rate how important you think each of the measures are based on a scale of 1-5 where 1 is not important and 5 is extremely important?

For further information on each measure, please see page 23 of the 'Clinically-led Review of NHS Access Standard for Urgent & Emergency Care' document which can be accessed here: Transformation of Urgent & Emergency Care: Models of care and measurement report

Pre-hospital	1 - not important	2	3	4	5 - extremely important	Unsure
Response times for ambulances	❑	❑	❑	❑	✓	❑
Reducing avoidable trips (conveyance rates) to Emergency Departments by 999 ambulances	❑	❑	❑	❑	✓	❑
Proportion of contacts via NHS111 that receive clinical input	❑	❑	❑	✓	❑	❑

A&E	1 - not important	2	3	4	5 - extremely important	Unsure
Percentage of Ambulance Handovers within 15 minutes	❑	❑	❑	❑	✓	❑
Time to Initial Assessment - percentage within 15 minutes	❑	❑	❑	❑	✓	❑
Average (mean) time in Department - non-admitted patients	❑	❑	❑	❑	✓	❑

Hospital	1 - not important	2	3	4	5 - extremely important	Unsure
Average (mean) time in Department - admitted patients	❑	❑	❑	❑	✓	❑
Proportion of patients admitted within one hour of it being safe to do so (Clinically Ready to Proceed)	❑	❑	❑	❑	✓	❑

Whole System	1 - not important	2	3	4	5 - extremely important	Unsure
Percentage of patients spending more than 12 hours in A&E	❑	❑	❑	❑	✓	❑
Critical Time Standards	❑	❑	❑	❑	✓	❑

Please explain your answers

- We support the bundle of measures which follow the whole patient pathway. These are useful to highlight “pinch points” in local places as well as across larger geographical systems
- We welcome the level of clinical and patient engagement in the process of designing and developing these proposals in the subsequent testing across the 14 hospital systems
- We support the ability to aggregate the individual standards into a composite single measure
- We would welcome greater clarity on certain aspects, for example, clinical time standards
- We support the measure of contacts with NHS 111 that receive clinical input, however, would comment that it is important to know the outcome of the clinical contact, for example, proportion of patients receiving an emergency department or ambulance disposition.

Are there any additional measures that should be included within the bundle?

- We would welcome further clarity on the thresholds to be applied to the measures and feel that whilst they should be aspirational, they should not be unrealistic
- We understand the importance of the category 2 ambulance response times, however, we would not wish to lose focus on the other ambulance response measures
- We support the bundle of headline measures, however, we would wish to develop supporting measures locally to give a greater understanding of factors affecting performance. This may include outcome measures, whole population measures, quality metrics, etc
- We would wish to have early sight of technical guidance to enable our systems and processes to be enabled to capture the data in an accurate and consistent manner.

To what extent do you agree with the recommendation to replace the current measure with the proposed new bundle of measures?

❑ 1 - Strongly disagree ❑ 2 ❑ 3 ❑ 4 ✓ 5 - Strongly agree

To what extent do you agree that measuring the average time for all patients is a more appropriate or meaningful performance measure than the percentage of patients treated within a pre-determined time frame?

❑ 1 - Strongly disagree ❑ 2 ❑ 3 ❑ 4 ✓ 5 - Strongly agree

To what extent do you agree that the bundle of indicators adequately measures the elements of the Urgent and Emergency Care pathway that are important to you?

❑ 1 - Strongly disagree ❑ 2 ❑ 3 ❑ 4 ✓ 5 - Strongly agree

Please explain why you think the measures identified are appropriate or not?

Pre-hospital

- We welcome the inclusion of the ambulance conveyance routes to support the reduction in avoidable emergency department attendances. It is also helpful to understand and measure conveyance to other destinations as then we know that there is significant variation between areas and, therefore, opportunities to standardise pathways and adopt best practice
- We recognise the important focus on category 2 ambulance response, however, we believe we should not lose sight of the other categories of ambulance response
- We believe the measure of clinical intervention in NHS 111 is important, however, it is important to understand the output of the intervention. As we move towards a more integrated model there will be increased flexibility in the use of clinicians from both 111 and 999 services. This measure may need to be reviewed at some point in the future to accommodate this.
- We have, and continue to develop, the ambulance crews clinical skills to support them in treating patients away from the emergency department. This measure allows us to identify variation and understand the impact of the availability of suitable alternative services.

A&E

- We support the measure of 'Time to Initial Assessment' and think this should be measured for other pathways, not just the emergency department, eg, urgent treatment centres
- We strongly believe the measure of ambulance handover is essential due to the impact on the ability of ambulance services to meet community demand and achieve performance standards. Locally, we will continue to measure the total turnaround time, not just the 15 minute handover.

Hospital

- We feel that more detailed definitions are required to understand the measures especially around clinically ready to proceed
- We support the measure of the mean time in the emergency department, however, we need to recognise that increasingly as alternative pathways are developed, we have consistent standards in access, eg, urgent treatment centres, Same Day Emergency Care, community rapid response, etc.

Whole system

- Whilst we welcome a measure on Critical Time Standards, we would seek further clarification to understand this fully
- We support the measure of the average time in the emergency department, however, would need to understand the threshold to be applied and whether it is viewed as a measure or a target and how potentially this may drive behaviours
- Critical time standards for treatments should be limited to a small specific group in order that these standards are achievable and readily understood.

What do you think are the best ways to advise and communicate the proposed new urgent and emergency care measures to patients and visitors to urgent and emergency care departments?

- Needs to be aligned to wider communications about urgent and emergency care, particularly the NHS 111 First approach of ensuring only those that need the emergency department, go to the emergency department, and that other services may better meet their needs, reduce overcrowding, etc, and the role of NHS 111 in assessing patients and booking them in to services
- Patient communication needs some focus on understanding that response will be based on clinical need, eg, emergency department wait time, ambulance response time
- Will require major engagement with urgent and emergency care system staff. Current standards have driven behaviours and service models to better meet the old 4-hour standard; we need to change the way services are delivered to meet the new standards and ensure the shift of activity is away from the emergency department.

What are the key issues/barriers that should be taken into account for implementation of the bundle of measures and establishing thresholds for performance? What additional support might providers need for implementation?

- We are mindful that the proposed new measures and changes to models of care will mean some significant changes across our systems at a period when the NHS is under significant pressure managing the response to COVID-19, delivering the vaccination programme and ultimately managing the restoration of services
- We would request a clear timeline for implementation of the new measures and early notification of supporting technical guidance to ensure the data is able to be captured accurately and consistently to enable effective decisions to be made on improving system performance
- We appreciate that introducing the new measures in isolation will not improve overall system performance without the required changes to service models. We also recognise that the existing 4-hour standard has been in place for 15 years and the new measures will take time for staff and patients to adjust behaviour. Communications and engagement will be critical to successful implementation to support the required culture changes.

