Formal Integrated Care System (ICS) Board
2 June 2021, 10 am -12 noon
Via MS Teams Videoconference

Agenda

Item	Description	Owner	Action	Format
Routine Items of Business				
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Declarations of Interest/Conflicts of Interest relating to the items on the agenda	Chair	Note	Verbal
3.	Minutes of previous formal ICS Board meeting held on 5 May 2021, matters arising and actions	Chair	Approve	Attached
4.	Key Messages	Amanda Doyle	Discuss	Verbal
Managing 2021/2022				
5.	Elective Recovery Accelerator Programme	Kevin McGee	Discuss	Verbal
6.	Revenue Financial Plans (Current Year H1 Plan)	Gary Raphael	Discuss	Attached
7.	Capital Planning 2021/22	Gary Raphael	Discuss/ Support	Attached
8.	Primary Care Restoration	Peter Tinson	Discuss	Attached
Building the System for 2022 and Beyond				
9.	System Development: Progress Update and Forward Plan for 2021/22	Andrew Bennett	Discuss/ Support	Attached
Outturn Reports for 2020/2021				
10.	Revenue and Capital Outturn 2020/21	Gary Raphael	Discuss	Attached
Any Other Business				
11.	Any Other Business	All	Note	Verbal
Date and Time of Future ICS Board Meetings: Formal meeting - Wednesday, 7 July 2021 – 10.00 am to 12.30 pm, MS Teams Videoconference				

Subject to ratification at the next meeting

Minutes of a Formal Meeting of the ICS Board Held on Wednesday, 5 May 2021 via MS Teams

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Dr Amanda Doyle	Chief Officer	Lancashire and South Cumbria ICS
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	Executive Medical Director	Lancashire and South Cumbria ICS
Carl Ashworth	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Gary Raphael	Executive Director of Finance and Investment	Lancashire and South Cumbria ICS
Caroline Donovan	Chief Executive	Lancashire and South Cumbria NHS Foundation Trust
Karen Partington	Chief Executive	Lancashire Teaching Hospitals NHS Foundation Trust
Geoff Jolliffe	Clinical Chair	NHS Morecambe Bay CCG
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Roy Fisher	Chair	NHS Blackpool CCG
Dr Stephen Hardwick	Chair	Local Medical Committee
Cllr Shaun Turner	County Councillor	Lancashire County Council
Mike Wedgeworth	Non-Executive Director	Lancashire and South Cumbria ICS
Ian Cherry	Non-Executive Director	Lancashire and South Cumbria ICS
Isla Wilson	Non-Executive Director	Lancashire and South Cumbria ICS
Peter Armer	VCFS Representative	Voluntary Community Faith Sector
Gary Doherty	Director of Service Development	East Lancashire Hospitals NHS Trust
Jackie Hanson	Director of Nursing and Care Professionals	NHS England and Improvement
In Attendance		
Anthony Gardner	Director of Planning & Performance	NHS Morecambe Bay CCG
Jerry Hawker	Senior Responsible Officer, New Hospitals Programme	Lancashire and South Cumbria ICS
Rebecca Malin	Programme Director, New Hospitals Programme	Lancashire Teaching Hospitals NHS Foundation Trust
Vicki Ellarby	Programme Director – System Reform	Lancashire and South Cumbria ICS
Phillipa Cross	ICP Programme Director	Pennine Lancashire ICP
Jackie Moran	ICP Programme Director	West Lancashire ICP
Paula Wigglesworth	ICP Programme Director	Fylde Coast ICP
Sarah James	ICP Director	Central Lancashire ICP
Karen Kyle	System Programme Director	Bay Health and Care Partners
Paula Roles	Strategic Workforce/HR Lead	Lancashire and South Cumbria ICS

Sarah Sheppard	Interim Executive Director of HR & OD	Lancashire and South Cumbria ICS
Jane Scattergood	COVID-19 Vaccination Director	Lancashire and South Cumbria ICS
Louise Taylor	Executive Sponsor Intermediate Care Programme	Lancashire and South Cumbria ICS
Victoria Tomlinson	Programme Manager – Intermediate Care	Lancashire and South Cumbria ICS
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Rebecca Higgs	Business Manager to Dr Amanda Doyle	Lancashire and South Cumbria ICS
Nicki Latham	Deputy Chief Executive/Director of Strategic Partnerships	Blackpool Teaching Hospitals NHS Foundation Trust
Sandra Lishman	Corporate Office Co-Ordinator (Minute Taker)	Lancashire and South Cumbria ICS

Routine Items of Business	
1.	**Welcome, Introductions and Apologies** **Welcome and Introductions -** The Chair welcomed all to the formal meeting of the Integrated Care System (ICS) Board held virtually via MS Teams. Due to Purdah the meeting was not held in public. **Apologies -** Apologies had been received from Aaron Cummins, Denis Gizzi, Eileen Fairhurst and Kevin McGee.
2.	**Declarations of Interest** **RESOLVED: All members declared an interest in System Reform.**
3.	**Minutes of Previous Formal ICS Board Meeting** **RESOLVED: The minutes of the meeting held on 3 March 2021 were approved as a correct record. Seconded by Roy Fisher.** **Action Log** *Vaccination Uptake Update* – Jane Scattergood (JS) spoke to a presentation highlighting the following:- - 950,000 first dose vaccine had been delivered across Lancashire and South Cumbria, with nearly 450,000 people having received their second dose vaccine - Local data by practice, CCG and PCN level had been shared with colleagues for interrogation to help make informed decisions about vaccine hesitancy or where uptake was low - Uptake by ethnicity was shown for Lancashire and South Cumbria as a whole; members were asked to note that the chart did not provide a complete picture as some people were not eligible for the vaccine at this stage, eg, under 40 year olds, and some demographics had bigger numbers under 30 years of age - In relation to second dose vaccine uptake, there was a lag in some of the Asian and black Afro-Caribbean communities, mainly due to uptake hesitancy - Pop up sessions had begun, which had proved popular - Specially commissioned services provided by Lancashire and South Cumbria Foundation Trust were reaching out to under-served groups, ie, homeless, very vulnerable people

- First dose vaccination uptake rates were shown for residents and staff in adult care homes. The uptake of Blackpool and Cumbria's care home staff was much higher than England as a whole. Significant work was being undertaken with partners in the local authority to promote take up. Hesitancy had been seen amongst care home staff under 30 years of age
- Due to national supply, a slight delay had been seen in the first dose vaccine programme; the delay should be resolved from mid to late May
- The national target was to conclude the whole adult population by the end of July with a first dose vaccine
- National guidance was awaited regarding whether a third dose vaccine may be required for the over 50 cohort as an autumn booster or potentially a newer vaccine that included vaccine escape variants
- Interrogatable data could now be accessed with geographical coverage of the offer of the MRNA vaccine suitable for the next cohort, ie, those under 30 years, university students and pregnant women. Pfizer would be available at Lancaster, Ulverston and Burnley mass vaccinations centres and Moderna at Preston, and potentially at West Moreland shopping centre mass vaccination sites. Community Pharmacy continue to see the blend of AstraZeneca and Pfizer and it was understood that the balance would be towards Pfizer as an MRNA vaccine for the younger population
- Plans were being refined for pregnant women as they must be offered an MRNA vaccine.

JS continued that work was underway in relation to ensuring that GPs had the correct contact telephone numbers for Lancashire residents planning to go to University; it was planned that all students attending universities in Lancashire or residents going to university, to be vaccinated prior to going or access a vaccine on arrival at university. Teams were working with universities to include details in welcome packs to ensure students were aware of how to access the vaccine almost immediately on arrival, if not already received.

Neil Greaves (NG) recently met with university representatives looking at getting messages to students prior to term finishing. Focussed messages would be required for all students, including those from Lancashire, from other parts of the UK and from abroad. Parent focussed messages would also be made for students returning to Lancashire from other universities.

PCNs in Pennine, East Lancashire, Blackburn with Darwen, and two PCNs in the Fylde Coast did not opt into providing the vaccine to people under 50 years of age, however, continue to immunise second doses and for cohorts 1-9. Some PCNs in Central also did not opt to provide this service, however, work had been picked up by a neighbouring PCN. As a result, additional community pharmacy had been commissioned in Pennine and on the Fylde Coast, which have access to the national booking solution. Capacity had increased in Pennine at Blackburn Cathedral Crypt and Burnley Town Hall. East Lancashire Hospitals and Blackpool Teaching Hospitals Trusts had made a citizen offer via the hospital hub to bridge the gap between now and when the community pharmacies come online. This may result in the platform of delivery changing; however, a suitable geographical spread continued and should not create barriers to communities.

Concern was raised as to the workload for general practice over the next few months, as it was envisaged that the staff deployed to provide vaccine would be required at general practice. JS responded that there were signals for a national vaccine service, more centrally controlled, however, science on the life of antibodies was awaited prior to a decision being made as to how frequently boosters may need to be given and how frequently a vaccine for variant escapes may need to be given. A national strategy was awaited. A sustainable plan on the future requirements

	of vaccine would be required for autumn 2021 to ensure primary care would not be overburdened with mass vaccinations. Amanda Doyle (AD) confirmed that work was being undertaken regionally and nationally on demand on primary care, capacity available, and the catch up. The impact of not catching up with long-term condition management would be seen across the system. Currently there was a huge risk around primary care as demand had grown; the ICS Board would be updated when further detail was known. **ACTION: Amanda Doyle**
4.	**Key messages** Amanda Doyle (AD) introduced Sarah Sheppard, as ICS Interim Director of OD and HR. The CSU, as Sarah's current employer, provide HR support to all 8 CCGs. Given the transition work and HR and OD requirements in establishing the ICS and bringing together organisations, it had been agreed that Sarah carry out this ICS role for the rest of this financial year or until a HR and OD Director was substantively appointed. Lancashire and South Cumbria ICS had been identified as one of the potential national accelerator sites for the elective recovery programme. Investment support would be received to expedite recovery electives. Members were asked to not circulate/discuss wider than this meeting until after Purdah. Amanda Pritchard is scheduled to visit Lancashire and South Cumbria on 1 July 2021 to look at some of the work currently being undertaken.
Future System	
5	**Operational Planning H1 Submission** - **Financial Plan Submission/Remaining Submission Elements –** Gary Raphael (GR) reported that the draft operational plans for the first half of 2021/22 was due for submission on 6 May 2021 and in complete form by 3 June 2021. The final system financial plan must be submitted as a balanced plan on 6 May. The following summarised GR's presentation:- - Templates for the mental health finance submission covered the whole year - There were several planning priorities, including the restoration of elective procedures, including cancer services. Planning would be undertaken as a system, with colleagues taking a reasonable view on financial sums being made and what could be achieved. The other elements (non-financial) of our plans would be revisited and adapted if necessary after the financial elements had been submitted - Critical success factors had been identified, based on a wide range of discussions across the system. Safe services, plans within the financial envelope, plans as a single system with clear accountability for delivery, communicating clearly with patients/public must be achieved - Various groups were working on plans; the ICS team had tried to understand policy areas across all organisations - Financial aspects of plans must be submitted on 6 May. Additional funding for the first half of 2021/22 amounts to £280m. From a national perspective, money had been received for COVID, etc, and financials would be expected to balance. Additionally, there would be access to £1bn national funding for elective recovery and £0.5bn for the mental health fund - Allocation for the first half of 2021/22 would be broadly the same as for the second half of the last financial year with a few minor adjustments. The national message was we have enough money to continue at the run rate funded in H2 last year. If there would be difficulties in being able to balance the position, systems must clarify how they would

return to a balanced position. Lancashire and South Cumbria had ended 2020/21 in deficit of £59m; approval had been given to overspend by £61m.

Commentary on key issues:-

- The national team had calculated system top up funding for each trust, the distribution of which had not been changed by the ICS team for H1
- Similarly, the ICS team proposed that trusts should be funded for COVID based on their estimates for H1
- Funding for system growth and balance for COVID would be allocated to systems on a weighted capitation basis.

The overall distribution of system money was disproportionate due to system top up funding. The position at close of play on 4 May was at break-even position. There was a minimum CIP of 3% in providers for H1 and 3% on influenceable spend in CCGs. Organisations were asked to make assumptions on delays in fully implementing key policy requirements, such as continuity of care, population health management measures and implementation of mental health developments, due to difficulties in appointing staff and late decision making. Discussions had been held with mental health trust colleagues regarding £5.7m, non-recurring, which was top sliced from system growth in H2 last year. The proposal for the H1 plan was for the mental health trust to manage the remaining implementation of the long-term plan aspects in the same way as other organisations, however, the issue was whether the £5.7m would be made available recurrently.

It had proved complicated to understand where organisations were up to with their core plus estimates for elective recovery, costs incurred to date and likelihood of success. Within the planning estimates was an assumption of circa £10m for H1 in reaching current activity levels of circa 90% with £20m income assumed from the ERF.

There was no information on H2 allocations as yet, however, national discussions had included the possibility to have the same regime in H2 as in the current half of the year but with a requirement of a significant level of CIPs, or a return to the previous allocations, which would be challenging.

GR asked that the views of the Board were expressed so that feedback could be provided to those completing the returns.

Isla Wilson (IW) felt that given historic under investment in learning disability, it would be counter intuitive not to invest in mental health.

GR responded that organisations had been asked not to actively manage slippage in workforce, but to recognise the realistic time delays in appointing staff and factor this into their estimates assuming funding would be required only when staff were in post.

Ian Cherry (IC) raised concern that incremental budgeting does not show the total picture of the health economy in the area. The last half of 2020/21 received £280m of additional funding for COVID. Consequently, a deficit budget was allowed of £60m. On a like by like basis, as we moved into first half of 2021/22, a deficit budget of £60m would remain; it was questioned how this had risen to £67m. Concern was also raised regarding the previously agreed target for £200m savings.

GR responded that it was still planned to have £200m recurring savings in place by 31 March 2022. All organisations must achieve 3% savings for the first and second half of this year in their plans. System-wide schemes would be scoped to achieve another 2%, to get to 5% on a recurring basis. He explained that guidance for the H1 plan was published a few weeks ago and this cut across our previous thoughts on dealing with the underlying financial deficit, because the requirement now was on elective recovery. Our previous discussions at the ICS Board assumed we would revert back to our historic allocations. National requirements must be met for the planning process, rather than to focus on saving money. For this year we were now planning to meet a 3% CIPs in each organisation in order to be able to meet national requirements, whilst continuing with the programme to achieve £200m recurring savings by the time we exit this current year.

