Lancashire and South Cumbria
Health and Care Partnership

Formal Integrated Care System (ICS) Board
7 July 2021, 10:00 am -12.30 pm
Via MS Teams Videoconference

Agenda

Item	Description	Owner	Action	Format
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 2 June 2021, Matters Arising and Actions	Chair	Approve	Attached
4.	Key Messages • Perfect week feedback	Dr Amanda Doyle	Note	Verbal
Building the System for 2022 and beyond				
5.	System Reform Update	Andrew Bennett	Discuss	Attached
6.	Greater Lancashire Plan	Phil Green Director Growth Environment and Planning, LCC	Discuss	Attached
7.	Anchor Collaboratives	Andy Knox / Julie Higgins	Endorse	Attached
8.	New Hospitals Programme	Jerry Hawker	Discuss	Attached
9.	Equality, Health Inequality Impact Assessments and Quality Impact Assessments	Talib Yaseen	Discuss	Attached
Managing 2021/2022				
10.	Elective Care Recovery	Sam Proffitt	Discuss	Verbal
11.	System Financial Recovery Programme and Terms of Reference	Gary Raphael	Discuss	Attached
12.	Financial Report	Gary Raphael	Note	Attached
13.	System Performance	Andrew Bennett	Note	Attached
14.	Items to Forward for the next ICS Board meeting	All	Note/ Support	Verbal
15.	Any Other Business - For information - LSC System Development Programme - Highlight Report	All Andrew Bennett	Note Note	Verbal Attached
Date and Time of next formal ICS Board meeting: Formal meeting - Wednesday, 1 September 2021, 10 am to 12.30 pm, MS Teams videoconference				

Item 3

Subject to ratification at the next meeting

Formal Meeting of the ICS Board

Minutes of Meeting	
Date	Wednesday, 2 June 2021
Venue	Microsoft Teams Videoconference
Chair	David Flory

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 of Strategic Transformation / Locality Director	NHS England and NHS Improvement NW
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
Kevin McGee	Chief Executive	Blackpool Teaching Hospitals NHS Foundation Trust/East Lancashire Hospitals NHS Trust
Karen Partington	Chief Executive	Lancashire Teaching Hospitals NHS Foundation Trust
Aaron Cummins	Chief Executive Officer	University Hospitals of Morecambe Bay NHS Foundation Trust
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Roy Fisher	Chair	NHS Blackpool CCG
Peter Gregory	Chair	NHS West Lancashire CCG
Denis Gizzi	Chief Officer	Central Lancashire CCGs
Cllr Graham Gooch	Cabinet Member for Adult Services/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
Eileen Fairhurst	Chair	East Lancashire Hospitals NHS Trust
Claire Heneghan	Chief Nurse	West Lancashire CCG
Jackie Hanson	Director of Nursing and Care Professionals	NHS England and Improvement
In Attendance		
Karen Smith	Director of Adult Social Services (attended in Neil Jack's absence)	Blackpool Council
Peter Tinson	Director of Collaborative Commissioning	Lancashire and South Cumbria ICS
Sam Proffitt	Director of Provider Sustainability	Lancashire and South Cumbria ICS
Jerry Hawker	Senior Responsible Officer, New Hospitals Programme	Lancashire and South Cumbria ICS
Mark Britton	Communications and Engagement Manager	Lancashire and South Cumbria ICS
Nicki Latham	Deputy Chief Executive/Director of Strategic Partnerships	Blackpool Teaching Hospitals NHS Foundation Trust
Pam Bowling	Corporate Office Team Leader	Lancashire and South Cumbria ICS
Maria Louca	Executive Assistant to Amanda Doyle	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Office Co-Ordinator (Minute Taker)	Lancashire and South Cumbria ICS

Public Attendees		
Manual Nohra	Oliver Duffy	Matthew Burch
Oliver Duffy	Paul Faulkner	Ed Parsons
Phillipa Marr	Natalie Lee	Frank Dasu
James Lee	Tricia	John Kerr

Routine Items of Business

1. Welcome, Introductions and apologies

The Chair welcomed all to the formal meeting of the Integrated Care System (ICS) Board held virtually via MS Teams. Cllr Gooch was introduced from Lancashire County Council.