Do you support the idea of a composite measurement approach to presenting the effectiveness of urgent and emergency care across a system?

✓ Yes
❑ No

How frequently should this composite be updated and published?

- We would support the publication of a monthly composite measure but will monitor the bundle of measures more frequently locally to support a more “real time” ability to improve performance.

ICS Board

Date of Meeting	3rd February 2021
Title of Paper	The longer term financial challenges for the Lancashire and South Cumbria Integrated Care System
Presented By	Gary Raphael
Author	Gary Raphael
Contributor/s	
Agenda Item	Item 6
Confidential	No

Purpose of the Paper
For noting as the context to the forthcoming annual financial planning process.
Executive summary
On 23rd December an operational priorities letter from NHSEI outlined, among other things, a key number of financial planning aspects for 2021/22. A subsequent operational guidance letter on 13th January postponed the start of 2021/22 financial and other planning processes until Q1 of the new financial year. This provides an opportunity for the system to consider best processes for taking forwards our financial plans for 2021/22 within the context of a longer term planning perspective, which is what this short report has outlined.
Recommendations
1. The Board is asked to note: • The run rate exercise being undertaken by finance directors • A subsequent analysis to extrapolate this information into 2021/22 and taking account of factors specific to that year to determine a potential level of spending should we not do anything to change the pattern of expenditure • The plan to develop a system 'diagnostic' to help us to understand the reasons for and patterns of expenditure • A need, during April 2021, to determine a process for general and financial planning to underpin ICS decision making on the allocation of resources from Q2 to Q4 (should that requirement be confirmed by NHSEI) • The support being received to develop financial frameworks at ICS and ICP levels 2. Taking into account the issues raised in the foregoing paragraphs, members of the Board are invited to express their initial views about the level of ambition for savings that we may wish to plan for in 2021/22 and the years thereafter, to frame the development of a cost reduction programme for the system.
Governance and Reporting (List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome
None		N/A

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 and provide a risk description and risk reference number in this box if there are any associated risks. Financial decisions can have a major impact on the above and assessments will be required once plans are underway.					

The longer term financial challenges for Lancashire and South Cumbria system

Introduction

3. On 23rd December an operational priorities letter from NHSEI outlined, among other things, a key number of financial planning aspects for 2021/22. A subsequent operational guidance letter on 13th January postponed the start of 2021/22 financial and other planning processes until Q1 of the new financial year, enabling health services across the country to focus on tackling the second wave of the Covid 19 pandemic. This provides an opportunity for the system to consider best processes for taking forwards our financial plans for 2021/22 within the context of a longer term planning perspective.

4. In this paper I will outline the longer term financial challenges for the L&SC health system and touch on the preparations being made in financial circles for the initiation of planning from April 2021 covering Q2 to Q4.

Operational planning priorities – 23rd December letter

5. This letter signalled how system budgets would be set in 2021/22 and the ways in which funds will flow across and around them. The essential points made in the letter are shown below:
    - Revenue funding will be distributed at system level, continuing the approach introduced this year. These **system revenue envelopes will be consistent with the LTP financial settlement**. They will be based on the published CCG allocation and the organisational Financial Recovery Fund each system would have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.
    - Systems will **need to calculate baseline contract values to align with these financial envelopes** so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.
    - Systems and organisations should start to develop plans for **how Covid-19 costs can be reduced and eliminated** once we start to exit the pandemic.
    - **System capital envelopes** will also be allocated based on a similar national quantum and using a similar distributional methodology to that introduced for 2020/21 capital planning.

    We [NHSEI] will aim to circulate underlying financial numbers early in the new-year. We will then provide fuller planning guidance once we have resolved any further funding to reflect the ongoing costs of managing Covid-19. Further detail of non-recurrent funding announced in the recent Spending Review for elective and mental health recovery will also be provided at that point.

6. The implications of the above points are substantial. Were the system to go back to 2019/20 outturn as the basis for provider income levels and CCG allocations as notified previously, the gap between current expenditure levels on current run rates and income could be up to £340m. The above guidance does indicate that some NR funding may be available and we cannot assume that current Covid spending would continue at the same level, but all in all the implication of the guidance is that L&SC could be in deficit somewhere within a range of £240m to £340m (depending on how much NR money may be made available). The Board may recall that in February 2020 the assessment was of a deficit of £277m which, when taken together with the 23rd December NHSEI letter, leads me to advise that the gap could be at around the £300m mark.

7. Furthermore, the guidance suggests that it would be up to the ICS to allocate both revenue and capital funding. Clearly, agreement on principles and any further guidance form NHSEI is required before the ICS Board could be in a position to do this with confidence.

Dealing with a deficit over a period of time

8. The total turnover of the system will be around £3.7bn in 2021/22 based on notified allocations for CCGs and specialised services. A deficit of £300m is just over 8% in percentage terms.

9. NHSEI has in the past issued targets for systems in deficit – for 20/21 pre-Covid ours was a deficit target of £97m, meaning that we were £180m away from that sum. Clearly our system could not plan to break even in the near future and therefore we will need to agree improvements over a period of time. The most likely scenario is that NHSEI will impose an improvement target for 2021/22, but as a system we may also want to establish a level of ambition to achieve break-even over a number of years.

10. So how might we think about setting our own targets for improvement? Would we wish to be more ambitious in the short term or build up to a larger savings target in future years? Would we have a choice? Where should we look for savings? What is possible? Do we know where we have opportunities? Should savings be required from all parts of the system e.g. primary, secondary and tertiary care, physical and mental health services? Can we avoid service reductions, given the scale of the financial challenge that we have, or is there still the opportunity to achieve savings through efficiencies? What about the need to catch-up on elective services post Covid? Surely this will require more, not less resources?

11. A £300m deficit reduced to zero over three years = £100m (2.7%) savings a year and over 5 years = £60m (1.6%) per annum. L&SC has never managed an absolute reduction in the amount spent on health services. These facts illustrate the huge challenge facing our system.

Analysing a deficit

12. A system deficit can be analysed as follows:
    - Structural
    - The service offer
    - Efficiency

13. A **structural deficit** is one where the nature of services is inherently expensive because of the configuration or composition of provision. For example, some trusts manage services that are spread out over a wide geographic area in smaller units that duplicate provision, whereas in others they are contained within a single site. Current orthodoxy is that it is more cost effective to have expensive, major services on a single site where the complex inter-dependencies can be managed together e.g. trauma services with access to 24/7 diagnostics/imaging, access to critical care and specialised clinicians. It is evident that a service that operates from one site serving a defined population must be more cost effective than one that would serve the same population from two sites. Transitions to different configurations incur one off costs that have to be factored into any change proposals.