GR also reported on recent discussions held with finance directors and a range of colleagues from the Elective Care Group to scope whether the additional elective activity above the national thresholds could be delivered within our current financial envelope. Analysis would be continued with the final activity plans due for submission in early June. However, an initial assessment based on activity levels likely to be achieved during April suggested that it was safe to assume a minimum 90%, which is significantly above national thresholds in April, May and June, enabling Elective Recovery Fund (ERF) income to be earned. The key question was how much were providers spending above their end of March run rate levels to be able to deliver this level of performance? It appeared that the level was in the region of £10m in total for H1. Therefore, if current trends continued to the end of September, earnings could be in the region of £30m. On looking at the core plus option, to reach 100%, costs would rise substantially and income not at the same rate; careful consideration must be made as to how to achieve the extra 10% and furthermore, how to reach accelerator targets, which would require us to achieve activity levels of 120% of 2019/20 outturn levels. At this stage in financial plans the underlying assumption for electives was to operate at 90% of 2019/20 activity levels and therefore, a £20m contribution to the bottom line was considered a reasonable assumption, however, there was more work to do to validate the assumption.

GR mentioned that the Financial Recovery Board had recently met; much work was being undertaken on cost the improvement plans and the Board had endorsed the need for all organisations to deliver 3% CIPs this year while further work is undertaken on a system basis to identify another 2% in recurring terms.

More conversations were required regarding the proposal for mental health. Caroline Donovan (CD) understood challenges in the system regarding mental health investment. Previously, when there had been significant national focus and scrutiny on mental health, there was challenge about the portion of system money being spent on mental health which at that time was around 13%. The challenge by the national team was to look at 15-16% given the deprivation and geography of the population; longer term, this would need to be addressed in overall strategies. CD was supportive on a non-recurring basis, to contribute back any underspend that could not be recruited against. Investment of £5.7m was based on the significant under investment of previous years that had been received on a recurring basis, providing confidence to the system and national team that the plan could be delivered. Recruitment had been on a recurring basis and if reversed would prove a significant risk. Significant challenges remained on learning disability and mental health pathways. With transformation plans, there was confidence to reach an improved, sustained position. However, investment to previous commitment levels would be required.

Amanda Doyle supported the view that the funding agreed for mental health services must be recurrent, even if last year the funding came from a non-recurring source.

The Chair summarised that out of the context of the pandemic and COVID response and the need to recover, the financial regime operating would change significantly. Additional funding had been received to cover essential costs recognising pressures on the system in the previous year. The system went into the pandemic period with an unsolved financial problem which had not been improved. Understandably, during the pandemic period progress was unable to be made and additional funding was provided. Money had been received to cover any deficit, with further additional funding to cover COVID costs; the deficit remained. The £60m deficit last year was mainly a result of the underlying deficit not being dealt with prior to the pandemic. The system had been unable to come together to deliver a balanced plan, despite extra funding. Isolating £2.8m of mental health spend for H1 was not supported by the Chair and he proposed that it should be added to any balancing figure required. The income going into the second half of the year was not known at this stage.

RESOLVED: The ICS Board endorsed the following assumptions to enable the balanced submission to be made to NHS England:-

- **A minimum CIP of 3% in providers and 3% on influenceable spend in CCGs. This level of CIP is in accordance with the decisions made at 26 April 2021 meeting of the System Financial Recovery Board**
- **No contingency reserves to be held in CCGs**
- **Assumptions on delays in fully implementing key policy requirements, such as continuity of care for mothers, population health management measures and implementation of mental health developments, due to difficulties in appointing staff and late decision making**
- **Extra recurring money (£2.8m) for mental health LTP, not included in H1 financial plans**
- **A £20m contribution from the Elective Recovery Fund**
- **Other measures requiring detailed negotiations with organisations (£10m).**

6. **System Reform**

a) Development of Place-Based Partnerships - Geoff Joliffe (GJ) explained that the ICP development, with collaboration from all organisations, provided the opportunity to work in different ways to achieve financial balance, and many other things. It was expected that each ICP would now move at pace to develop proposals, including the development groups and programme.

Vicki Ellarby reported that the previously circulated paper set out the approach taken to develop proposals and a number had been involved in various stages of development. Approaches ran in parallel and received positive feedback around the ICP maturity matrix; the recommendation was to repeat the process of the ICP maturity matrix towards November 2021. A set of proposals, including timeframes, had been created across 3 key areas. Proposal categories were a set of immediate actions and activities to take place in each ICP (or that could be undertaken collectively by sharing good practice). A broader set of proposals required further development over 2021/22, tackling more challenging issues which may require national guidance. Work would continue on a draft partnership agreement to meet timeframes. The ICP Development Advisory Group proposed to meet monthly for the rest of the financial year, would oversee implementation of actions collectively and within each

ICP, and would continue to be used as a forum to share good practice and help each other with challenges. The group would review national guidance as it was published and shape the development programme going forward. ICP Directors were thanked for undertaking work to date both individually and as a collective.

Amanda Doyle (AD) clarified that the place-based leader appointment would be a very specific role as part of appointing to the formal ICS Executive appointments and would be the leader of the ICS locality team who would hold a delegated budget for that place. Nominations had been asked for a named Executive for each place as a link person. This role would not necessarily be the system leader who would Chair the partnership. System working was moving faster than the ability to appoint to senior roles.

Peter Armer reported that through VCFSE discussions, it was emerging that cross-cutting services were being developed with capabilities centrally. Peter asked how the ICPs would take these capabilities as they are developed and how would they be deployed in ICPs.

It was highlighted that the scheme be mirrored with the executive team and Lay Chairs as it would be important to have a balance between executives lead and lay leads in terms of shaping the future of an organisation. It was felt that both the interim chairs and interim place leaders-role should be filled quickly.

The Chair summarised that development work within the ICPs and DAG was an example of the Lancashire and South Cumbria system working well.

Sarah James (SJ) emphasised that each place-based partnership must agree a Chair by 30 June. To avoid confusion in roles, different terminology would be considered and clarity/reassurance would be provided on the appointment of the permanent roles to ensure involvement of ICP partners.

RESOLVED: The ICS Board:-

- **Noted the approach used to engage system leaders in Step 2 of the ICP development programme, particularly the ICP Maturity Matrix and the externally facilitated workshops**
- **Approved the proposals on:**
  - **Immediate actions to accelerate the development of place-based partnerships in the next 3 – 6 months, and**
  - **The content of a broader development programme across the whole of 2021/22, linked to the more challenging aspects within the common ICP strategic narrative and informed as appropriate by national guidance**
- **Noted the progress made on the development of core content of a partnership agreement for use by each of five place-based partnerships**
- **Approved the continuation of the ICP Development Advisory Group and its key activities**
- **Approved the use of the ICP Maturity Matrix process in November 2021.**

b) System Narrative, Toolkit for Leaders and Case Studies – Andrew Bennett (AB) explained the narrative was an explanation of integrated care at system place and neighbourhood levels, being a toolkit of content, not a fixed document that could be used with staff and stakeholders. The document was open to having more case studies coming through and would remain a living document. It was felt that the acronym 'ICS' was now starting to create confusion in light of

	the White Paper; Neil Greaves/Andrew Bennett would ensure clarity in future when referring to ICS'. **RESOLVED: The ICS Board:-** - **Endorsed progress on the integrated care narrative and the toolkit for use by leaders when describing the development of integrated care in Lancashire and South Cumbria** - **Endorsed the use of the summary document (currently in draft and would include minor amendments) and case study examples for use with staff, partners, and stakeholders as part of a wider engagement plan involving partner communications and engagement teams.**
7.	**Development of Remote Health Monitoring in Lancashire and South Cumbria and Docobo Contract** Gary Raphael (GR) explained that the pilot would be for 1 year only and built onto the contract being run by West Lancashire CCG, linking into national preferred contractors for NHSX who had provided funding for this year to examine whether the solution that was being tested would work in the long term. A report update would be brought to a future meeting, explaining how this would prevent people coming to hospital as emergency admissions throughout the year. Members expressed support to the report in general. Discussion included:- - Caroline Donovan (CD) expressed concern about the longevity of the contract and pilot, which had been written whilst in the pandemic, with assumptions made about mental health patients; CD and GR to discuss outside of this meeting. The ICS would need to be advised by the Lancashire and South Cumbria Foundation Trust Board **ACTION: CD/GR** - GR confirmed that the decision today (for a pilot study) would not necessarily be the future way of working or limit working with different partners - This was taken forward as a single tender waiver as Doboco already delivered a similar approach in West Lancashire - The clinical model would need consideration, ie, what this looks like, how this fits - SFI require ICS Board approval for any value over £0.5m; approval to spend the amount of money was sought. The money would be provided by NHSX and the ICS would be required to report to them. The procurement team had advised this to be an acceptable way forward. The ICS Board was asked to approve the amount being spent by the ICS - It was confirmed that there were many different projects taking place in digital both across the system and in individual organisations. This pilot was an ask of the national team - Karen Partington asked to ensure that clinical information officers and digital teams in wider organisations had been engaged in process - The pilot would be about digital infrastructure to enable services to be put in place. Clinical models were being worked by individual teams - Work on local models would continue. **RESOLVED: Subject to agreement by Lancashire and South Cumbria Foundation Trust on mental health patients within the contract award, the ICS Board:-** - **Noted the progress regarding remote health monitoring across Lancashire and South Cumbria to date and future plans** - **Approved the amount spent being over £0.5m, in line with SFIs**

	- **Agreed to receive a further report on remote health monitoring from the rapid review options appraisal exercise.**
8.	**Elective Recovery Accelerator Programme –** Members noted the update provided by Amanda Doyle under 'Key messages' at this meeting. Discussion to take place at the next meeting.
Routine Items	
9.	**Items to forward to the next ICS Board Meeting** No items were raised at the meeting.
10.	**Any Other Business** There was no other business raised.
Date and Time of the next Formal ICS Board Meeting: Wednesday 2 June 2021, 10.00 am -12.30 pm, MS Teams Videoconference	

Lancashire and South Cumbria
Health and Care Partnership

ICS Board – Action/Decision Log (Updated 21 May 2021)

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
ICSB210505-07	Remote health monitoring and Docobo Contract – Concerns made re longevity of contract and pilot; assumptions had been made about mental health patients. GR and CD to discuss outside of this meeting.	Caroline Donovan Gary Raphael	Open	June 2021	
ICSB210505 – 03	Primary Care Demand – To update the ICS Board re capacity and demand on primary care	Amanda Doyle	Open	July 2021	On 2 June 2021 Agenda.
ICSB210704 – 07	**System Reform –** To ensure ICS Board has sight and clarity on review of progress to the priorities, ie, mental health, elective restoration, cancer, 52 week wait, etc.	Amanda Doyle / Executive Team	In progress	May 2021	
ICSB210704 – 05b	**Elective Recovery Plan –** Refreshed trajectories to be reported to future meeting.	Kevin McGee	In progress	July 2021	
ICSB201202	Ensure process for equality impact assessments	Talib Yaseen	In progress	April 2021	• Exploratory work completed with Midlands and Lancashire CSU to explore the process for EIA that is in place across all 8 CCG's and provided by the CSU under contract to the CCG's. • Paper to be prepared on transitioning to this service and the interim arrangements for the ICS in 21/22 to ensure EIA are completed in a timely manner. • On completion of the above paper, a meeting to be arranged with the lead ICS Board Non-Executive Director on

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
					EIA process and the proposed plan before presentation to the ICS Board

ICS Board

Title of Paper	ICS Operational Plan – 2021/22 H1		
Date of Meeting	2 June 2021	Agenda Item	5/6

Lead Author	Carl Ashworth, Gary Raphael		
Contributors	-		
Purpose of the Report	Please tick as appropriate		
	For Information	✓	
	For Discussion	✓	
	For Decision		
Executive Summary	The Lancashire & South Cumbria ICS is required to submit operational plans for the first half of 2021/22 on Thursday 3rd June 2021. This paper is intended to provide the ICS Board with an assessment on the content of the operational plans and how they compare to the expectations of the 2021/22 H1 priorities and operational planning guidance.		
Recommendations	The Board is asked to **note** the summary assessment.		
Equality Impact & Risk Assessment Completed			Not Applicable
Patient and Public Engagement Completed			Not Applicable
Financial Implications	Yes		
Risk Identified			No
If Yes : Risk			
Report Authorised by:	Carl Ashworth, Strategy and Policy Director		

1. Introduction

The Lancashire & South Cumbria ICS is required to submit operational plans for the first half of 2021/22 on Thursday 3rd June 2021 - the full portfolio of plans comprises:

- Executive Summary/Context
- Narrative template
- Activity and performance template
- Workforce template: Acute, primary care and community
- Workforce template: Mental Health
- Finance template: System submission
- Finance template: Mental Health submission
- Finance template: Provider finance submission
- APPENDIX – supporting documentation

The narrative submissions are intended to provide additional information against the activity, performance and workforce plans and further detail to support national and regional assurance on our system operational plans. The narrative aligns with local delivery plans being developed to address each service area.

The financial plans were submitted in final form on the 6th May, although some revisions to take account of Accelerator income and expenditure will be required – all other plans were submitted in draft form on that date and have been subject to regional and national scrutiny. The final versions respond to feedback delivered through this process and take account of the more detailed work undertaken to scope and develop elective recovery and reform plans.

The financial plans are discussed elsewhere on the Board agenda – suffice to say here that we have ensured that the constraints imposed by submitting plans that balance to the system financial envelope for the first half of 2021/22 have also been reflected in the final versions of the activity, performance and workforce templates and the associated narrative.

This paper is intended to provide the ICS Board with an assessment on the content of the operational plans and how they compare to the expectations of the planning guidance.

2. Process for plan development

The operational plans have been developed via system-wide forums, including an Operational Planning Coordination Group; the Elective Care Recovery Group; and the ICS Hospital and Out-of-Hospital cells. All Trusts, CCGs and Local Authorities that make up the ICS have been engaged via a number of supporting working groups including activity, finance and workforce.