Apologies had been received from Sarah Sheppard, Neil Jack, Geoff Jolliffe and Andy Curran.

2. Declarations of Interest / Conflicts of Interest relating to items on the agenda

RESOLVED: No new declarations of interest were declared. All involved in CCGs/primary care had a conflict of interest for item 8.

3. Minutes of the previous formal ICS Board meeting held on 5 May 2021, matters arising and actions

Matters Arising – An update on H1, system reform and the accelerator programme would be discussed at this meeting. Gary Raphael reported that discussion had not yet taken place with the mental health trust around progress on mental health aspects, however, the contract was now in place.

RESOLVED: The minutes of the meeting held on 5 May 2021 were approved as a correct record.

Action Log – *Equality impact assessment process* **–** Amanda Doyle updated that the CSU currently carry out equality impact assessments for the 8 CCGs within Lancashire and South Cumbria. Talib Yaseen was preparing a paper for the next meeting regarding transitioning to this service and the interim arrangements for the ICS in 2021/22.

4. Key Messages

Amanda Doyle (AD) provided the following update:-

COVID – There was a rising community rate of infection relating to the new delta variant, with a 62% increase in numbers of infections in the 7 days prior to 31 May 2021. Blackburn with Darwen now had the highest rate of infection in the country, 8 of the highest rate areas were within Lancashire and South Cumbria. Infection was largely in young people, over school age and in their 20s, showing that the vaccine roll-out had been successful, having a protective effect. Hospital admissions had risen over 40% in the last week, mainly in East Lancashire. The solution would be to continue efforts to vaccinate adults, encourage all to follow guidelines and test for Covid.

COVID Vaccination – Cohorts 1-11, were now invited to receive the vaccine. This cohort included people over 30 years of age, clinically vulnerable, people who work/live with anyone clinically vulnerable, and all working in social care. To date, 80% had been vaccinated and 67% of those have received 2 doses. For cohorts 1-5 (over 50s, clinically vulnerable and health and care staff), 96% have received 2 doses of vaccine in Lancashire and South Cumbria. This group would be the most at risk of contact with the virus. The surge vaccination programme continued; this had been undertaken for 2 weeks in Blackburn and had now started in Burnley, Pendle and Rossendale. To date, the programme had been very positive. Anyone who had not been vaccinated or who had only received 1 dose must be encouraged to come forward.

There were no plans to enforce vaccine uptake for care home staff. Blackpool Council worked with care home staff, providing targeted education, encouragement and support which resulted in the highest uptake in this area in England. Uptake was increasing in these groups.

Cllr Gooch reported that there was 1 active outbreak within the 409 residential homes in Lancashire. Lancashire County Council was firmly encouraging care home staff to receive the vaccine, currently concentrating on 3 homes where fewer than 50% had been vaccinated. Over 90% of residents had received the vaccine, with

many homes having 100% resident uptake. AD confirmed that all care home residents have had the opportunity to receive 2 doses of the vaccine.

Managing 2021/2022

5. Elective Recovery Accelerator Programme

Kevin McGee (KM) reported that the bid to be part of the accelerator programme had been accepted nationally. The aim was to restore activity by 120% by the end of July 2021 for three months compared to the same months in the previous year. This was an ambitious task in terms of the level of waiting lists currently being seen. In April 2021, delivery exceeded that of April 2019, however, based on planning, May's figures would fall below primarily as there had been a high level of activity in May 2019. The scheme would start in June/July 2021 when Lancashire and South Cumbria would be expected to reach the agreed targets.