14. A **service offer** deficit is related to the way managers and clinicians have established a service which could be undertaken more cost effectively and efficiently were a different service offer made available e.g. access to procedures of limited clinical value or having more clarity on the thresholds for surgical interventions. Also, whether we have got the balance right between services that should be provided in General Practice and in hospital, in specialisms like dermatology and gastroenterology. Essentially this is about whether or not pathways are operating optimally.

15. **Efficiency** relates to our ability as a system to be able to offer the same services for lower cost. For example, higher throughput per session in theatres; fewer agency and locum staff; lower staff sickness levels; obtaining the best prices for consumables and equipment; reduction in costs for back office functions; etc.

The position in L&SC

16. Finance directors are currently specifying a piece of work that will assist us in answering some of the questions arising from the above discussion. Where, for instance, we have a structural deficit requiring substantial changes/decisions to be made, there will be little point in trying to reduce those costs through an efficiency programme.

17. It is evident that in Morecambe Bay and Central Lancashire there are structural issues that, were they to be addressed, would require formal public consultation, as indeed the OHOC programme recognises for central Lancashire. However, this is not to say that in the meantime progress should not be made on the service and efficiency aspects of the agenda.

What does the latest analysis/information tell us?

18. In the past the ICS has received information in the form of a compendium of benchmark data known as the ‘Bronze Pack’. The data from this is now quite old (2017/18) and it is in the process of being updated. In the meantime, our efficiency lead has been mining various data sources to create a view of potential savings opportunities across CCGs that can be summarised as follows:

Rightcare benchmarking of CCG spending areas	Opportunity compared to peers £m
Musculoskeletal	25
Circulatory diseases	24
Respiratory diseases	14
Same day emergency care	14
Neurology	13
Ambulance conveyances	13
Trauma and injuries	10
Total CCG for opportunities above £10m	**113**

19. It is important to appreciate that the analysis indicates where, as a system, we should be looking to explain cost variations from groups of similar CCGs. It does not tell us what we need to do but works on the principle that a better understanding of variation will assist us to agree programmes of work to achieve cost reduction, whether that be through greater efficiency, an improved service offer to patients or through structural changes in the longer term.

20. Similarly, an analysis of the data from 'Model Hospital' has identified variations from average within the hospital sector. A summary of the variations from average and potential maximum opportunities is shown in the table below:

Model hospital maximum opportunity assessments	Maximum opportunity £m
Obstetrics and Gynaecology	27
Emergency medicine	21
Cardiology	16
General medicine	12
Orthopaedic and spinal	11
Non-clinical services (back office, estates, etc)	67
Total for opportunities above £10m	**154**

21. The figures in the above tables should not be added together as they overlap considerably. For example, Cardiology/circulatory diseases feature strongly for both CCGs and providers. CCG opportunities may arise from higher costs incurred and higher levels of demand (warranted or not) compared to elsewhere.

22. Clearly, the opportunities shown above could not conceivably be realised in full across every area and in fact they do not add up to the amount we may need to find as a system; there may be another £150m to find above what could be realised from the opportunities above.

23. So what about the remaining savings that may be required? At present it is unclear from where these would come and therefore further work is required to come to a view on how this might be achieved. Once we have agreed what we can do in the immediate future, we will need to move on to looking at other opportunities not included in the above tables.

Is there any evidence that we are underfunded as a system?

24. The total place based allocation for L&SC in 2021/22 (notified as part of 5 year allocations in 2018/19) is £3.674bn which is assessed as 1.27% below our fair share of the national budget = £47.3m short.

25. The weighted population for L&SC is 2,001,071 compared to a registered population of 1,771,732 and since allocation targets are set using weighted populations, it is possible to state that our system receives an extra 13% compared to the average for England because of the level of deprivation and other factors giving rise to extra funding.

26. Clearly this does not account for our deficit, unless the weightings do not adequately reflect the extra needs of our population, but if that were true it would also hold true for other areas where high levels of deprivation exist, such as in parts of Greater Manchester, Merseyside and the Northeast.

Other factors

27. In other parts of the country providers have advantages linked to medical schools, research facilities, private patients' income, allocation of trainees and even trust funds. How big an advantage this may be is not clear, but for L&SC we are convinced that they are factors. Some work is being undertaken to examine the impact of the allocation of training posts by the HEE, but for the other areas we do not have any answers yet to the questions raised above.

Annual planning process

28. Unless there is a change of direction at national level, annual planning will be initiated during April 2021, after the current response to Covid 19 is, hopefully, over and management capacity is released to consider meeting any financial targets that will be set by NHSEI.

29. The implications of the points raised in paragraphs 3 and 4 are that the ICS Board could be responsible for agreeing income/allocation levels for trusts and CCGs as well as the allocation of capital funding across providers. This would be a big responsibility and would require a robust process to determine sound recommendations. We have an opportunity to consider carefully what process we wish to follow and the strategic context within which an annual plan needs to be constructed.

30. NHSEI has a support offer to ICSs which we have taken up. The finance community has had two sessions with a senior director of finance assigned to us by NHSEI to assist with the development of our approach to an ICS financial framework and further work will be initiated to look at the requirements at locality level.

31. Three major pieces of work are being undertaken:
    - to establish the exiting run rates for CCGs and providers this year;
    - moving onto extrapolating what this could mean for expenditure levels in 2021/22 quarters 2 to 4 if we did nothing to change existing patterns; and

- the development of a ‘diagnostic’ better to understand the reasons for and pattern of expenditure in each organisation, so that we do not waste time trying to force a solution that cannot work

32. Once this work is completed by finance staff, from April as a system we will move on to consider the wider aspects of the planning process.

Conclusion

33. Lancashire and South Cumbria has a very large underlying financial deficit of circa £300m that could not be reduced to zero in a single year and therefore will need to be tackled over a number of years. The benchmarking information we have on potential savings suggests that we could aspire to achieve figures of around £150m, maybe £200m, but that still leaves us considerably short by £100m to £150m.

34. The system will probably not be invited by NHSEI to determine its own savings trajectory over a longer period of time, but that should not stop us thinking about what we may wish to aim for and it does not stop us from starting to develop a programme of the savings we can make.