Engagement with leaders across L&SC has been through the meetings of the System Leaders' Executive Group. For oversight and sign-off, the following role for the ICS Board was agreed and actioned:

- To guide executives on deciding relative (competing) priorities across the various sectors in the ICS
- Where policy is clear, for example the money required for mental health, the consequential beneficial impacts on other parts of the system are determined
- To test the extent to which our aspirations are sufficiently ambitious.
- Whether or not the plan is sufficiently coherent, and activity, finance and workforce aspects are aligned.
- Testing the credibility of our plans.
- To seek assurance on the extent to which the plans align with strategic clinical plans and intentions
- Assurance on meeting requirements within the resources available without committing large elements of recurring resource to elective recovery

In line with this role, at the meeting on the 5th May 2021, the ICS Board received an update on the status of the draft operational plans and in particular the position on system financial plans. The Board accepted the proposed approach to finalising these plans before submission - this was subsequently communicated to partners prior to final submissions of organisational finance plans.

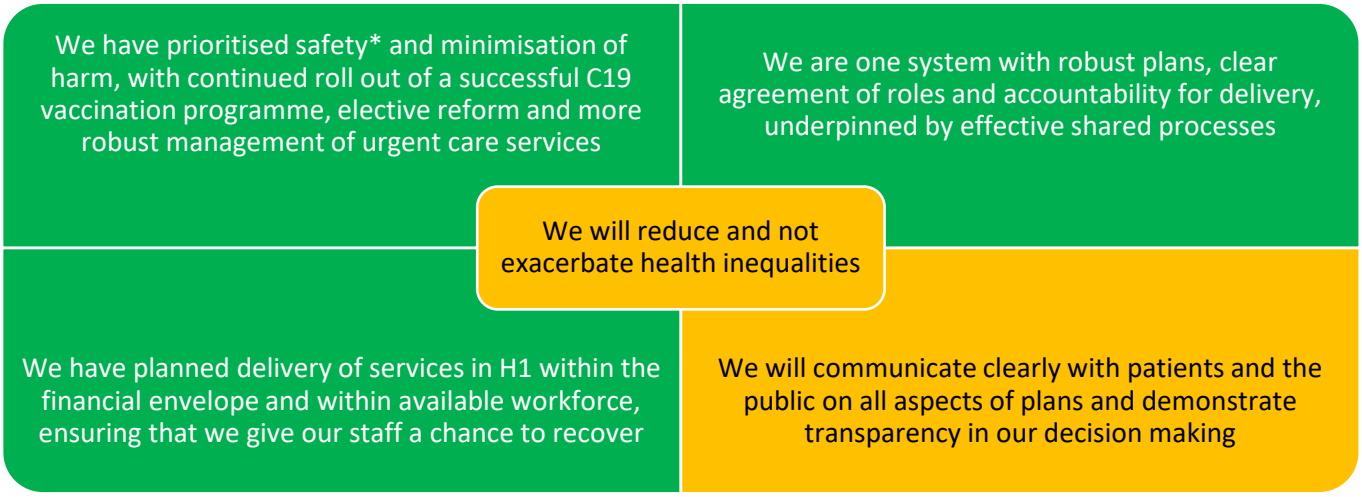
The Board acknowledged that:

- given the time constraints on the development of our plans, we have had to run the agreement of final, balanced financial plans in parallel with the development of the plan narrative and our activity, performance and workforce plans
- the final set of decisions that has allowed us to live within our financial envelope for H1 has meant that implementation of some elements will occur later in the year
- during May the system needed to amend the activity, performance and workforce plans, and the underpinning narrative, to reflect the impact of the constrained financial position.

The final versions of the operational plans have been developed in line with the above expectations.

3. Delivery against critical success factors

The following critical success factors were agreed at the commencement of the system operational planning process:



**mapping delivery of care to CQC Domains*

All critical success factors have been met, either fully (coloured green above) or in part (coloured amber):

- The constraints of the submitted financial plans mean that we have limited funds available in H1 to focus on the population health management approach needed to reduce health inequalities immediately. However, we are assured that the process in place to restore services – especially elective care – has been designed to ensure that we do not exacerbate such inequalities
- Detailed communication plans are being developed to support the restoration of services – however, we are not yet at the point where we have mobilised those plans

4. Key changes from draft plan submissions

In advance of the submission of our final plans, we have notified the NHSEI NW regional team of the following changes to our plans since the draft versions we shared in early May:

- we will be uprating our activity trajectories to achieve Accelerator programme targets at 120% of 2019/20 baselines by Quarter 2
- workforce plans will be amended to show increased use of agency and locum staff to assist us in delivery of the Accelerator programme
- financial plans will change to reflect the cost of Core plus and Accelerator programmes and the extra income we expect

5. Summary assessment against expectations of our operational plans

The tables in the Appendix to this document provide the ICS Board a summary of the expectations of the operational planning guidance by priority area and an assessment of the extent to which we have been able to meet these expectations in our plans given financial and workforce constraints. For ease of reference, these have been given RAG status to indicate expectations fully met (green) partly met (amber) and not met (red).

6. Next steps

Following submission of the final H1 operational plans on 3rd June, there will be a further process of regional and national review and assurance. In the meantime, if not already underway, the plans we have outlined for each priority service area will be mobilised immediately. Organisational cost improvement plans have been developed to deliver the 3% savings necessary to deliver H1 financial plans; and system-wide schemes are being scoped to ensure delivery of another 2% (£88m) in a full year, with assumptions on the part year effect this year being the subject of further investigation over the next three months. This is being overseen by the System Financial Recovery Board.

Carl Ashworth
Gary Raphael

1st June 2021

APPENDIX

ASSESSMENT OF COMPLIANCE OF OPERATIONAL PLANS vs GUIDANCE

Priority Area Ref	Priority Areas	Specific Action	LSC Plan compliance	Notes
A	Supporting the health and wellbeing of staff and taking action on recruitment and retention	**A1 Looking after our people and helping them to recover**	High	All organisations have developed and mobilised plans for: - Staff to carry over unused annual leave - Individual health and well being reviews - Occupational health & well being support, including the MH resilience hub
		A2 Belonging in the NHS and addressing inequalities	Medium	System plans to improve diversity through recruitment and promotion practices. International recruitment plans limited due to COVID travel restrictions. Assessments undertaken for staff more at risk from Covid infection.
		A3 Embed new ways of working and delivering care	High	All organisations have developed plans to maximise utilisation of e-rostering systems to support more effective deployment of staff, mutual support and continue to develop staff digital passport to allow the movement across system
		A4 Grow for the future	Medium	All organisations have submitted robust workforce supply plans that cover all service areas, including Acute care, MH, community services and PCNs. Whilst we have plans to maximise the use of medical support and healthcare support workers, supply plans to reduce reliance on bank and agency staff rely upon international recruitment which is currently constrained due to COVID travel restrictions
B	**Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID**		High	The ICS COVID vaccination programmes continues successful rollout across populations and cohorts in line with national and regional expectations. The system continues to monitor tactically pressures across providers through Gold Command and further surge plans, with set thresholds for action, have been agreed. Access to ongoing support for patients suffering from long COVID have been implemented to ensure they receive coordinated support to a wide range of ongoing symptoms

Priority Area Ref	Priority Areas	Specific Action	LSC Plan compliance	Notes
C	Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services	**C1 Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services**	High	System partners have developed plans to maximise capacity, including utilisation of the independent sector. Core/core plus plans aim to deliver elective capacity at the 2019/20 outturn levels in line with the trajectory set out in the planning guidance. The Accelerator bid submitted by the ICS goes beyond this ambition, looking to deliver 120% of the 2019/20 baseline through investment in key enablers. Plans to reduce waiting lists prioritise the most clinically urgent and address longest waiters but aim to minimise the further exacerbation of health inequalities. Although plans require additional staff to deliver them, account has been taken for opportunities to implement high impact service models, reduce unwarranted variation in practice and embed the out-patient transformations seen during the pandemic.
		C2 Restore full operation of all cancer services	High	ICS Cancer Alliance partners have developed plans for service restoration, aiming to return over 62 day waiters to Feb 20 levels and to address shortfall in number of first treatments. Cancer activity levels require achievement of 105% of 2019/20 levels in order to meet current demand and up to 115% in order to clear backlogs, this being facilitated through the accelerator scheme. However, there are constraints around access to endoscopy capacity - it is intended to ensure that Accelerator funds support action to overcome this risk.
		C3 Expand and improve mental health services and services for people with a learning disability and/or autism	High	System service and worksforce plans for MH aim to deliver the service improvement ambitions of the Long Term Plan, as well as maintain benefical changes to delivery seen under COVID. Additional investment set out within financial plans goes beyond the required MH Investment Standard in line the expectations set out by the ICS Board. Plans for services for people with Learning Disabilities deliver access to annual health checks and to reduce reliance on inpatient care for people with LD. Plans also mobilise national LEDER policy.
		C4 Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review	High	System plans for maternity services deliver service improvement expectations of the Long Term Plan as well as setting out partner responses to the early outcomes of the Ockenden review. Some providers are developing business cases for aditional midwives to deliver Continuity of Care expectations - associated costs have not been covered within H1 financial plans, but will look to delivery in H2.

Priority Area Ref	Priority Areas	Specific Action	LSC Plan compliance	Notes
D	Expanding primary care capacity to improve access, local health outcomes and address health inequalities	D1 Restoring and increasing access to primary care services	Medium	Plans developed across all LSC ICS PCNs continue to make progress on restoring access to primary care and to increase service capacity in line with LTP expectations, including the increase of PCN roles such as social prescribers and the expansion of GPs towards the national target. Challenges currently being faced in relation to 'stored up' demand, covid care and covid vaccination delivery pressures are being managed by largely the same workforce
		D2 Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities	Medium	The ICS has well established plans to reduce ill health being developed by partners through clinical networks and Local Authority PH leads and implemented through ICPs and PCNs. In developing its Population Health Management programme, the ICS aims to maximise improvement in outcomes and tackle inequalities at neighbourhood level, using PHBs, social prescribing and personalised care. Anticipated investment in PHM for H1 has been constrained by plans to live within the system financial envelope, pushing significant actions into H2 and 2022/23
E	Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay	E1 Transforming community services and improve discharge	Medium	Work across community service providers has developed plans to accelerate the roll out of 2 hour crisis response for such services, as well as support timely and appropriate discharge from hospital. Whilst funding is available through the Ageing Well programme, workforce contraints suggest that current plans for signficant staff increases to deliver the 2 hour crisis response may be ambitious in the short term, without impacting on other sectors of the system.
		E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments	High	The LSC UEC network has developed with NWAS plans to promote NHS 111 as the primary route into urgent care and to maximise utilisation of direct referral from NHS 111. Plans have been developed to adopt a common Same Day Emergency Care model across the system. System partners have agreed the roll out reporting of the Emergency Care Data Set

Priority Area Ref	Priority Areas	Specific Action	LSC Plan compliance	Notes
F	**Working collaboratively across systems to deliver on these priorities** *NB Assurance on this section of the operational plan guidance is taking place outside of the scope of this planning return*	**F1 Effective collaboration and partnership working across systems**	High	The system had developed its capabilities prior to Covid and has since progressed significantly in the delivery of the vaccination programme, operation of an effective Gold control function as well as ensuring effective arrangements for planning and control functions, e.g. capital. Plans are in place for the ICS to set out and agree an MOU with NHSEI by Q2 to underpin assurance on ICS operation during transition to a formal ICS. The MOU will set out ICS oversight structures to deliver the national system oversight framework
		F2 Develop local priorities that reflect local circumstances and health inequalities	Medium	The ICS response to the Long Term Plan, agreed in January 2020, set out ICS plans to improve population health and tackle health inequalities through the PHM programme. Financial constraints limit impact during H1, with the expectation that activities will be ramped up during H2. The ICS LTP also set out plans to enhance productivity and contribute to the broader social and economic development (anchor institution requirements) - both of these remain key priorities for the ICS as we move away from the pandemic response
		F3 Develop the underpinning digital and data capability to support population-based approaches	Medium	The ICS has a clear digital strategy and a major work programme for the implementation of a common approach to EPRs, common departmental systems like maternity and a data orchestration eco-system that will deliver the information required for operational delivery and BI/population health insights. Implementation of Graphnet to support the vaccination programme across NW England will be assessed to obtain insights into its ability to support PHM and a concurrent approach to procurement of Graphnet in the longer term or another system will ensure that from April 2022 the ICS has a robust system to support population-based approaches
		F4 Develop ICSs as organisations to meet the expectations set out in Integrating Care	High	The ICS is developing a System Development Plan for this transition year in preparation for the move to statutory footing in April 2022 and has well-established governance arrangements to manage the transition to a statutory ICS and ensure delivery of priorities in 2021/22.
		F5 Implement ICS-level financial arrangements	Medium	The ICS has submitted a balanced system financial operating plan for H1 of 2021/22 in line with national expectations, has implemented strengthened system financial governance to oversee delivery of the plan (a system financial recovery board) and is working with Regional and National finance teams on longer term financial sustainability. If this aspect of our plans were assessed on the longer term, rather than H1 plans, the RAG rating would be red.

ICS Board

Title of Paper	Revenue Financial Plans (Current Year H1 and issues for H2)		
Date of Meeting	2 June 2021	Agenda Item	6

Lead Author	Gary Raphael, Executive Director of Finance and Investment	
Contributors	Elaine Collier, Head of Finance	
Purpose of the Report	Please tick as appropriate	
	For Information	✓
	For Discussion	✓
	For Decision	
Executive Summary	This paper reports on the H1 plan submission for 2021/22 for the L&SC system, updates the Board on the result of the call with the national CFO and looks forward to the issues for resolution in H2.	
Recommendations	The Board is asked to **note** the updates on the H1 planning submission for 2021/22 and the look forward to issues requiring resolution in H2 and beyond.	
Next Steps	As above.	
Equality Impact & Risk Assessment Completed	Not Applicable	
Patient and Public Engagement Completed	Not Applicable	
Financial Implications	Yes	
Risk Identified	Yes	
If Yes : Risk	As detailed in the report	
Report Authorised by:	Gary Raphael	

Revenue Financial Plans
(Current Year H1 and Issues for H2)

Introduction

1. This paper reports on the H1 plan submission which covers the first half of the year April to September 2021. This refers to the system financial submission rather than individual organisation plans as detailed submissions for providers are not due until after the writing of this report. The report also looks forward to the issues for resolution in H2.

2. As reported in the financial outturn report, also on this Board's agenda, the System returned a deficit of £19.8m in 2020/21 which, if the annual leave accrual and non-NHS income losses are added back to give a comparison to the plans for H1 this year, would be equivalent to a £59m deficit. It is this magnitude of deficit brought forward that provides the backdrop for the development of H1 plans.

System Planning Overview

3. L&SC submitted a compliant plan for H1, demonstrating that we were planning to break-even after applying the benefit of Elective Recovery Funding (ERF) income.