In the context of overall elective recovery there was significant activity from both a COVID and general perspective. A shared waiting list tool had been developed, with a viewer that allowed all activity to be seen by speciality and pathway across all organisations. Conversations had begun to enable activity to be managed in a different way in relation to capacity. 'Advice and Guidance', linked with primary care, was being rolled out across all organisations. Every aspect of flow and capacity was being considered, including weekend working, insourcing/outsourcing of activity and surgical elective hubs. As part of COVID an emergency hub had been set up allowing pressures and emergency flow through all hospital sites to be seen; it was felt that if flow could be improved in this area, capacity would be freed up to allow focus on elective work.

Risks included the tight time frame and ambitions. Ongoing issues included financial risks, additional pressure on staff, COVID and its impact on critical care and capacity across organisations. Staff were being offered support in terms of their health and wellbeing. A national call was being held later that day to go through mitigations and national support to help deliver ambitions. There was both local and national assurance around the accelerator bids.

KM to provide key data on numbers, focussing on P1 and P2, number of cancellations, etc, at a future meeting.

ACTION: Kevin McGee

This would be the start of a different way of working, eg, if there was ophthalmic capacity at the Blackpool Victoria Hospital site and significant waiting lists in Morecambe Bay and East Lancashire Trusts, some of this activity could be transferred to Blackpool.

It was recognised nationally that Covid infections would continue, therefore, the elective and red pathways would continue to be separated. Elective hubs were ringfenced to maintain throughput.

Aaron Cummins and Karen Partington added their support to this approach acknowledging the risks as described. The Chair added his appreciation for the excellent work undertaken by everyone involved.

Two funding streams existed to increase elective activity – our share of a national recovery fund of £1bn and a share of funding of up to £20m to start work for accelerator bids, however, the elective recovery fund was primarily based on the amount of activity undertaken as a system. If activity targets were not achieved as a system, income would not be forthcoming even if an individual trust had met its target.

Members discussion included:-

- Specialised services – these needed to be worked through to ensure these patients were not being disadvantaged
- To find ways to mitigate risks
- The willingness of patients to go into hospital was picking up and cancellation rates were low
- Consideration should be made for patients living in areas with low car ownership and high deprivation. KM responded that issues around transport were being considered and conversations were being held with NWAS regarding additional transport. Movement of patients/lists would only be part of the solution, local services and services accessed in a timely manner would continue to be required. A key indicator would be to reduce and improve health inequalities.

RESOLVED: **The Board noted the report.**

6. Revenue Financial Plans (Current Year H1 Plan)

Operational Plans – Carl Ashworth (CA) had circulated a paper which provided the Board with an assessment on the content of the operational plans for the first half of the year, as submitted to NHSE/I. The narrative part of paper described the process for the development of the operational plans and provided an indication against key success criteria. The appendix provided an assessment of compliance of operational plans with guidance and were also RAG rated. All expectations were rated as fully met (green) or partly met (amber). Workforce and financial constraints were highlighted, however despite the challenges there was a commitment to achieve.

Revenue Financial Plan – Gary Raphael (GR) reported on the H1 plan submission for 2021/22 for the Lancashire and South Cumbria system, updated the Board on the result of the call with the national Chief Finance Officer and looked forward to the issues for resolution in H2.

Members were reminded that it had been agreed in February/March 2021 to achieve a £200m savings programme this year, on the assumption that historical allocations would be reverted to. This assumption was not realised as H1 requirements were more about continuing the response to COVID and scaling up elective work within a financial envelope similar to H2 in 2020/21. The requirement for the first half of the year was to be financially balanced, which requiring 3% savings assumptions for organisations who had committed to deliver elective recovery and other national priorities. Given the requirement to meet H1 priorities within H1 funding, achieving a £200m CIP for the year was not a requirement and therefore GR was proposing that the system should aim to exit 2021/22 with £200m savings on a recurring basis, whilst meeting the requirement to balance in H1.