Recommendations

35. The Board is asked to **note**:
    - The run rate exercise being undertaken by finance directors
    - A subsequent analysis to extrapolate this information into 2021/22 and taking account of factors specific to that year to determine a potential level of spending should we not do anything to change the pattern of expenditure
    - The plan to develop a system ‘diagnostic’ to help us to understand the reasons for and patterns of expenditure
    - A need, during April 2021, to determine a process for general and financial planning to underpin ICS decision making on the allocation of resources from Q2 to Q4 (should that requirement be confirmed by NHSEI)
    - The support being received to develop financial frameworks at ICS and ICP levels

36. Taking into account the issues raised in the foregoing paragraphs, members of the Board are invited to **express their initial views** about the level of ambition for savings that we may wish to plan for in 2021/22 and the years thereafter, to frame the development of a cost reduction programme for the system.

Gary Raphael
Executive Director of Finance and Estates
26th January 2021

HIP2 (NEW HOSPTIALS PROGRAMME) UPDATE

1 Introduction

1.1 This report is the quarter 3 update from the HIP2 (New Hospitals Programme)

2 Background

2.1 Board Colleagues will be aware that University Hospitals of Morecambe Bay NHS FT (UHMB) and Lancashire Teaching Hospitals NHS FT (LTHTr) were awarded £5m each as seed funding to progress the required business cases to secure capital investment to redevelop/replace the ageing estate which is no longer fit for purpose.

2.2 In line with our commitment to the programme taking a whole view of the ICS geography and patient flows, East Lancashire Hospitals Trust (ELHT), Blackpool Teaching Hospitals NHS FT (BTHFT) and Lancashire and South Cumbria NHS FT (LSCFT) joined the programme throughout Q2-Q3.

2.3 The programme timetable as stated by NHSEI requires a pre consultation business case including an evaluation of options to be completed ready for public consultation throughout Q3 2021/22. A decision making business case will then be submitted Q4 2021/22.

2.4 Clearly, this is a fundamental and critical programme which will shape the future service model for our people; those who work within it, those cared by it and the wider population of Lancashire and South Cumbria for a whole generation.

3 Programme Governance

3.1 The programme governance structure can be seen in Appendix A.

3.2 Members will be aware of the challenging programme timeline and the need for agile endorsement and/or approval of critical milestones. Company Secretaries have developed a proposal for how this is achieved. This will be presented to Boards for approval over the coming period and will detail the critical milestones due between February – June 2021 (see Appendix B).

3.3 A Board-to-Board between LTHTr and UHMB is scheduled for February 2021. Chairs and Chief Executive Officers have reflected on the aim and purpose of this first Board to Board given the current pressures and the need to meet virtually. All remain committed and keen to proceed albeit with a reduced time and agenda. A follow up Board-to-Board will be arranged for the spring.

3.4 Due to the potential capital allocation this programme is deemed to be a significant transaction for the Trusts receiving the capital funding (UHMB and LTHTr). This is as per the Trust's constitutions and underpinned by legislation. With this in mind it is anticipated the Trusts must obtain governor support for the transaction.
Working with Company Secretaries, third party support will be appointed to support the Governors (working together) to understand their roles and responsibilities.

4 NHSE/I – DHSC

4.1 A series of discussions have taken place with the national team at NHS England/Improvement (NHSE/I) and the Department of Health and Social Care (DHSC). Together they are centrally managing all schemes in the HIP (New Hospitals Programme) across the country. This brings some helpful support, skills and synergies for example, learning from other schemes and getting technical support regarding

achieving net zero carbon in healthcare, standards on repeatable design and digital blueprint for new hospitals.

4.2 The programme team recently met with the national teams who were particularly encouraged by the system wide approach the Lancashire and South Cumbria programme is taking.

4.3 In December, a letter was received detailing how the national team wish to move forwards together. Key points are:

4.3.1 The Lancashire and South Cumbria scheme will take place 2025 onwards.

4.3.2 We are to prioritise the first 3-6 months of 2021 to progress feasibility work, improving digital readiness and thinking about the future sustainable operational model.

4.3.3 Progress work to define the clinical need and demand projections against a standard set of assumptions ensuring thought is given to the building solution best suited to deliver this.

4.3.4 All market engagement with construction contractors is to be aligned via the national team.

4.3.5 All external communications are to be agreed with NHSEI and DHSC prior to publication.

4.4 A 'round-table' meeting is anticipated in January/February 2021 (date TBC) to clarify the scope of the programme and its deliverability. This will be attended by representatives of NHSEI (regional and national) and DHSC. Work is underway to prepare for this and to identify attendees.

5 Narrative

5.1 Members will be aware of the national narrative regarding the Government's Health Infrastructure Plan (HIP). "The Prime Minister today confirmed for the first time that 40 hospitals will be built by 2030 as part of a package worth £3.7 billion, with 8 further new schemes invited to bid, delivering on the government's manifesto commitment."[1] The narrative regarding 40 new hospitals has remained consistent throughout 2019-2020 and now 2021.

5.2 In parallel, the Health Infrastructure Plan published by the Department of Health and Social Care in September 2019 discussed how "NHS infrastructure is more than just large hospitals. Pivotal to the delivery of more personalised, preventative healthcare in the NHS Long Term Plan is more community and primary care away from hospitals. That requires investment in the right buildings and facilities across the board, where staff can utilise technology such as genomics and Artificial Intelligence (AI), to deliver better care and empower people to manage their own health."[2]

5.3 Whilst the Lancashire and South Cumbria Integrated Care System (ICS) committed to delivering the HIP in the context of the NHS Long Term Plan[3] and the ICS Clinical Strategy, clarity was required around the 'H' in the HIP; Health or Hospital.

5.4 In January 2021 the Department of Health and Social Care announced the appointment of Natalie Forrest, a Senior Responsible Owner (SRO), to "lead the government's plans to build 40 new hospitals by 2030." In the announcement, Matt Hancock (Health and Social Care Secretary) said, "The New Hospital Programme – as part of our Health Infrastructure Plan – will transform the delivery of NHS healthcare

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[1] Department of Health and Social Care, 2 Oct 2020. PM confirms £3.7 billion for 40 hospitals in biggest hospital building programme in a generation - GOV.UK (www.gov.uk)

[2] Department of Health and Social Care, 30 Sept 2020. Health infrastructure plan - GOV.UK (www.gov.uk)

[3] NHS Long Term Plan

infrastructure to build back better and will ensure our country has world-class healthcare facilities right across the country for decades to come."[4]

5.5 Chief Executive Officers from across the ICS came together to discuss this change in narrative. This has brought some welcome clarity to the Lancashire and South Cumbria HIP programme which will now be renamed the New Hospitals Programme. Updated narrative and associated communications will be published in the coming weeks.