4. The table below shows the position submitted was a net system deficit of £22.4m offset by ERF income of £20.4m. The remaining £2m deficit shown relates to a technical deficit for NWAS 111First and recognises that funding has only been allocated for quarter one at this stage. This presentation was directed by the national team prior to submission and is an issue that they are following up.

Table 1 – L&SC system planning overview for H1:

System Planning Overview	2021/22 H1 £m
CCG local organisation contribution	0.0
Provider local organisation contribution	(22.4)
Net system position	(22.4)
Elective Recovery Fund Income	20.4
L&SC SYSTEM SURPLUS / (DEFICIT)	**(2.0)**

Planning Risks

5. Whilst the plan is compliant, there are a number of risks identified which may impact on delivery, namely:

- An ambitious level of efficiencies – this is covered separately below
- Removal of CCG contingencies of 0.5% (normally a planning business rule)
- Spending deferred to H2 e.g. continuity of carer
- Spend retained but recognising the realistic delays in implementation, especially where additional staffing is required e.g. population health management

- Slower recovery of non-NHS income than planned
- Out of envelope costs not being eligible for national funding (vaccinations and testing costs for trusts, hospital discharge programme costs for CCGs)
- ERF activity/workforce costs being higher than planned
- Activity targets not being met, putting ERF income at risk

Efficiencies

6. L&SC have set an ambitious target for efficiencies in H1, being 3% for all trusts and 3% of influenceable spend for CCGs. This equates to £55.8m for the system as shown in the table below. This is currently the biggest area of risk identified in CCG and provider plans.

Table 2 – L&SC planned efficiencies for H1:

Efficiencies Overview	Identified Schemes	Currently Unidentified	2021/22 H1
	£m	£m	£m
CCG efficiencies	8.1	10.7	18.8
Provider efficiences	28.7	8.3	37.0
L&SC TOTAL EFFICIENCIES	**36.8**	**19.0**	**55.8**
	66%	34%	

7. A recent exercise has identified that organisations have identified schemes for 66% of this total. The table shows that a higher proportion of CIPs has been identified in providers. Three CCGs that have been unable to provide the detail behind their plans have nevertheless reported the intention to meet CIP targets. Work is ongoing to identify schemes for the remaining 34% and organisations are stepping back up their internal governance and processes to monitor delivery, having previously stepped these down during the Covid response. The ICS will be tracking performance against these plans.

8. Delivery of these efficiencies in H1 is critical, not just to meet the planning requirements but also to start the recovery of system finances. The ask in H2 will be even greater, as our ambition is to end the financial year with plans for 5% efficiencies. This means that organisational plans will need to be supplemented by system wide schemes to ensure we are able to put L&SC on a more sustainable footing for the future.

9. Overall the System is on the way to be able to confirm and have greater confidence in its plans, but the acid test for delivery will be our progress in demonstrating that the monthly run rates for April 2021 are no higher than those for March 2021 (to the extent that we can disentangle the technical complexities) and that from April onwards run rate positions are in line with our planning profiles. This will be reported to the Board once we have the figures for April and May 2021.

Other Considerations / Mitigations

10. As previously indicated, the H1 plan includes ERF assumptions in respect of the level of activity that can be delivered (90% of 2019/20 activity in line with actual delivery in April 2021) and the level of ERF income that may be earned. This is currently being used to show a balanced/compliant plan assuming £20m non-recurring ERF income. However, we have currently been quite prudent in our assumptions and if our activity numbers reach the levels that we think should be achievable from our 'core-plus' scenario, this will earn additional ERF income and therefore help to mitigate some of the delivery risks previously identified. Of course, the key

issue here is to ensure costs incurred do not rise above income levels (less the £20m already included in the financial plans).

11. The H1 plan also includes a level of system development funding (SDF) of £20m. This has been allocated to L&SC to deliver specific national LTP requirements. The plan currently assumes both income and expenditure for this SDF, but where it can be evidenced that these LTP requirements are already being delivered as part of business as usual, then we must ensure that we are not utilising this funding to create additionality.

12. The H1 plans for finance were submitted as final on 6 May 2021 but the final activity and workforce submissions will only be submitted at the beginning of June. Assumptions have been made in the finance return for the impact of elective recovery but once all the submissions are final, we will need to ensure that our assumptions align. Work is also currently progressing on the elective recovery core-plus and accelerator schemes, requiring revision of finance plans by 21st June.

Looking forward to H2 Planning

13. We are still awaiting details on the form of planning for H2. It is perhaps unlikely that we will revert back to CCG allocations but rather that we will have some form of hybrid arrangements again. It may be prudent to assume that we will not get any additional system funding in H2, particularly for Covid, and therefore we need to constantly review our expenditure run rates to ensure we are not recurrently committing spend that does not have recurrent funding, and that we are continually questioning whether items of spend are still relevant. This will be informed though the peer review process being undertaken by the System and supported by an external director of finance colleague, with an interim report due at the end of June.

14. The Financial Recovery Group is up and running and has identified key pieces of work to support the system. To help deliver the ambitious efficiency plans for both H1 and H2, the ICS is working to supplement organisational schemes with collaborative system-wide schemes. A system diagnostic piece of work has also been commissioned to identify key cost drivers/drivers of deficit to help focus transformation plans to support H2 and 2022/23 planning.

15. In the meantime, and following the call with the national CFO, the System has been asked to provide details of this year's cost improvement programme, including savings profiles, for the £200m savings committed to by the ICS Board.

16. H1 has cut across our original intentions, which were articulated before the arrangements for H1 were known. H1 plans are about spending more money (funded by the ERF) to recover elective activity levels and treat more patients on the waiting list, which have built-up during the Covid pandemic. We have a compliant H1 plan, but we know that when we revert to our historic allocation levels we will have a substantial deficit, which makes it essential that we continue with our recurring savings programme.

17. The Board will be aware that we have taken a twin track approach to the recovery programme:
    - A pragmatic set of proposals in H1 and H2 this year, to ensure we meet planning requirements and gain momentum on recurring savings – overseen by the System Financial Recovery Board
    - Use of a system diagnostic to enable the System Financial Recovery Board to develop a strategic approach to cost effective service changes

18. Our objective for H1 and H2 will be to ensure that organisations deliver their 3% CIPs (£56m + £56m = £112m) and that a system-wide approach is adopted to scope and ensure implementation in organisations of another 2% recurring savings (£88m) with as large a part year effect as possible in H2 this year. It is on this basis that a report will be produced for the national CFO by the 4th June.

Conclusion

19. The System has developed complaint H1 financial plans for which a reasonable degree of confidence can be obtained from the reports of CIP identification – our highest risk area. The Board will wish to have confirmation that all CIPs have been identified in the near future, together with any contingency measures that can be put in place.

20. Assurance on delivery of financial plans awaits further information on run rate analyses; the first checkpoint next month (July) will be to compare April and May run rates to that of March 2021, together with any other information that enables delivery risk to be assessed.

21. Our plans for H2 will be linked to the previous decision of the Board to deliver a £200m recurring savings programme (adapted to take account of H1 plans). An early view on 3% CIP delivery and potential additional system-wide schemes will be reported to the national CFO, who will want to hold us to account for delivery.

Recommendation

22. The Board is asked to **note** the updates on the H1 planning submission for 2021/22 and the look forward to issues requiring resolution in H2 and beyond.

Gary Raphael
ICS Executive Lead for Finance
24 May 2021

ICS Board

Title of Paper	Capital Planning 2021-22		
Date of Meeting	2 June 2021	Agenda Item	7

Lead Author	Gary Raphael, Executive Director of Finance and Investment	
Contributors	Gareth Jones, ICS Finance	
Purpose of the Report	Please tick as appropriate	
	For Information	✓
	For Discussion	✓
	For Decision	✓
Executive Summary	This paper reports on the 2020/21 provider capital plan in the context of an envelope of £112m.	
Recommendations	The Board is asked to **note** the work undertaken to date, the process going forward to control spending and the requirement to review the position at 6 and 9 months, particularly to ascertain our ability to fund backlog maintenance items from any slippage that may occur. The Board is also asked to **approve** the capital plan.	
Next Steps	As above.	
Equality Impact & Risk Assessment Completed	Not Applicable	
Patient and Public Engagement Completed	Not Applicable	
Financial Implications	Yes	
Risk Identified	Yes	
If Yes : Risk	As detailed in the report	
Report Authorised by:	Gary Raphael	

Capital Planning 2021/22

1. For 2021/22 the ICS has been allocated a capital envelope of £111.977m. In 2021/22 the capital envelope was £138.772m. The reduction in year is primarily linked to the fact that the 2020/21 envelope included an additional amount for emergency capital loans which were already approved. Notwithstanding this the envelope for 2021/22 presents a significant challenge for the ICS and one that will need to be carefully managed as the year goes on.

2. Capital spend that scores against the envelope includes all internally generated resources (i.e. depreciation) as well as spend against emergency capital loans, new or pre-approved, received in the form of PDC. Spend on nationally funded projects such as HIP2 and Urgent and Emergency Care do not score against the capital envelope.

3. Organisations within the ICS were required to submit a capital plan to NHSI/E at the end of April. The ICS managed a process around this which culminated in an envelope compliant capital plan being submitted, i.e. total planned spend of £112m which included a contingency of unallocated monies totalling £10.7m. Outside of these plans there was futher requests for capital spend by providers totalling £58.3m. This is summarised in the tables below.

Table 1: ICS Delegated CDEL - Opening Plan

	LTH £000	ELHT £000	BTH £000	UMBHT £000	L&SCFT £000	NWAS £000	Total £000
Self Financed - Depreciation less PFI/Finance Lease payments	18,984	6,068	14,800	17,118	10,102	15,278	82,350
Capital loan repayments (net of Capital Refinancing PDC)	(3,756)	(200)	(2,800)	(507)	(2,571)	0	(9,834)
Sub total: Net Internal Sources	15228	5868	12000	16611	7531	15278	**72,516**
Approved/Pre committed:							
Interim Support Capital PDC (Pre Committed) R2C	4,000	1,500	900	2,000	100	0	8,500
Other PDC (Pre Committed) - Approved:							
LTH Ophthalmology - final instalment	2,000						2,000
ELHT EPR		3,851					3,851
BTH 2020/21 Emergency Loan carried forward			5,600				5,600
BTH RAAC			1,200				1,200
UHMB emergency loan				7,600			7,600
Total Other PDC (Pre Committed) - Approved:	**2,000**	**3,851**	**6,800**	**7,600**	**0**	**0**	**20,251**
Total pre committed	**6,000**	**5,351**	**7,700**	**9,600**	**100**	**0**	**28,751**
Total Charge against Capital Allocation	**21,228**	**11,219**	**19,700**	**26,211**	**7,631**	**15,278**	**101,267**
Contingency							**10,710**
Allocation							**(111,977)**
Balance							**0**
Total Charge against Capital Allocation as per plan submission	**23,473**	**12,406**	**21,783**	**28,983**	**8,438**	**16,894**	**111,977**

Table 2: Additional Requests

	LTH £000	ELHT £000	BTH £000	UMBHT £000	L&SCFT £000	NWAS £000	Total £000
Two hubs - Bpool and Preston						5,786	5,786
Emergency generators - Emergency funding		1,900					1,900
Backlog maintenance	4,200	1,900	1,900	6,000	2,200	800	17,000
TBD					2,571		2,571
MH Dorms					3,060		3,060
Stroke (PYE)	2,000	2,000					4,000
Thrombectomy (PYE)	1,500						1,500
Vascular	1,500						1,500
Elective streaming		6,000		8,000			14,000
Diagnostics streaming	3,000			1,000			4,000
Digital	3,000						3,000
	15,200	11,800	1,900	15,000	7,831	6,586	58,317

4. The plan submitted was therefore comprised of £72.5m of internal resource spend, £8.5m reinstatement of the 2020/21 revenue to capital transfers, £20.3m of other approved PDC already committed (i.e. loans pre approved plus £1.2m relating to RAAC at Blackpool) and £10.7m contingency.

5. It was apparent that a peer review of individual organisational plans was required in order to validate the spend funded by net internal resources (£72.5m) to gain assurance that this spend is appropriate, consistent across all providers and not being spent on discretionary items such as development business cases. Trusts were therefore asked to provide more information on their internally funded schemes and also to flag any other pre-committed schemes.

6. The make up of the £72.5m is shown in the table below. This shows that only £2.772m of the planned spend is uncommitted. Note in the table below capital loan repayments of £9.8m are the first call on the £81.5m of total internally generated funds.

Funding Source	21/22 Plan	Medical Equipment (Replacement)	Medical Equipment (New)	Backlog - Significant and High Risk	Backlog - Other	IT	Clinical Improvement	Major Schemes	Legislative / Regulatory Compliance	Vehicles	Uncommitted	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
PDC	57,131	0	0	6,000	0	4,823	0	41,861	0	0	2,772	1,675
Matched funding	200	0	200	0	0	0	0	0	0	0	0	0
Internally Funded	81,450	7,493	500	6,951	2,892	16,215	6,829	25,364	5,375	5,501	0	4,330
Carried forward PDC (drawn in Pyr and not spent)	0	0	0	0	0	0	0	0	0	0	0	0
Loans (Normal)- approved	5,602	1,693	0	580	907	795	118	0	1,509	0	0	0
Loans (Normal)- to be approved	900	0	0	900	0	0	0	0	0	0	0	0
Loans other (e.g. Salix)	0	0	0	0	0	0	0	0	0	0	0	0
Carried forward Loans (drawn in Pyr and not spent)	0	0	0	0	0	0	0	0	0	0	0	0
Normal course of business loan finance - Approved (National Allocation)	0	0	0	0	0	0	0	0	0	0	0	0
Proposed new capital loan 1 - to be approved	0	0	0	0	0	0	0	0	0	0	0	0
Proposed new capital loan 2 - approved	0	0	0	0	0	0	0	0	0	0	0	0
Proposed new capital loan 2 - to be approved	0	0	0	0	0	0	0	0	0	0	0	0
	145,283	**9,187**	**700**	**14,431**	**3,799**	**21,833**	**6,947**	**67,225**	**6,884**	**5,501**	**2,772**	**6,005**

7. Trusts have flagged further pre-committed schemes, which has reduced the contingency to £0.9m as shown below. The list of additional requests has also been refreshed and now totals £60.9m as also shown below.