Following the ask from the National Finance Director, savings plans were being established to meet the national requirement that the System improves its financial position. Delivery would be monitored to ensure plans were delivered. Last year's run rates would be looked at to ensure this year's were below that level, in line with profiles confirmed for this year's financial envelope.

Concern was expressed regarding the amber rated areas including restoration of primary care, addressing health inequalities and transforming community services and assurance sought on the intention to improve and recover this position.

Amanda Doyle (AD) responded that these areas were rated amber to ensure credibility where challenges were likely and where there was risk to deliver what was required. Being rated amber would keep a focus on these areas. Isla Wilson asked for urgent assurance as to the plan for health inequalities.

GR continued that due to requirements to submit compliant H1 plans, the focus had been the plan to deliver £56m savings in order to balance our budget and meet national priorities. The National Finance Director was concerned about the underlying position being as high as £343m if nationally we reverted to historic allocations. The areas being looked at, in addition to the £112m for H1 and H2, were medicines management, procurement, continuing healthcare; a session had been held with clinical colleagues looking at common formularies and dressings. Based on discussions at the System Financial Recovery Board some areas would be scoped in the process of writing the report for submission to the national CFO. The Regional Finance Director had requested sight of the draft report, for comment, prior to submission to the national team. Our current plans, although compliant with the national requirements, had not provided assurance to the regional and national teams that the System was dealing with its underlying position.

The Chair recognised members' frustration; it was difficult for the Board to understand and have confidence in a plan that was so close to submission.

Caroline Donovan (CD) commented on mental health services being rated as 'green' bearing in mind the scale of challenge and the high demand for mental health and learning disability services in Lancashire and South Cumbria. CA explained that plans developed had been agreed with national teams as being a credible plan, on the basis of this assessment. There were significant challenges across all services and restoration; assessment was not about the size of gaps but about the extent to which we had a credible plan developed in order to close it.

Reassurance was provided around population health management and the use of the approach to tackle health inequalities; Julie Higgins was developing a proposal to report to a future meeting setting out planned spend in detail, and the proposal to build on within the 2nd half of year. System leaders would provide high level operational oversight against plans and would report to the ICS Board.

RESOLVED: The ICS Board noted the updates on the H1 planning submission for 2021/22 and the forward look to issues requiring resolution in H2 and beyond.

7. Capital Planning 2021/22

Gary Raphael (GR) explained that for 2021/22 the ICS had been allocated a capital envelope of just under £112m. The capital plan submitted to NHSE/I was envelope compliant however outside of the plans were further requests for capital spending by providers, which were described in the report including backlog maintenance. Good reporting procedures had been developed over the last 6 months, and there was likely to be some slippage on schemes. The system would look at delivering the high priority schemes not currently in the programme should slippage occur. The plan would be monitored closely to ensure there was no overspend.

Kevin McGee suggested that consideration should be made for a more strategic capital plan in future.

Aaron Cummins referred to the importance on the identification and mitigation of risk.

Roy Fisher raised concern regarding the backlog maintenance and the need for the ICS Board to understand operational risks in terms of particular services/health and safety risks. Kevin McGee responded that there were mitigations in place in terms of managing this.

The Chair commented it was difficult for the ICS Board to approve a plan when there was not enough money to take forward the work they would wish to. The Board needed to understand the way priorities had been worked through, and that ways must be sought to work flexibly, addressing as many of the priority areas as possible.

RESOLVED: The ICS Board approved the Capital Plan for 2021/22.