6 Public, patient and workforce engagement

6.1 A communications and engagement approach (*"Building the hospitals of tomorrow, today")* was approved by the SOG in Q3.

6.2 With the support of our communications and engagement partner work has progressed well over this last period, including narrative development, horizon scanning across all media, stakeholder mapping and action planning and preparing our engagement platform. As per our early commitment, I am pleased that plans are underway to formally recruit patients to work with us throughout the programme.

6.3 Communications leads from across the ICS have given significant thought as to how best to involve our workforce throughout the programme, particularly under COVID restrictions. I am delighted that plans are underway for a colleague summit in April 2021. As members will be aware, we employ in excess of 20,000 people across our local NHS organisations involved in the programme. There is a clear need for the delivery of consistent messaging, therefore the approach will utilise existing leadership and structures within each organisation to cascade a 'global' message, enabling leaders and managers to contextualise the briefing for their own areas. This virtual summit will be hosted by Dr Amanda Doyle, Chief Officer and ICS lead, and the Chief Executives from each organisation.

7 Progress (for the period October – December 2020)

7.1 The programme plan, critical path and risk register is now established and formally reviewed at the monthly Programme Management Group (PMG). Throughout Q3 the programme remained on track against the critical path milestones. A weekly deep dive of progress against plan is established with risks identified with associated mitigation and/or escalation as per governance arrangements.

7.2 The PMG also focused on ensuring awareness and understanding of the business case process applicable to this programme namely the:

- NHSE Service Change Assurance Process of which the Pre Consultation Business Case (PCBC) is one element of.
- NHSI Capital Approvals Process of which includes the Strategic Outline Case, Outline Business Case(s) and Full Business Case(s).

7.3 Programme principles

- Members of the Strategic Oversight Group (SOG) and Clinical Oversight Group (COG) have developed a set of principles we can stand by when making important decisions. It was important to contributors to articulate the legacy we wish to create via the programme. Final approval will be in January 2021 ahead of implementing our communications and engagement plan.

[4] New leadership for construction of 40 new hospitals - GOV.UK (www.gov.uk)

7.4 *Programme team*

- Following a period of recruitment, core team members will start in post throughout Q4. In line with a commitment the programme will be clinically led, a number of medical, nursing and operational appointments have been made. Together, this brings welcome capacity and leadership to the team.
- The internal team is further supported by a number of external organisations bringing expertise in the development of significant capital business cases, risk assurance, health planning, communications and engagement and legal.

7.5 Health planning

- Phase 1 of the health planning work concluded in Q3. This provides a baseline of the current service provision and associated activity data. Over the coming period work will progress to develop the principles by which clinical specifications and options will be developed.
- The health planning work has been supported by many clinical and operational colleagues from across all provider and commissioner organisations. Their input is acknowledged and greatly appreciated, particularly given the pressure due to COVID.
- Our health planning work will consider the opportunity to bring services closer to home for our patients. This is in line with the NHS Long Term Plan and our ICS strategy. Throughout Q3, focused work alongside commissioning colleagues to understand what the data is telling us and scale of opportunity.

7.6 Engaging with other HIP (New Hospitals Programme)

- To avoid reinventing the wheel and to learn from each other, the programme team has connected with other schemes namely Leeds Teaching Hospitals and University Hospitals of Leicester. In addition, PWC and ETL have established networks of other schemes. Sessions have included estates advice, governance, carbon zero and developing the PCBC. Over the coming period, discussions will take place with South Devon and Torbay and the Cornwall schemes. Initial findings suggest these schemes may have similarities with the L&SC programme therefore I look forward to learning from our New Hospitals Programme colleagues.

7.7 Stakeholder management

- The Board will recognise there will be a breadth of stakeholders in such a programme. A full stakeholder analysis was undertaken in December with action planning underway. In the meantime, the programme team has attended a number of forums as a means of increasing awareness and providing an opportunity to discuss the programme.

8 Conclusion

8.1 This paper is a summary of progress on the HIP2 (New Hospitals Programme) throughout Q3 2020/21.

9 Recommendation

The Board is requested to:

1 Note the key points as per the letter from NHSEI and DHSC in particular the request to focus on digital readiness.

2 Note a change in the programme name from HIP2 to the New Hospitals Programme

3 Note the intention of a colleague summit in April 2021.

Rebecca Malin, Programme Director
January 2021

Healthier Lancashire & South Cumbria

Appendix A – Programme Governance

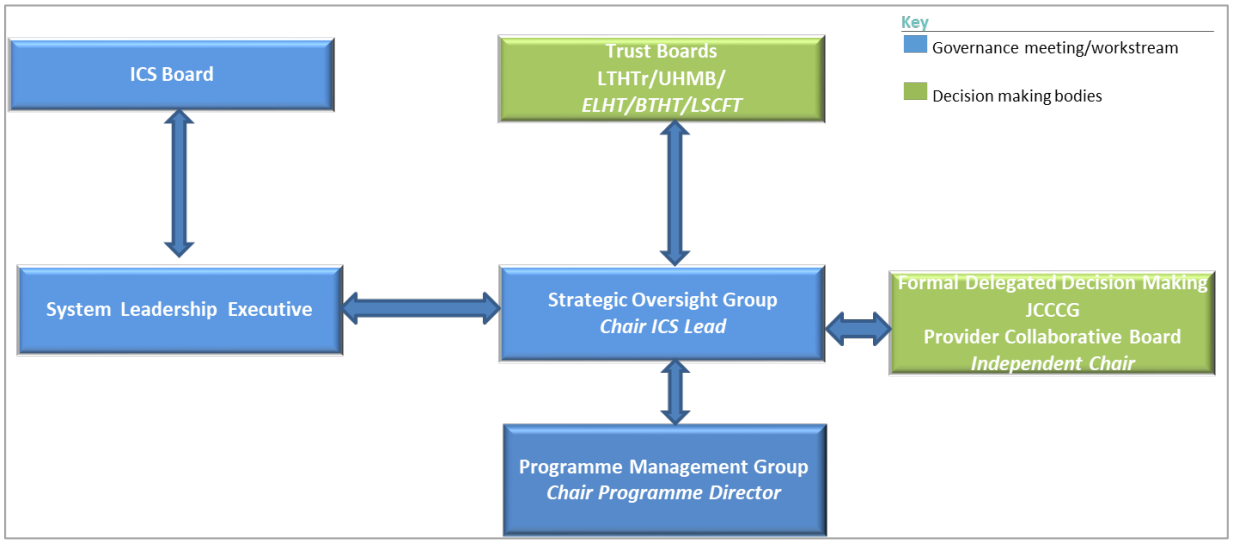


Chart 1: Programme governance level 1

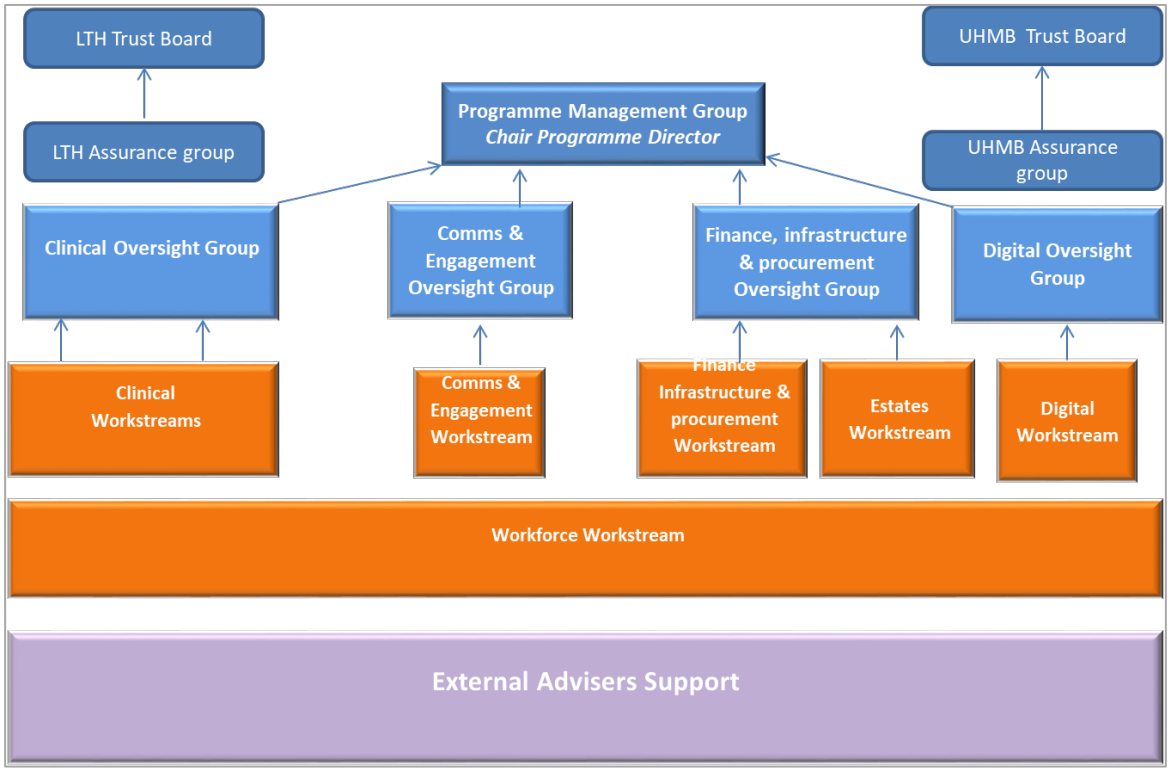


Chart 2: Programme governance level 2

Appendix B – Critical Path Milestones/Governance Road Map

Critical Milestone and	Strategic Intentions	Description of Key Activities/	Timeline
Case for Change	Demonstrate a compelling case for service changes	Review and comment Endorse	26/02/21 – 15/03/21 26/03/21
Clinical Models	Produce new ways of working which address the issues in the system described in the case for change	Review and comment Endorse	17/03/21 – 29/03/21 08/04/21
Long List of Options	Produce a long list of Options which support the new ways of working	Review and comment Endorse	30/04/21 – 07/05/21 11/05/21
Strategic case of the SOC	The section of the capital business case which sets the strategic context for the programme	Review and comment Endorse	12/05/21 – 20/05/21 28/05/21
NHSE/I Checkpoint	Comments on the programme to date and Gain NHSE/I approval to continue the PCBC process	Issue information to NHSE/I Case for change Clinical models Long list of options NHSE/I Review meeting	12/05/21 June 2021

ICS Board

Date of Meeting	3rd February 2021
Title of Paper	System Reform
Presented By	Andrew Bennett
Authors	Andrew Bennett, Jerry Hawker, Gary Raphael
Agenda Item	8
Confidential	No

Purpose of the Paper

The purpose of this paper is to update the ICS Board on the range of activities taking place to implement the ICS's System Reform Plan. Actions are taking place in the light of a recent national consultation document which set out a number of proposals for the continued development of Integrated Care Systems across England.

The ICS Board is also asked to endorse proposals for the development of NHS commissioning governance arrangements. It is proposed to utilise the Joint Committee of CCGs to act as a Strategic Commissioning Committee during 2021/22.

Executive summary

This document updates the Board on the extensive development work now taking place across the ICS which has built on the System Reform Plan agreed in October 2020. The pace of this work is accelerating after publication of national proposals to advance the development of Integrated Care Systems. It is clear, subject to legislation, that 2020/21 is now viewed as a pivotal, transitional year for System Reform.

The paper provides a specific update on the proposals which have been developed for the evolution of commissioning governance arrangements in 2021/22. The proposals are being recommended to CCG Governing Bodies by the Joint Committee of CCGs.

The ICS Board will continue to review the progress of system reform plans at its meetings in the coming months.

Recommendations

The ICS Board is asked to:

1. Note the update on on the range of activities taking place to implement the ICS's System Reform Plan

2. Endorse the proposals for the creation of a Strategic Commissioning Committee to support the development of decision-making within the ICS during 2021/22.

Governance and Reporting (List Other Forums that have Discussed this Paper)		
Meeting	**Date**	**Outcome**

Conflicts of Interest Identified						
Given the implications of system reform for changes in organisational and leadership models, a number of colleagues are declaring financial interests prior to discussion on the issues raised.						
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					

System Reform

Introduction

The purpose of this paper is to update the ICS Board on the range of activities taking place to implement the ICS's System Reform Plan. Actions are taking place in the light of a recent national consultation document which set out a number of proposals for the continued development of Integrated Care Systems across England.

The ICS Board is also asked to endorse proposals for the development of NHS commissioning governance arrangements. It is proposed to utilise the Joint Committee of CCGs to act as a Strategic Commissioning Committee during 2021/22.

1. **National Consultation:** ***Integrating Care: next steps to building strong and effective Integrated Care Systems across England (published 26th November 2020)***

The ICS Board received a copy of this national consultation document at its meeting in December. It is clear that there is a positive correlation between the direction of travel set out in the national document and the ICS System Reform Plan which had been submitted to the Regional Director (NHSEI) in early October 2020.