	LTH £000	ELHT £000	BTH £000	UMBHT £000	L&SCFT £000	NWAS £000	Total £000
Self Financed - Depreciation less PFI/Finance Lease payments	18,984	6,068	14,800	17,118	10,102	15,278	82,350
Capital loan repayments (net of Capital Refinancing PDC)	(3,756)	(200)	(2,800)	(507)	(2,571)	0	(9,834)
Sub total: Net Internal Sources	15,228	5,868	12,000	16,611	7,531	15,278	**72,516**
Approved/Pre committed:							
Interim Support Capital PDC (Pre Committed) R2C	4,000	1,500	900	2,000	0	0	8,400
Other PDC (Pre Committed) - Approved:							
LTH Ophthalmology - final instalment	2,000						2,000
ELHT EPR		3,851					3,851
BTH 2020/21 Emergency Loan carried forward			5,600				5,600
BTH RAAC			1,200				1,200
UHMB emergency loan				7,600			7,600
Emergency Oxygen		475		600			1,075
Emergency Generators		1,950					1,950
Lift Hardening for Fire				200			200
Steam Pipe replacement				486			486
Blackpool H&S						3,083	3,083
Disposal of Ridge Lea					(2,500)		(2,500)
Wesham & MH Dorms commitments					2,571		2,571
MH Dorms (Hurstwood)					3,060		3,060
Total Other PDC (Pre Committed) - Approved:	**2,000**	**6,276**	**6,800**	**8,886**	**3,131**	**3,083**	**30,176**
Total pre committed	**6,000**	**7,776**	**7,700**	**10,886**	**3,131**	**3,083**	**38,576**
Total Charge against Capital Allocation	**21,228**	**13,644**	**19,700**	**27,497**	**10,662**	**18,361**	**111,092**
Contingency							**885**
Allocation							**111,977**
Balance							0
Total Charge against Capital Allocation as per plan submission	**23,473**	**12,406**	**21,783**	**28,983**	**8,438**	**16,894**	**111,977**

Table 2: Additional Requests

	LTH £000	ELHT £000	BTH £000	UMBHT £000	L&SCFT £000	NWAS £000	Total £000
Two hubs - Bpool and Preston							0
Emergency generators - Emergency funding		0					0
Backlog maintenance	4,200	0	1,900	6,000	2,200	850	15,150
Backlog maintenance - HIGH RISK		1,850					1,850
Backlog maintenance - SIGNIFICANT RISK		5,552					5,552
TBD					0		0
MH Dorms					0		0
Stroke (PYE)	2,000	2,000	750				4,750
Thrombectomy (PYE)	1,500						1,500
Vascular	1,500						1,500
Elective streaming		6,000		8,000			14,000
Diagnostics streaming	3,000			1,000			4,000
Digital	3,000						3,000
Pharmacy Robot			600				600
Electronic Patient Record Components (PAS) incl eObs and Blood Tracking			3,300				3,300
Agile Working (Emis Optimisation)			1,103				1,103
Community diagnostics			3,536				3,536
Parkwood demolition			1,100				1,100
							0
							0
	15,200	15,402	12,289	15,000	2,200	850	60,941

8. The £2.77m of uncommitted spend (at UHMB) for backlog maintenance figure has been added to the contingency in the plan to bring that figure up to £3.7m, which means that Trusts' **committed** plans are fully affordable within the envelope, but this leaves £25.3m of backlog maintenance to be funded from the £3.7m contingency, a £21.6m funding gap.

9. Working with ICS Estates colleagues, a process of validating the £25.3m additional request for backlog maintenance will be undertaken identifying backlog classed as 'high' and 'significant' with first call on any spare resource given to the former.

10. As the year progresses there will likely be splippage against a number of schemes included within the plan presented above. The ICS finance team will monitor the capital forecast closely each month and are in the process of establishing monthly meetings with Deputy Directors of Finance and Capital Accountants with DoFs expected to attend at month 6 and month 9. At month 6 we expect accurate forecasts to be submitted by Trusts and they will be challenged on these forecasts based on year to date spend and historic spend. It is at this point that we expect to identify slippage that can then be used to fund some or all of the backlog maintenance schemes in the additional requests table above.

11. At this point in the process we do not envisage there being enough slippgage to fund any of the schemes from stroke down to parkwood demolition, but it is important to keep them on the list should more funding be available and as part of planning for future years capital plans. These schemes are also subject to, as yet, unapproved business cases which will have implications for both capital and revenue and therefore need to be understood in more detail particularly given the challenge the system is facing in terms of revenue.

Key Messages

12. Key messages are as follows:
    - A robust process has been undertaken with regards to drawing up a deliverable envelope compliant capital plan.
    - Trust pre-committed and internally funded schemes are affordable within the envelope.
    - ICS finance and estates colleagues will work together to validate the request for £25.3m for backlog maintenance which currently sit outside the plan.
    - Monthly monitoring of forecasts will be undertaken with Trust finance teams with formal reviews at month 6 and month 9 with the intention of identifying slippage to fund the backlog maintenance request.

Recommendations

13. The Board is asked to **note** the work undertaken to date, the process going forward to control spending and the requirement to review the position at 6 and 9 months, particularly to ascertain our ability to fund backlog maintenance items from any slippage that may occur. The Board is also asked to **approve** the capital plan.

Gary Raphael
Executive Director of Finance and Investment
25th May 2021

ICS Board

Title of Paper	Primary Care Restoration		
Date of Meeting	2 June 2021	Agenda Item	8

Lead Author	Peter Tinson		
Contributors	Primary Care Sub Cell		
Purpose of the Report	Please tick as appropriate		
	For Information	✓	
	For Discussion	✓	
	For Decision		
Executive Summary	The attached presentation provides an overview of the restoration of general practice services, including challenges, support and key messages.		
Recommendations	ICS and ICP colleagues (via the Primary Care Sub Cell) finalise the emerging support ask and immediately progress.		
Next Steps	As above.		
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		
If Yes : Risk	Challenges facing the delivery of general practice services.		
Report Authorised by:	Peter Tinson		

Primary Care Restoration

ICS Board – 2 June 2021

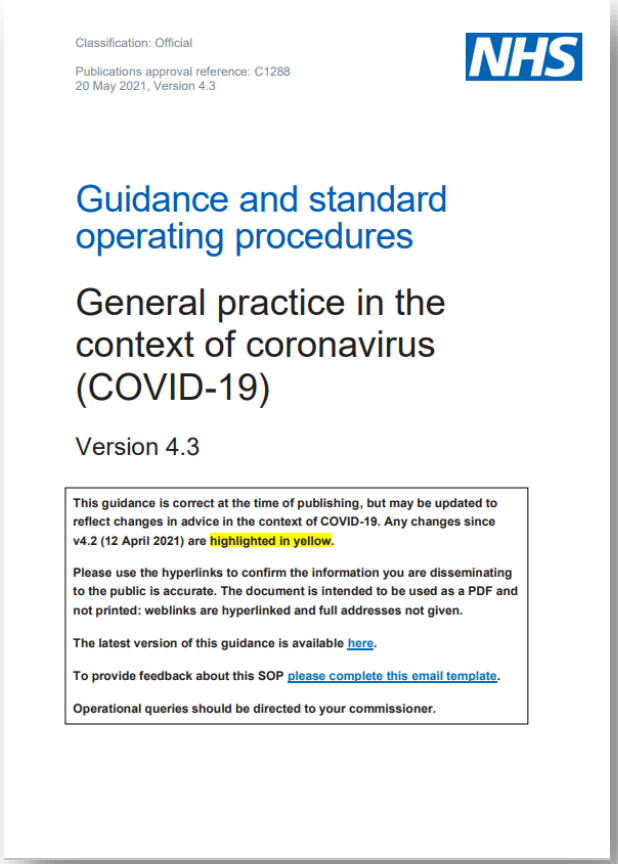
Introduction

- Today focusing on general practice restoration
- Pharmacy, dental and optometry providers have also made important contributions to the COVID-19 pandemic response and are restoring service provision
- General practice has rapidly transformed in response to COVID-19
- Rapid implementation of remote models of access and care delivery
- Mix of COVID-19 care, “business as usual” care and COVID-19 vaccination programme
- Overview of service provision and related activity
- Challenges facing general practices (and patients) and support

Service provision

- General Practice coronavirus service provision has been directed by successive national Standard Operating Procedures (SOP)

- The procedures include:-
  - Infection prevention and control
  - Guidance for staff
  - Operating model
  - Information and support for patients and public
  - Managing patients with symptoms of or exposure to COVID-19
  - Patients at increased risk of severe illness from COVID-19
  - Other considerations, e.g. medicines and prescribing



Classification: Official

Publications approval reference: C1288
20 May 2021, Version 4.3

NHS

Guidance and standard operating procedures

General practice in the context of coronavirus (COVID-19)

Version 4.3

This guidance is correct at the time of publishing, but may be updated to reflect changes in advice in the context of COVID-19. Any changes since v4.2 (12 April 2021) are highlighted in yellow.

Please use the hyperlinks to confirm the information you are disseminating to the public is accurate. The document is intended to be used as a PDF and not printed: weblinks are hyperlinked and full addresses not given.

The latest version of this guidance is available here.

To provide feedback about this SOP please complete this email template.

Operational queries should be directed to your commissioner.

Service provision

- Related contractual flexibilities to ensure general practice remains open and safe for patients and to support roll out of COVID-19 vaccination

Red: can be paused
Amber: can consider standing down
Green: must continue

Clinical Services						
	Service	Wave 1	New Normal	Wave 2	Restore	Comments
National	QOF					
	Dispensing services quality scheme					
	Investment and Impact fund					
	Network contract DES service					
	Network contract DES workforce					
	New patient reviews					
	Over 75 health checks					
	Annual patient reviews					
	Routine medication reviews					
	Clinical reviews of frailty					
	Minor surgery					
	Acutely unwell adults and children					
Local	LIS/LES					ICPs to agree locally
	Quality contracts					ICPs to agree locally

- Also some non-clinical services were paused, for example, friends and family test and non essential paperwork

Service access

"Primary care never stood down but it did change its priorities and methods"

Four ways to seek healthcare advice from general practice:-

1. Visit GP surgery website and complete confidential online form to request advice or treatment. Receive a response as soon as possible, usually within two working days. Should not be used for very urgent medical problems

2. Call surgery to arrange an appointment. Usually telephone call with clinician first, with face-to-face care arranged if clinically needed. If preference about how to access care discuss it with practice

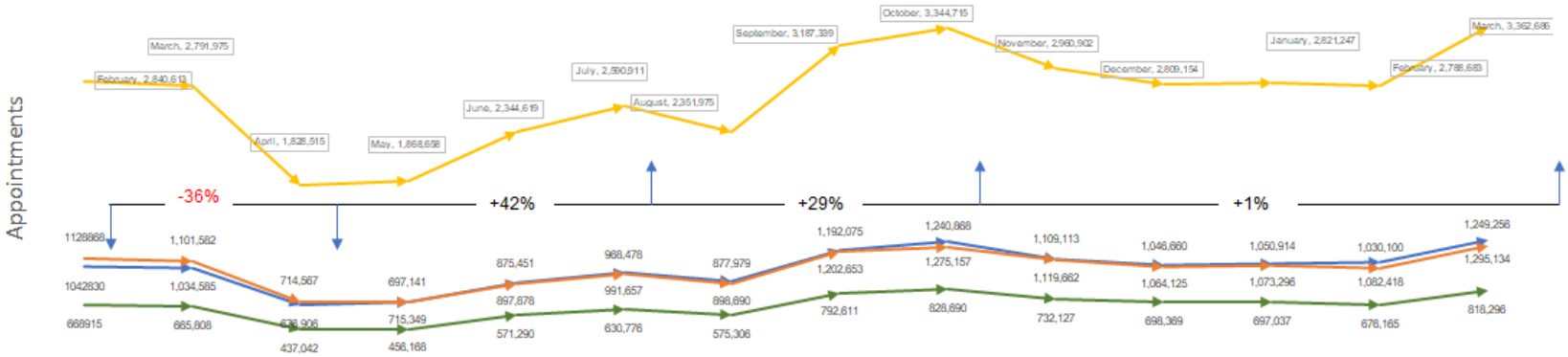
3. For urgent issues or out of hours call the NHS on 111 or go online to seek NHS advice 111.nhs.uk

4. Download the NHS App to order repeat prescriptions and get health advice

Service access – ICS

- L&SC general practice appointments now greater than pre-pandemic levels

Overall GP Appointment Data 2020- 2021 North West



	February	March	April	May	June	July	August	September	October	November	December	January	February	March
C&M	1042830	1,034,585	676,906	715,349	897,878	991,657	898,690	1,202,653	1,275,157	1,119,662	1,064,125	1,073,296	1,082,418	1,295,134
GM	1128868	1,101,582	714,567	697,141	875,451	968,478	877,979	1,192,075	1,240,868	1,109,113	1,046,660	1,050,914	1,030,100	1,249,256
L&SC	668915	665,808	437,042	456,168	571,290	630,776	575,306	792,611	828,690	732,127	698,369	697,037	676,165	818,296
NW Region	2,840,613	2,791,975	1,828,515	1,868,658	2,344,619	2,590,911	2,351,975	3,187,339	3,344,715	2,960,902	2,809,154	2,821,247	2,788,683	3,362,686

Monthly Data

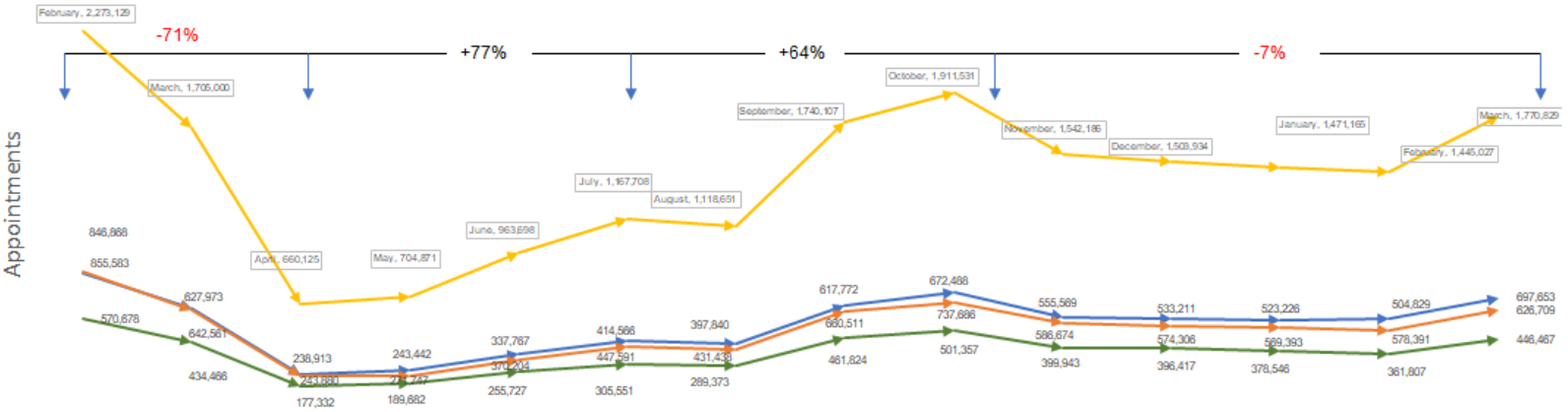
- For the North West, there was a sharp 36% decrease in appointment activity between February and April 2020 as COVID 1st Wave Impacted.
- From April to June 2020, there was a recovery in appointment activity, with an increase in appointments of 42% from April's appointment activity position to July.
- The recovery trend continued June to October 2020, with an increase in appointments of 29% in the 3 month period from July's activity position to October.
- GP appointment activity in January 2021 had <1% variance than at February 2020 prior to the onset impact of Covid 1st Wave. Illustrative of the successful efforts over the 11 month period indicated of General Practice to restore appointment activity to pre-covid levels.