At the time of writing, the outcomes of the consultation are still awaited. However, it is understood that national colleagues expect proposals for legislation in the form of a White Paper to be placed before Parliament during the spring. Oversight Groups at both national and regional levels have now been established in advance of these changes.

This means that 2021/22 can be viewed as a transitional year with local systems encouraged to continue the development of collaborative arrangements. The focus for collaboration will remain on recovery and restoration from the pandemic as well as improvements in service quality, outcomes and financial performance. Subject to the legislative process, further planning guidance for ICS and partner organisations is also expected later in the year.

2. Narrative for System Reform

It is vital that the ICS is able to endorse a clear narrative about the purpose, aims and success measures for system reform. This needs to be cross-referenced to work already taking place already across the partnership and then communicated to our key stakeholders, members of the public and employees. The ICS Board has already taken the first steps in this regard by approving the narrative setting out how our place-based partnerships (ICPs) will continue to develop.

Further work is now underway to set out how we expect the ICS to continue its development, explaining the purpose of working at system, place and neighbourhood levels. The scope and scale of provider collaboration will be explained and further

discussions are now being planned with Local Authority colleagues to identify their priorities for working together during this transitional period.

Once drafted with the input of leaders across the system, this narrative will be presented to the ICS Board.

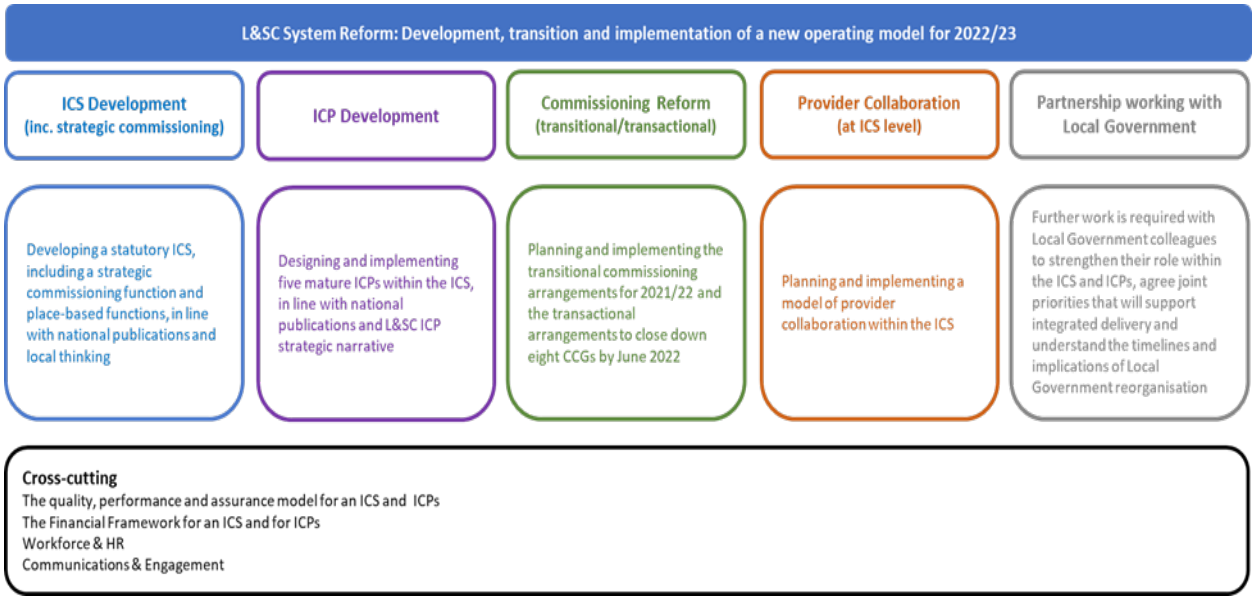
3. Moving into a transitional year: 2021/22

The purpose of the national proposals for System Reform were set out clearly in the *Integrating care* document:

- 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.

Whilst any changes remain subject to the legislative process which is expected during the spring, it is already clear that this is a major change programme for the ICS and its partner organisations. As figure 1 below indicates, there are several key areas of work and multiple cross-cutting issues. Board members will be aware that we are using a number of groups e.g. ICP Development Advisory Group, Commissioning Reform Group, Provider Collaboration Board to lead the development of this work.

Figure 1: System Reform workstreams



It has become apparent with the publication of *Integrating Care* that there will be a number of key milestones during 2021/22 which will guide the ICS's development through a period of transition. These are now being identified as part of a "Critical Path" process.

It is also clear that several of the workstreams which had initially been identified in 2020 as part of the commissioning reform process are now much broader in scope and likely to impact on the whole of the System Reform programme. These are shown in the cross-cutting box in Figure 1 and include:

- the quality, performance and assurance model for an ICS and ICPs
- the financial framework for an ICS and ICPs
- Workforce and HR
- Communications and Engagement

To ensure there is clear oversight of the critical path for system reform and for the cross-cutting workstreams, it is proposed to create an ICS Development Group during February 2021. The ICS Development Group will work as required with the other groups charged with leading key elements of the system reform programme.

4. Commissioning Reform

The Joint Committee of CCGs and its sub-committee focusing on commissioning reform have already examined the implications of *Integrating Care* for the workstreams which had already been established.

Workstream priorities have been reviewed and, in some cases, refocused to support the direction of national policy. The plan to hold a vote of member general practices on proposals for CCG reconfiguration is not now expected to take place given the two options laid out in the *Integrating Care* document. Commissioning leaders emphasise that the work to realign resources and roles previously attributed to CCGs must support the whole system reform programme - with particular reference to the development of ICPs, the evolution of strategic commissioning and effective working arrangements with the provider collaborations.

Strategic Commissioning Committee

The Commissioning Reform Group (CRG) was established originally to support the intention to establish a single commissioning body across Lancashire & South Cumbria from April 2022. The CRG Governance work stream has worked with CCG representatives, NHSEI and taken legal advice to consider a number of options to enable single decision making across Lancashire & South Cumbria, shadowing the role of a Strategic Commissioning body for Lancashire and South Cumbria whilst ensuring decision making continues to comply with the minimum legal statutory duties of each individual CCG and their constitutional Schemes of Reservation & Delegation (SORDs).

The JCCCGs met on the 14th January 2021 to consider recommendations from the CRG and endorsed the establishment of a Strategic Commissioning Committee

supported by a limited number of sub-committees. The Strategic Commissioning Committee will have increased delegated authority to make decisions across finance, quality, performance, and consultations.