8 | Data Source: NHS Digital

Service access – ICS

- L&SC face to face appointments represent 55% of total appointments at March 2021

Face to Face GP Appointment Data 2020-2021 North West



	February	March	April	May	June	July	August	September	October	November	December	January	February	March
C&M	846,868	642,561	243,880	271,747	370,204	447,591	431,438	660,511	737,686	586,674	574,306	569,393	578,391	697,653
GM	855,583	627,973	238,913	243,442	337,767	414,566	397,840	617,772	672,488	555,569	533,211	523,226	504,829	626,709
L&SC	570,678	434,466	177,332	189,682	255,727	305,551	289,373	461,824	501,357	399,943	396,417	378,546	361,807	446,467
NW Region	2,273,129	1,705,000	660,125	704,871	963,698	1,167,708	1,118,651	1,740,107	1,911,531	1,542,186	1,503,934	1,471,165	1,445,027	1,770,829

Monthly Data

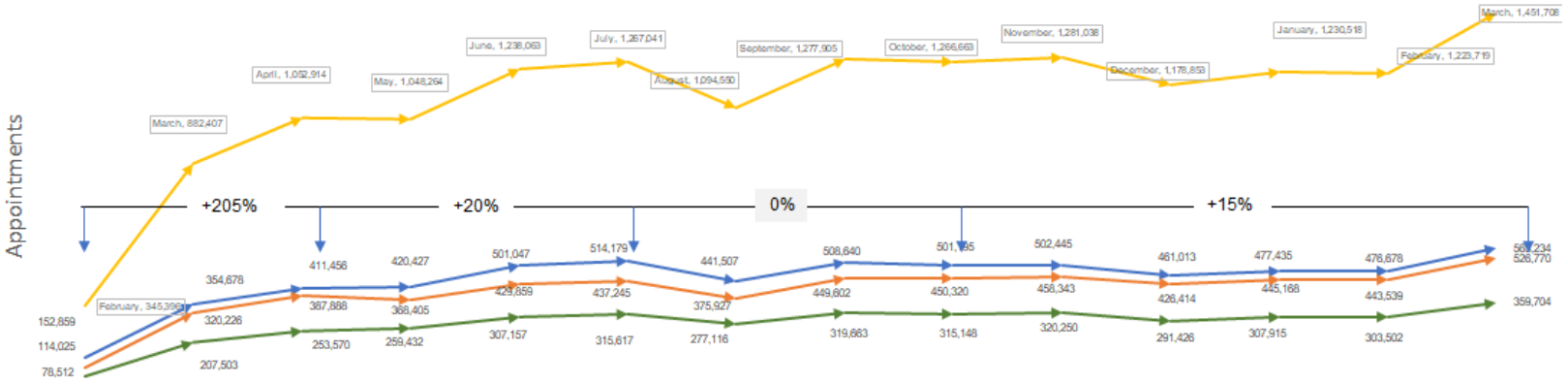
- For the North West, there was a very sharp 71% decrease between February and April 2020, which coincides with when the first wave impacted.
- We then saw, throughout the first lockdown, between April and July, a steady 77% increase in F2F appointment activity.
- Between July and October, as restrictions were lifted and we saw some service recovery, there was a sharper 64% increase in F2F appointments.
- As restrictions were brought back in from 1st November, we see a sudden dip which eases off into a steady decline throughout the first lockdown months resulting in a 24% decrease in F2F appointment activity from October to February but with a rise in March, giving an overall decrease of 7% from the October position.
- February 2020 to February 2021 shows a 36% reduction / February to March 2021 shows a change to 22% reduction

Data Source: NHS Digital

Service access – ICS

- In response to the SOP significant increase in telephone appointments

GP Telephone Consultation Data 2020-2021 North West



	February	March	April	May	June	July	August	September	October	November	December	January	February	March
C&M	152,859	354,678	411,456	420,427	501,047	514,179	441,507	508,640	501,195	502,445	461,013	477,435	476,678	565,234
GM	114,025	320,226	387,888	368,405	429,859	437,245	375,927	449,602	450,320	458,343	426,414	445,168	443,539	526,770
L&SC	78,512	207,503	253,570	259,432	307,157	315,617	277,116	319,663	315,148	320,250	291,426	307,915	303,502	359,704
NW Region	345,396	882,407	1,052,914	1,048,264	1,238,063	1,267,041	1,094,550	1,277,905	1,266,663	1,281,038	1,178,853	1,230,518	1,223,719	1,451,708

Monthly Data

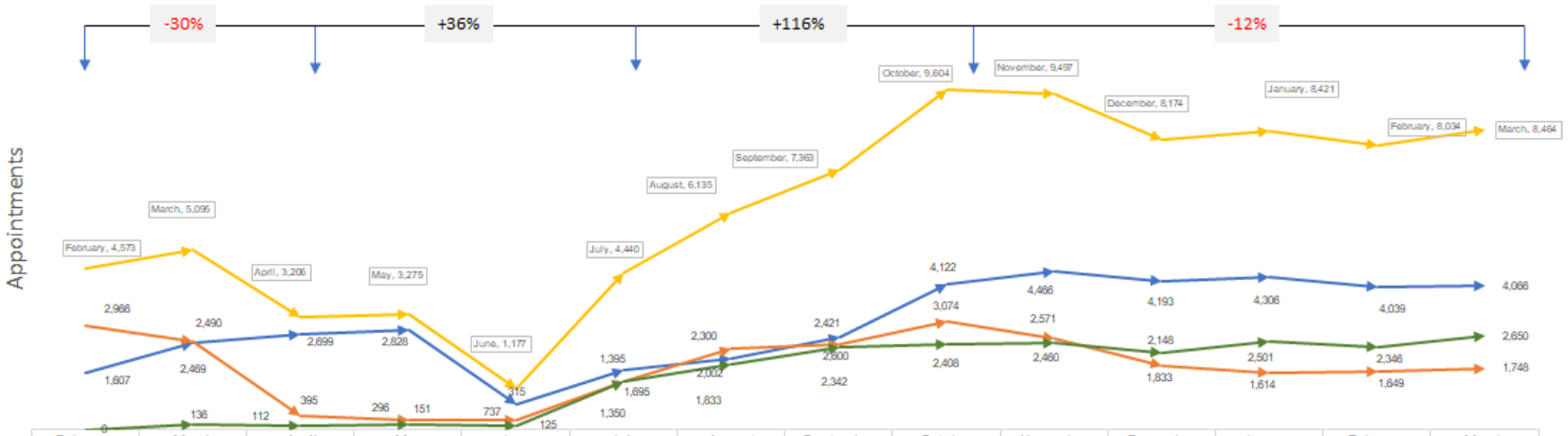
- For the North West, there was a very large 205% increase in telephone consultations as the first COVID wave hit between February and April 2020.
- To correlate with the decrease in face to face consultations demonstrated in the last slide, telephone consultations continued to rise with a 20% increase between April and July.
- Between July and October there was an overall 0% change but with a dramatic dip in August when restrictions were lifted and there was a general recovery trend with face to face consultations (July – October)
- Telephone consultations saw a 15% increase in activity from October to March.
- The Overall increase from February 2020 to March 2021 was by 320% for telephone consultations

10 | Data Source: NHS Digital

Service access – ICS

- Also significant increase in video consultations

GP Video Consultation Data 2020-2021 North West



	February	March	April	May	June	July	August	September	October	November	December	January	February	March
C&M	1,607	2,469	2,699	2,828	737	1,695	2,002	2,600	4,122	4,466	4,193	4,306	4,039	4,066
GM	2,966	2,490	395	296	315	1,395	2,300	2,421	3,074	2,571	1,833	1,614	1,649	1,748
L&SC	0	136	112	151	125	1,350	1,833	2,342	2,408	2,460	2,148	2,501	2,346	2,650
NW Region	4,573	5,095	3,206	3,275	1,177	4,440	6,135	7,363	9,604	9,497	8,174	8,421	8,034	8,464

Monthly Data

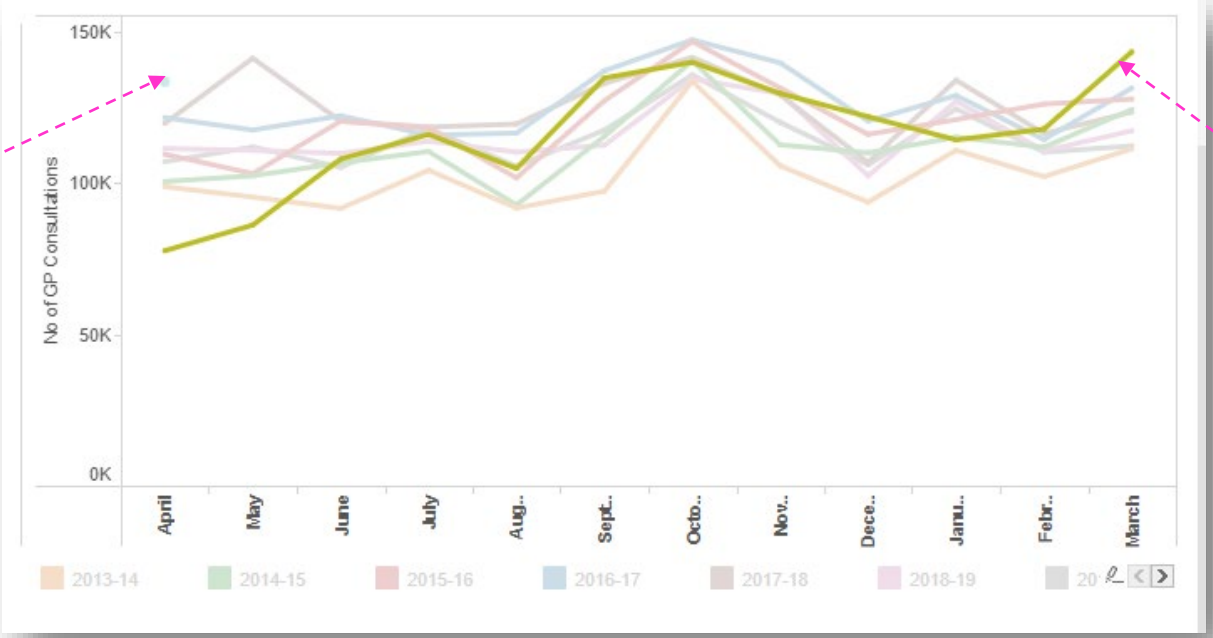
- From February to April, there was an overall drop of 30% in the North West.
- This rose back up by 36% y July, despite a dramatic decrease in June.
- Despite the recovery of face to face consultations through June to October, video consultations proved to be an increasingly popular method of consultation with a 116% surge in activity.
- October to March 2021 saw a steady decline of 12% across the North West.
- There was an overall 85% rise in activity between February 2020 and March 2021.