A number of statutory duties still need to be discharged by individual CCGs. These include sign-off of Annual Reports and Statement of Accounts. It is also recommended that the Primary Care Committees in each CCG should continue providing close links into General Practice, but should operate closely with the ICS Primary Care Group.

The JCCCGs agreed that a formal recommendation should be made to each CCG Governing Body to approve the establishment of the Strategic Commissioning Committee and associated changes to the Terms of Reference of the JCCCGs.

The establishment of the Committee continues to comply with and supports each statutory organisation's requirements in 2021/22, and is an approach endorsed by NHS England/Improvement and their intended approach to assurance during 2021/22.

The proposed membership of the Strategic Commissioning Committee (SCC) retains the core expertise from the JCCCGs, whilst expanding voting membership to capture the LSC strategic commissioning nature of the new committee.

The SCC will continue to meet in public to retain transparency and public accountability

The proposed decision making roles of a Strategic Commissioning Committee (using JCCCGs as the statutory vehicle for single decision making) are summarised below:

- Strategic commissioning decisions for all ICS Priority Programmes
- ICS level Quality & Performance assurance & oversight
- ICS level financial, activity and contract assurance and sign-off
- NHSE "Single point of Contact" for Assurance framework
- Consultation oversight and approval
- Delegation and funding arrangements to place (via "place representatives")
- Strategic coordination of Joint Commissioning arrangements with Local Authorities (s75/BCF etc)
- Approval of the annual commissioning work programme
- Assurance and oversight of CCG Transition Management (Statutory transition)

It is important to emphasise that the recommendations made in this paper are based on current statutory guidelines and have been "future proofed" as far as reasonably practical. It is likely that further guidelines may be issued as part of the 2021/22 planning arrangements or later in the year pending progress on proposed legislative changes and therefore arrangements will need to be reviewed periodically.

A number of sub-committees are proposed to enable the Strategic Commissioning Committee to fulfil its purpose. These are as follows:

- **Collaborative Commissioning Board** – This is an established Lancashire & South Cumbria Board with established arrangements for collaborative commissioning which can support the Strategic Commissioning Committee.
- **CCG Transition Board** – This would be a new Board accountable for making single recommendations to the Strategic Commissioning Committee for managing the CCG transition arrangements across LSC.
- **Quality & Performance Committee** – Accountable to the Strategic Commissioning Committee (and ICS Board) for ICS Quality, Safeguarding and Performance Assurance and delivery: Quality & Performance transition from CCG to SCC/ICS; Development of System & Place quality & performance dashboards. Providing a single interface with NHSEI.
- **ICS Finance Advisory Group / CCG Finance Group -** Responsibility and oversight of all System level/ strategic Finance, activity and contracting planning. Role likely to be defined further with 2021/22 Planning guidance. (A separate CCG Finance group will operate as part of the transition arrangements to ensure statutory financial duties are discharged providing assurance to SCC and CCGs.)

The recommendations to create a Strategic Commissioning Committee for Lancashire and South Cumbria will be considered by the 8 CCG Governing Bodies during February 2021.

5. ICP development

The ICP Development Advisory Group is continuing to oversee the next stage of ICP development work, as agreed by the ICS Board in December 2020. Membership of this group is being further enhanced with representatives from Local Government and primary care. It is important to emphasise that ICP development will be impacted by the expected publication of further national guidance during 2021/22.

The ICS Board approved the use of a bespoke ICP Maturity Matrix to understand the different levels of maturity in each ICP across a range of domains linked to the common ICP strategic narrative. Work has progressed at pace to develop the matrix, to have it independently reviewed and endorsed by the Advancing Quality Alliance (AQuA), and to develop and implement a process for the self-assessments and peer-to-peer reviews.

Partners within each ICP have been asked to complete the self-assessment (using an online tool) by early February 2021. This will be followed by a dedicated feedback session to review responses, understand similarities and differences across participants by sector, and consider what this means for each ICP. The sessions will

be facilitated by AQuA who will act as an independent presence to enable focused and honest conversations and ensure equity of input across all partners. Peer-to-peer reviews are planned for the first half of March 2021, which will also be facilitated by AQuA. The peer group will be selected from ICP Chairs, members of the ICP Development Advisory Group, and external subject matter experts provided via NHS England / Improvement and the Local Government Association. The Independent Chair of the ICS will participate in all sessions.

A wider ICP development programme is running in parallel, with the scope and design of this programme informed by the findings of the self-assessments and peer-to-peer reviews as well as work that has been taking place across the wider system reform programme. The ICP Development Advisory Group will host a number of workshops across February / March 2021 focused on success measures for ICPs, ICP leadership and ICP governance, and will be framed around building trusting relationships between partners within the ICPs. The workshops will be facilitated by subject matter experts provided via NHS England / Improvement and the Local Government Association. Proposals developed during these sessions will be shared and discussed more widely with senior leaders via a system wide workshop in early April 2021.

In addition, the existing finance workstream will support thinking around the financial framework for ICPs, identifying opportunities for planning and delivery of integrated services to be better supported by collective decision-making on finance.

6. Local Government Reorganisation

Colleagues in Cumbria County Council have now indicated that by the end of February 2021, national government will have confirmed the options for future configuration of councils which are to be considered via a public consultation. The process of consultation will take place in March-April.

7. Financial Framework

There are expectations that the financial framework for the ICS will evolve in 2021/22.

Revenue funding will be distributed at system level, continuing the approach introduced this year. These system revenue envelopes will be consistent with the Long Term Plan financial settlement. They will be based on the published CCG allocations and the organisational Financial Recovery Fund each system which would have been allocated in 2021/22. There will be additional funding to offset some of the efficiency and financial improvements that systems were unable to make in 2020/21.

Systems will need to calculate baseline contract values to align with these financial envelopes so there is a clear view of baseline financial flows. Our planning guidance will suggest that these should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes, not on the nationally-set 2020/21 block contracts.

8. Communication with stakeholders, the public and staff

System leaders are cognisant that the potential changes set out here as a consequence of *Integrating Care* need to be communicated effectively to our key stakeholders and members of the public. There may also be direct consequences for members of staff in CCGs, the CSU, provider organisations and the ICS core team which need to be addressed with a clear and transparent approach to organisational change.

Work has commenced on a communications/engagement plan for the ICS, identifying the key messages which will need to accompany the national process for legislative change.

Recommendations

The ICS Board is asked to:

1. Note the update on on the range of activities taking place to implement the ICS's System Reform Plan

2. Endorse the proposals for the creation of a Strategic Commissioning Committee to support the development of decision-making within the ICS during 2021/22.

Andrew Bennett Executive Director of Commissioning

27th January 2021