11 | Data Source: NHS Digital

Service access – an ICP example

- All consultations in general practice

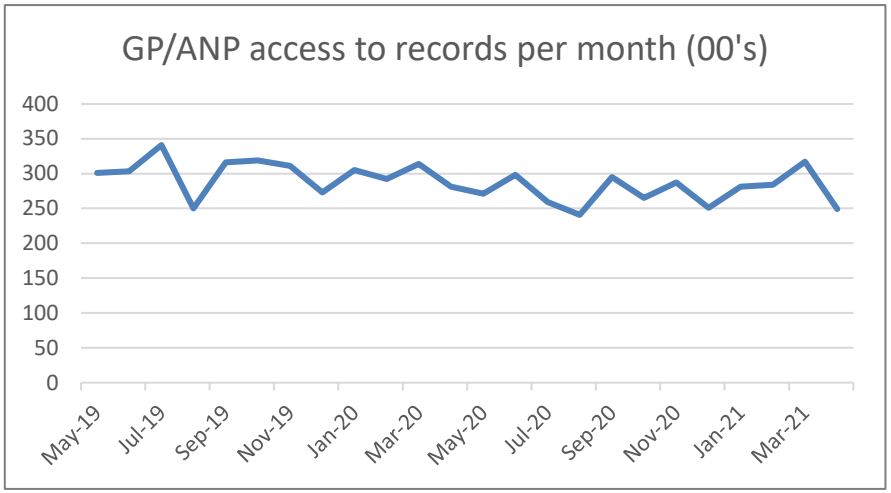
2021

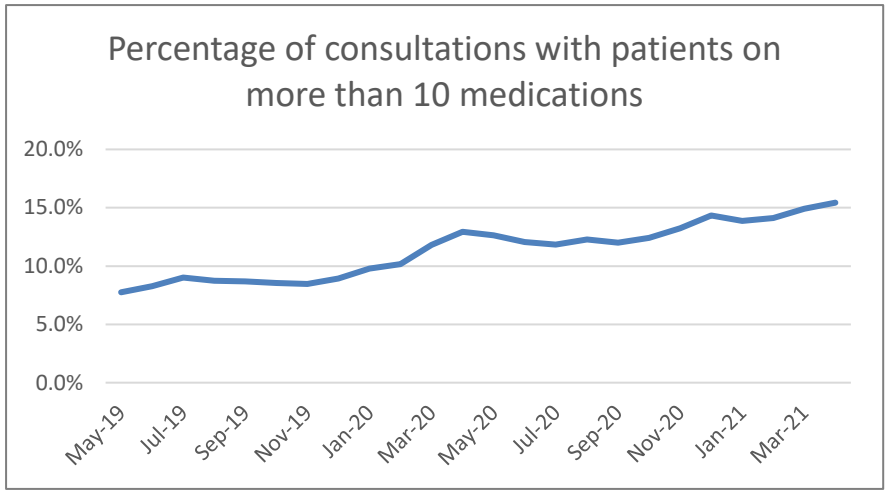


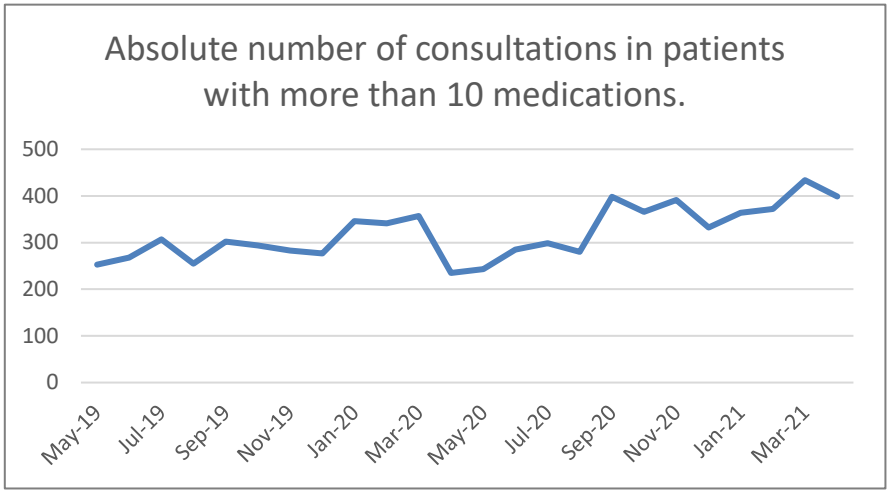
2020

- March/ April 2020 – initial lockdown and corresponding drop in activity
- June-October 2020 – restored activity levels to >90% of 2019 levels
- November-December 2020 no drop off of levels of activity compared with previous years, likely due to reduced annual leave
- February-April 2021 sustained higher levels of activity, with April 2021 reporting 133,465 consultations compared to April 2019, a 107,068 (25% increase)

Service access – a practice example







- Increase in complexity of workload

PCN/general practice vaccination provision

36 vaccination sites

1,060,833 vaccinations provided

62% of total L&SC vaccinations

PRAISE: Dr Lauren Dixon at the start of the vaccination programme at Alfred Barrow Health Centre

General practice (and patient) challenges

- Increase in patient demand
- Increase in medical primary care activity from follow up care within acute settings
- Increased need for rapid interventions following accelerated discharge
- Increase in nursing primary care activity, e.g. wound care/dressings
- Increased complexity of patients
- Administrative pressures, especially supporting the above and also supporting patients to access care appropriately
- Public expectations and responding to concerns about access to general practice services
- Workforce recruitment, retention and wellbeing
- Planning and preparing for phase 3 of the vaccination programme
- PCN support and funding

General practice support

- National
  - Additional Roles Reimbursement Scheme (ARRS)
  - GP recruitment and retention initiatives
  - General practice covid capacity expansion schemes (£150m and £120m)

- Local
  - Escalation and at scale aid/support models
  - Communications campaign, offer, how to access it and be kind to staff

- Emerging asks include:-
  - Ongoing communication support
  - Flexibility in usage of ARRS funding
  - Targeted support to implement approaches to improve patient access
  - Pause any non essential non clinical asks
  - Resolve EMIS and telephony issues
  - Explore further health and wellbeing offers for staff
  - Accelerate roll out of community pharmacy referral service

Key messages

Throughout the #COVID19 pandemic, all practices in Lancashire and South Cumbria have continued to see patients face to face when necessary

Many issues can be dealt with remotely via video or over the phone

Please be understanding of the pressures facing all #NHS services, including GP practices, despite the reduction in COVID-19 rates and the easing of Government restrictions

GP practices are also continuing to make a significant contribution to the delivery of the COVID-19 vaccination programme

Thank patients for their continued kindness and patience

Staff are here to help and we'd like to thank them for their continued hard work. Please treat staff respectfully and with kindness

ICS Board

Title of Paper	System Development: Progress update and forward plan for 2021/22		
Date of Meeting	Wednesday 2nd June 2021	Agenda Item	9

Lead Authors	Victoria Ellarby, Programme Director – System Reform, LSC ICS Andrew Bennett, Executive Director of Commissioning, LSC ICS	
Contributors		
Purpose of the Report	Please tick as appropriate	
	For Information	✓
	For Discussion	
	For Decision	✓
Executive Summary	The purpose of this paper is to set out the requirements of NHS England & NHS Improvement (NHSEI) in relation to the submission of the LSC System Development Plan; to outline the proposed approach to this submission using existing programme documentation wherever possible; and to provide a progress update on a number of key workstreams within the System Development Programme	
Recommendations	The ICS Board is asked to: 1. **Note** the requirements associated with the submission of a System Development Plan to NHSEI by 11th June 2021. 2. **Approve** the proposed approach to submission to be overseen by the ICS development Oversight Group. 3. **Note** the progress made across the LSC System Development Programme.	
Next Steps		

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	Expected delays in legislative process and publication of additional national guidance will result in reduction in timeframes available to undertake significant programme of change.	
Report Authorised by:	Andrew Bennett, Executive Director of Commissioning, L&SC ICS	

System Development: Progress update and forward plan for 2021/22

ICS Board
Wednesday 2nd June 2021

1. Introduction

1.1. The purpose of this paper is to set out the requirements of NHS England & NHS Improvement (NHSEI) in relation to the submission of the LSC System Development Plan; to outline the proposed approach to this submission using existing programme documentation wherever possible; and to provide a progress update on a number of key workstreams within the System Development Programme.

2. LSC System Development Plan – NHSEI requirements

2.1. The LSC system is required to submit its System Development Plan for the remainder of 2020/21 to NHSEI by midday on 11th June 2021.

2.2. There is no standard template for this submission. However, the Plan must set out how the LSC system will implement the contents of the White Paper, published in February 2021 (subject to parliamentary processes and resultant changes in legislation), as well as setting out key risks and issues.

2.3. As part of the submission, the LSC system is also required to undertake a self-assessment of its current position against a System Development Progression Tool (SDPT). This is similar to a maturity matrix (as has been used within LSC for ICP development) and will enable LSC to identify its areas of relative strength / development in relation to the other systems in the North West Region (Cheshire and Merseyside / Greater Manchester).

2.4. Following submission, NHSEI will facilitate a peer review process across the three systems in the North West Region.

3. LSC System Development Plan – proposed approach to submission

System Development Plan

3.1. It is intended to use existing programme documentation wherever possible to support the NHSEI requirements.

3.2. During the past three months, LSC has established a more formal programme management approach to the System Development Programme, identifying a number of key products for each of the major workstreams:

(i) **Plan on a page:** This will set out the scope of each workstream and the high-level outputs that are required across Q1 to Q4 of 2021/22, as defined by national expectations in the White Paper (subject to legislation), regional requirements across the North West, and/or local requirements in LSC. It also sets out the overarching deliverables in readiness for new ways of working in 2022/23.This enables identification of key interdependencies – both within the LSC System Development Programme, and with national workstreams that are supporting the publication of key guidance / policy documents.

Appendix A provides an illustration of this approach as applied to the development of the statutory LSC Health and Care Partnership and the LSC NHS organisation. This will be replicated for all workstreams.

(ii) **Risk and issues log:** This will identify the key risks and issues associated with each of the workstreams and for the programme as a whole. Those with an elevated risk score (of > 15) are escalated through the relevant governance route for the System Development Programme, including to the North West regional team where relevant (particularly for risks associated with delays to national publication of key guidance / policy documents).

(iii) **Highlight report:** This will be used to track progress against key deliverables and will be reported to the relevant oversight group each month.

3.3. It is intended that (i) and (ii) will be submitted to NHSEI as part of the required System Development Plan.

System Development Progression Tool

3.4. Whilst a draft version of this tool has been issued previously, the final version is not anticipated to be published until the end of May 2021. A self-assessment of progress against the levels of maturity across a number of domains described in the tool will be undertaken. This will allow LSC to identify areas that require accelerated development during 2021/22 and that may benefit from peer-to-peer support across other systems in the North West Region and/or across England.

3.5. Following this, all workstreams will be reviewed to ensure that areas requiring further development are addressed.

3.6. The outputs of the LSC self-assessment will be submitted to NHSEI as part of the required System Development Plan.

Process for agreeing submission to NHSEI

3.7. The ICS development Oversight Group has been established, chaired by the Independent Chair of the LSC ICS and with membership drawn from the various sectors within the LSC partnership. This group was constituted to act on behalf of the ICS Board to develop a statutory ICS, including a strategic commissioning function and place-based functions, in line with national publications and local thinking.

3.8. The ICS development Oversight Group confirmed its support for the above content of, and approach to, the submission of the LSC System Development Plan at its meeting on 11th May 2021.

3.9. The ICS development Oversight Group is therefore recommending that it receives a final draft of the System Development Plan at its meeting on 8th June 2021, with any further minor amendments before submission on 11th June 2021 to approved by the Independent Chair of the LSC ICS and the ICS Chief Officer.

3.10. The final submission will be shared with the ICS Board for information at its meeting on 7th July 2021, together with any feedback received from the Regional team by that date.

4. LSC System Development – progress update

4.1. Development of NHS Lancashire and South Cumbria and the LSC Health and Care Partnership

Whilst some key national guidance is awaited, LSC is continuing to undertake significant work in relation to future ways of working. This includes:

Identifying what success looks like for the LSC Health and Care Partnership: The ICS development Oversight Group is using the nationally identified key aims of a Health and Care Partnership as the basis for this work, augmenting them with locally defined aims that are structured around what is important to create an effective partnership. Initial work has been undertaken to identify the key drivers for each of these aims, before considering where the LSC Health and Care Partnership wishes to focus its collective efforts to make a significant difference. It has been noted that this must be on the areas where partnership working is essential and must be considered from the perspectives of all partners.

Considering the scope of the Boards for NHS Lancashire and South Cumbria and the wider LSC Health and Care Partnership: The ICS development Oversight Group has started to reflect on the scope and purpose of these two Boards, linked to the above work on success measures. Whilst there is greater clarity around the scope and purpose of the NHS Board, further development is required on the Health and Care Partnership Board. Although some national guidance is anticipated, key messages continue to stress the 'permissive nature' of the approach to developing health and care partnerships. Therefore, further work is now underway to consider the unique purpose of the Health and Care Partnership Board; how this will need to be different from the way in which the LSC ICS Board has functioned to date; what types of decisions the Health and Care Partnership Board will make; and what the relationship will be between the Health and Care Partnership Board and the Health and Wellbeing Boards.

Defining the functions of a LSC NHS organisation: Significant work is underway to determine the future functions that will be undertaken by the LSC NHS organisation. This will be a combination of functions that are currently undertaken by CCGs and those that will be delegated from NHSEI to a LSC footprint (e.g. primary care commissioning). This is being approached through two key routes – (a) consideration of the activities that will be required to support planning and delivery of key resident/patient facing services; and (b) consideration of the corporate services that a new statutory NHS organisation operating across LSC will need to deliver. In each case, activities are being allocated into system-level or place-level (including neighbourhoods), before considering the skills and resources needed to deliver. A number of functions have been selected to accelerate the development of new operating models, including primary/community services integration, population health management, quality and performance improvement, and communications and engagement. Whilst 2020/21 is a transitional year and individuals / teams will be asked to adopt new ways of working as far as possible, it must be noted that a formal management of change process will commence later in the year (likely Q4). Therefore, any interim changes must follow locally developed HR principles, and must not have a positive or negative impact on future substantive roles.

4.2. **Commissioning reform (transitional arrangements for CCG activities in 2020/21 and CCG closedown)**

Whilst national guidance is awaited, LSC is continuing to undertake significant work in relation to future ways of working, overseen by the CCG Transition Board. This includes:

Transitional governance arrangements for 2021/22: The Strategic Commissioning Committee has now been established, and all of its sub-committees are now established (Quality and Performance, Collaborative Commissioning, CCG Transition Board). An Expressions of Interest process has been completed to ensure an appropriate mix and sufficient numbers of lay oversight in the groups.

CCG closedown: A lead Accountable Officer and lead Executive Director have been assigned, along with key individuals from specific functions (e.g. finance). Development of a detailed work plan is underway, currently based upon previous experience of the transition from Primary Care Trusts to CCGs and/or CCG mergers. These will be validated against national guidance once received.

4.3. **Development of Place-Based Partnerships**

Whilst some key national guidance is awaited, nationally the approach to the development of place-based partnerships has been described as predominantly permissive in nature. LSC is continuing to undertake significant work in relation to future ways of working, overseen by the ICP Development Advisory Group (ICP DAG). Detailed proposals related to this were approved by the ICS Board in May 2021.

4.4. **Provider Collaboratives**

Whilst national guidance is awaited, LSC is continuing to undertake significant work in relation to future ways of working, overseen by the Provider Collaborative Board and the newly established Mental Health, Learning Disabilities and Autism Transition Board. This includes:

Acute Provider Collaboration: The four Trusts in LSC are working with NHSEI to pilot a collaborative development framework that will subsequently be used nationally. The five-stage process includes the includes the use of a Provider Collaborative Development Matrix, and work has commenced with an anonymous survey on progress to date and development needs, ahead of a workshop on 28th May 2021. Key aims in the early stages of this work are to create a common strategic narrative that describes the future landscape for acute provider collaboration in a way that is understandable to Trust staff and wider stakeholder organisations (similar to the ICP and ICS strategic narratives that have been approved by the ICS Board).

Mental Health Lead Provider Collaborative: A Mental Health, Learning Disabilities and Autism Transition Board has been established to oversee the transition to new ways of working in the planning and delivery of these services. This builds on the roadmap which was developed earlier in 2021 after consultation with leaders across the system. An early priority will be to agree an approach to the development of system strategies for Mental Health and Learning Disability/Autism services. It will also be important to create a common strategic narrative that describes the future landscape for the commissioning and provision of services under a 'lead provider' model.

4.5. **Workforce**

A significant amount of national guidance is still awaited in relation to the management of change process associated with the transition of staff into the new NHS LSC organisation, as well as the process for appointment of key executive level roles. Whilst this guidance is awaited, LSC is continuing to undertake work in relation to transitional ways of working, overseen by the CCG Transition Board. This includes the development of a set of people transition principles and a LSC system resourcing and recruitment protocol which will support the fair and transparent alignment of staff during 2021/22.

5. Recommendations

5.1. The ICS Board is asked to:

5.2. **Note** the requirements associated with the submission of a System Development Plan to NHSEI by 11th June 2021.

5.3. **Approve** the proposed approach to submission to be overseen by the ICS development Oversight Group.

5.4. **Note** the progress made across the LSC System Development Programme.

Appendix A: Plan on a page format for the development of the statutory LSC Health and Care Partnership and the LSC NHS organisation

Lancashire and South Cumbria System Development Plan (May 2021)

Design and implementation of a new operating model for 2022/23, including transition from current CCGs into system-level NHS organisation (subject to legislation)

	1. System Development	2. Place-Based Partnerships (Integrated Care Partnerships)	3. Commissioning Reform (transitional/transactional)	4. Provider Collaboration (across the LSC system)
Themes:				
Scope: (aligned with and subject to policy / legislation changes)	Establishing a statutory LSC Health and Care Partnership. Developing the NHS LSC organisation, including a strategic commissioning function and place-based teams.	Designing and implementing five mature Place-Based Partnerships within the LSC system.	Planning and implementing transitional commissioning arrangements for 2021/22. Planning and implementing transactional arrangements to close down eight CCGs by June 2022.	Planning and implementing models of provider collaboration for acute services and mental health, learning disabilities and autism services.
Key workstreams:	a. Strategic Narrative (COMPLETE) b. Defining the structure and functions of the LSC Health and Care Partnership and the NHS LSC organisation c. System-level governance and accountability d. System-level leadership & organisational development e. Use of the System Development Progression Tool (ONGOING)	a. Strategic Narrative (COMPLETE) b. Designing and implementing an ICP Maturity Matrix (COMPLETE) c. Overarching themes and success measures for places d. Place-based governance arrangements e. Place-based leadership and organisational development	a. Transitional governance arrangements for 2021/22 (COMPLETE) b. Transitional functional allocations and resource deployment for 2021/22 c. Transactional close down of CCGs	a. Acute Provider collaboration models b. Lead Provider Collaboration models for Mental Health, Learning Disability & Autism services

Cross-cutting themes:

5. Partnership working with Local Government: Strengthening the role of Local Government at system and place through alignment of priorities that will support integrated delivery (This is not an independent workstream. This theme is incorporated into a range of workstreams, particularly within System Development and Place-Based Partnerships)
6. Workforce and organisational development: Ensuring the safe and effective transfer and/or recruitment of staff into the new system architecture. Development of an organisational development plan.
7. Finance: Implementing the financial framework for systems, places and provider collaboratives.
8. Quality Improvement: Designing and implementing a quality improvement approach for the system.
9. Communications & Engagement: Ensuring effective communications and engagement with all stakeholders, including those staff who are affected by the transition of activities associated with the closedown of CCGs.

Lancashire and South Cumbria
Health and Care Partnership

1. System Development	1. b. Defining the structure and functions of the LSC Health and Care Partnership and the NHS LSC organisation	**Executive Lead:** Andrew Bennett **Workstream Lead(s):** Various	**External Support:** TBC

Scope:

- The structure of the LSC Health and Care Partnership and the NHS LSC organisation that forms part of this wider Partnership (e.g. boundaries of the system; places within the system and the boundaries of those places; partners within the Health and Care Partnership)
- Defining the functions that the NHS LSC organisation will undertake, ensuring the safe and effective transfer of functions in, and ensuring those functions support delivery of key priorities
- Designing the operating model for these functions at system level and in places as part of "LSC place-based teams", and allocating appropriate and equitable resources

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Confirm boundaries and partners of the LSC Health and Care Partnership • Confirm boundaries, partners & place-based arrangements for each of the five place-based partnership within LSC • Initial draft of functions in NHS LSC organisation • Proposals for operating model for those functions associated with transitional commissioning arrangements and/or that can accelerate new ways of working	• Roadmap for NHSE functions transferring into ICS NHS body • Operating model running in shadow form for those functions associated with transitional commissioning arrangements and/or that can accelerate new ways of working	• Operating model proposed for NHS LSC organisation to fulfil its functions at system level and at place level as part of an "LSC place-based teams" • CCG teams only operating at sub-system level where LSC plans to establish a significant place-based function at that footprint	• Operating models agreed for NHS LSC organisation to fulfil its functions at system level and at place level as part of an "LSC place-based teams" • Resource allocation in line with national HR frameworks / management of change processes

Overarching deliverables for 2022/23

- Statutory LSC Health and Care Partnership and NHS LSC organisation formed
- System and "LSC place-based teams" operating model implemented
- Staff successfully transferred to ICS NHS body

Lancashire and South Cumbria
Health and Care Partnership

1. System Development	1. c. System-level governance and accountability	**Executive Lead:** Andrew Bennett **Workstream Lead(s):** Various	**External Support:** Transformation Unit

Scope:

- Overarching governance arrangements for the system, including the scope and composition of the LSC Health and Care Partnership Board and the NHS LSC Board, and the role of Health and Wellbeing Boards
- Development of success measures for the LSC Health and Care Partnership
- Accountability framework for place-based partnerships, provider collaboratives, and organisations within the system
- Decision-making framework that will support collective decision-making across the system
- Support the development of MoUs for 2022/23 – between the national / regional teams and LSC; between the LSC Health and Care Partnership and place-based partnerships / provider collaboratives
- Development of the constitution for the NHS LSC organisation

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Initial proposals on scope and composition of the LSC Health and Care Partnership Board and the NHS LSC Board	• Proposals on success measures for the ICS Health and Care Partnership • Confirm proposals for the LSC Health and Care Partnership Board and the NHS LSC Board, inc. role of HWBs • Review draft of the MoU for 2022/23 between the national / regional teams and LSC • Develop draft MoUs between LSC Health and Care Partnership and place-based partnerships / provider collaboratives • Outline of planned governance and leadership models in place (linked to place-based partnerships development programme)	• Draft proposals on accountability and decision-making frameworks across the system (linked to place-based partnerships development programme) • Review draft of NHS LSC organisation constitution (template developed nationally)	• Confirm future governance arrangements for the LSC Health and Care Partnership Board and the NHS LSC Board, inc. role of HWBs • Agree MoU for 2022/23 between the national / regional teams and LSC • Agree MoUs between LSC Health and Care Partnership and place-based partnerships / provider collaboratives • Submit NHS LSC organisation constitution for approval

Overarching deliverables for 2022/23

- Statutory LSC Health and Care Partnership Board and NHS LSC Board implemented, with measures of success agreed and assurance processes commenced
- Accountability and decision-making frameworks implemented for system, places and provider collaboratives
- MoUs agreed - between the national / regional teams and LSC; between the LSC Health and Care Partnership and place-based partnerships / provider collaboratives
- NHS LSC organisation constitution approved by NHSE

1. System Development	1. d. System-level leadership and organisational development	**Executive Lead:** Amanda Doyle / Sarah Sheppard **Workstream Lead(s):** Various	**External Support:**

Scope:

- Design and implementation of the NHS LSC organisation leadership, including lay/non-executive, clinical and executive appointments
- Design and implementation of place-based leader roles (in conjunction with place-based partnerships) and composition of "LSC place-based teams" (linked to scope of 1.b.)
- Design and implementation of clinical/professional leadership & development at system level (and support to development at place & neighbourhood levels)
- Design and implementation of an organisational development programme to support senior leaders in the transition from organisational leadership to system leadership

Key outputs required from this workstream:	2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
	• Scope requirements of organisational development programme	• Model for NHS LSC organisation leadership • Define place-based leader role and process for appointment • Model for clinical/professional leadership at system place and neighbourhoods • Process agreed for appointment of the Chair of the NHS LSC organisation and the LSC Health and Care Partnership Board • Process agreed for appointment of the CEO and CFO of the NHS LSC organisation • Create model for organisational development programme	• Confirm designate appointments to Chair of the NHS LSC organisation and the LSC Health and Care Partnership Board, CEO and CFO of the NHS LSC organisation • Process agreed for appointment of other NHS LSC organisation Board roles • Confirm designate appointments of place-based leaders • Organisational development programme commences	• Confirm designate appointments to other NHS LSC organisation, inc. place-based leaders • All designate appointments formally ratified

Overarching deliverables for 2022/23

- NHS LSC organisation leadership implemented
- Place-based leaders implemented
- Clinical/professional leadership model implemented
- Organisational development programme commenced and ongoing

ICS Board

Title of Paper	Revenue and Capital Outturn 2020/21		
Date of Meeting	2 June 2021	Agenda Item	10

Lead Author	Gary Raphael, Executive Director of Finance and Investment	
Contributors	Elaine Collier, Head of Finance	
Purpose of the Report	Please tick as appropriate	
	For Information	✓
	For Discussion	✓
	For Decision	
Executive Summary	This paper reports on the final outturn for 2020/21 for the L&SC system. It covers the revenue and capital positions of all L&SC partners.	
Recommendations	The Board is asked to **note** the report.	
Next Steps	As above.	
Equality Impact & Risk Assessment Completed	Not Applicable	
Patient and Public Engagement Completed	Not Applicable	
Financial Implications	Yes	
Risk Identified	Yes	
If Yes : Risk	As detailed in the report	
Report Authorised by:	Gary Raphael	

Revenue and Capital outturn for 2020/21

Introduction

1. This paper reports on the final outturn for the 2020/21 financial year. It covers the financial performance for all L&SC partners in respect of both revenue and capital. The figures are subject to audit.

Financial Performance

2. The table below shows the final outturn position for the L&SC system. The plan figures in the table represent the last formal plan submissions in November 2020 which were loaded into organisation ledger systems. Further work to refine plans continued through the year, leading to region setting a residual deficit target of £22m for L&SC.

3. The final position shows that the system ended the year with a deficit of £19.8m. Whilst this is within the target set by region, this still represents a deficit against the financial envelope that we were set, and therefore it firmly keeps the level of pressure and national scrutiny on L&SC.

4. The Board should note that the plans against which organisations monitored their performance totalled a deficit of £90.7m in contrast to the £61.1m deficit finally agreed by the national finance team. This figure of £61.1m deficit included 'allowable' amounts for the annual leave accruals in trusts and loss of non-NHS income which, when excluded, gave a revised target of £20.2m deficit.

Table 1 – L&SC summary financial position as at the end of month 12, March 2021:

L&SC - M12			
	Year-to-date		
	Plan	Actual	Variance
	£m	£m	£m
CCG financial position	(155.9)	(155.5)	0.4
CCG Retrospective Top Up - M1-6	155.9	155.9	0.0
COVID-19 Reimbursement - M7-12	0.0	(0.1)	(0.1)
Commissioner Total	**0.0**	**0.4**	**0.3**
Trust Income excl Top Up	2,797.2	2,948.8	151.6
Pay	(2,124.6)	(2,226.7)	(102.1)
Non Pay	(970.9)	(994.9)	(23.9)
Non Operating Items	(39.9)	(34.6)	5.2
Trust Top Up - M1-6	247.5	243.8	(3.8)
COVID-19 Reimbursement - M7-12	0.0	43.5	43.5
Provider Total	**(90.7)**	**(20.2)**	**70.5**
L&SC Total	**(90.7)**	**(19.8)**	**70.8**

5. During the year SLE agreed that L&SC should adopt a tactical approach to balance CCG positions and show the financial gap against trusts. Taking this approach led to providers holding what effectively are ICP system deficits. Table 2 shows the ICP performance.

Table 2 – L&SC ICP summary financial position as at the end of month 12, March 2021:

SUMMARY OF FINANCIAL GAP BY ICP	Year-to-date		
	Plan	Actual	Variance
	£m	£m	£m
Central Lancashire ICP	(19.3)	2.2	21.5
Fylde Coast ICP	(20.6)	(22.2)	(1.6)
Morecambe Bay ICP	(25.0)	0.6	25.6
Pennine Lancashire ICP	(17.7)	(3.0)	14.7
West Lancashire MCP	0.0	0.2	0.2
Lancashire & South Cumbria FT	(4.1)	2.3	6.5
North West Ambulance Service	(4.0)	(0.0)	4.0
L&SC SYSTEM FINANCIAL GAP	**(90.7)**	**(19.8)**	**70.8**

Capital

6. For 2020/21, the ICS was set a capital envelope of £138.7m. This meant that capital spending using trust internal resources and loans must not be greater than this envelope.

7. The table below shows the final outturn position for the L&SC system was expenditure of £127.4m thus generating an underspend of £11.3m against the envelope, a loss to the system as capital cannot be carried forward into the next financial year. As indicated in previous reports, the expenditure includes £8.4m of expenditure transferred from revenue to help deliver the revenue position in table 1 and the main driver of the underspend was at Blackpool Teaching Hospital where the late notification of an emergency loan led to slippage, which will be a call against the envelope in 2021/22.

Table 3 - L&SC capital position as at the end of month 12, March 2021:

L&SC CAPITAL ENVELOPE - M12			
Net Expenditure	Year-to-date		
	Plan	Actual	Variance
	£m	£m	£m
Blackpool Teaching Hospitals NHS Foundation Trust	32.3	19.9	12.4
East Lancashire Hospitals NHS Trust	16.6	16.5	0.1
Lancashire and South Cumbria NHS Foundation Trust	9.8	9.8	0.0
Lancashire Teaching Hospitals NHS Foundation Trust	38.9	39.5	(0.7)
North West Ambulance Service NHS Trust	14.0	14.6	(0.5)
University Hospitals of Morecambe Bay NHS Foundation Trust	27.1	27.1	0.0
Total Capital Expenditure	**138.7**	**127.4**	**11.3**

8. During the year, additional national allocations were awarded totalling £102.5m. These were in addition to the envelope and primarily related to COVID.

9. Performance against the capital envelope is the key measure by which the system is held to account. As indicated in table 3, the ICS delivered its responsibility in relation to capital in 2020/21.

Recommendation

10. The Board is asked to **note** the updates on the 2020/21 final outturn.

Gary Raphael
ICS Executive Director of Finance and Investment
24 May 2021