8. Primary Care Restoration

Primary Care Restoration

Peter Tinson (PT) took members through a slide deck focusing on general practice restoration, summarising primary care and general practice work on COVID care, business as usual care and the COVID vaccination programme. The following points were highlighted:-

- Much coronavirus service provision had been directed by National Standard Operating Procedures (SOPs)
- Most services had been stood up, but local flexibility around contracts remained
- Primary care had not been stood down; the way it was delivered had changed
- Throughout the COVID period, face to face appointments had been made available. Around 55% of GP appointments across L&SC were face to face. In response to the SOP there had been an increase in telephone appointments and video consultations
- For 2021, levels of activity were higher than pre-pandemic levels
- General practice had provided over 1 million COVID vaccinations from 36 vaccination sites; 62% of the total vaccines given to the Lancashire and South Cumbria population
- Significant challenges were now facing general practice in terms of the demand built up over the pandemic period. It was important to plan for the impact of the accelerator programme in primary and community care services
- There had been national and local press releases around expectations regarding face to face and non-face to face provision. Patients were struggling to understand what was on offer and how to access. In the last few weeks, standard communications in Lancashire and South Cumbria had increased
- The Phase 3 vaccination programme would be planned going forward. No detail had been received to date, however, it was expected primary care and PCNs would play a significant role in undertaking the programme. Additional funding would be available to provide additional capacity, however, the issue was workforce and how to secure workforce
- Emerging support asks also include the roll out of community pharmacy referral service.

Members discussion included:-

- Patient expectation had changed
- General Practice were constrained with guidance
- Rising cases were expected due to the Delta variant of COVID
- The challenge for primary care was to adjust working practices to accommodate new roles to meet demand
- The timeline of comparison with NW ICS' were consistent with these types of consultation. Cheshire and Mersey/Greater Manchester had an earlier start in terms of implementing video consultation than in Lancashire and South Cumbria
- Morecambe Bay were exploring the principal of mutual aid at ICP level, eg, wound care, phlebotomy

- Increasing pressure across all services around demand for unscheduled care. A different profile was seen in the timing of demand in 111 services; 111 calls used to peak much later in the day, however, the number of calls were now sustained throughout the day
- Many patients were happy with telephone consultations as problems were generally solved on the call. Many practices had been undertaking telephone consultations for a long time, adding patient value. Face to face consultations were undertaken in addition to telephone consultations
- One of the biggest issues for practices over the last few weeks had been dealing with increasing challenges in an environment of blame for being unable to provide what people want. Communication and information sharing was important
- Services for acute primary care, extended out of hours, etc, into restoration and walk-in patients had all been restored to pre-pandemic for patients to access urgent services
- Challenges around primary care visiting patients in care homes had been overcome with all care homes having been vaccinated for 1st and 2nd dose vaccine
- Important relationships remained with PCNs and services provided to care homes.

The Chair recognised the huge challenge and asked the system to be mindful of the need to continue to support primary care. Amanda Doyle (AD) commented that Peter Tinson and the primary care leaders group had undertaken much work around solving problems across the system and agreeing common approaches across the patch. AD reassured the Board that all efforts were being made to deliver the services that were needed.

RESOLVED: That the ICS Board note the update on primary care restoration.

Building the System for 2022 and Beyond

9. System Development: Progress Update and Forward Plan for 2021/22

Andrew Bennett (AB) provided an update on the submission to NHSE/I of a system development plan for Lancashire and South Cumbria before the end of Q1. The Plan is required to set out how the LSC system will implement the contents of the White Paper as well as key risks and issues. The LSC system is also required to undertake a self-assessment of its current position against a System Development Progression Tool (SDPT). Since the last ICS Board meeting, the timetable for presentation of the legislation to Parliament had changed to the end of July 2021, which would impact on the work described within the report due to delays in the publication of national guidance..

A number of workstreams were being led by named Executive Directors and each building submission. To ensure the breadth of work could be managed, plans were being created each quarter, providing clarity of what was being done for each workstream and being clear about risk. Work was being undertaken on the basis that the plan would be updated as the year progressed due current lack of clarity on with the legislative process. The ICS Board were asked to enable the ICS development Oversight Group to receive a final draft of the System Development Plan at its meeting on 8 June 2021 with any further minor amendments before submission on 11 June to be approved by the Independent Chair of the LSC ICS and the ICS Chief Officer. The submitted version would be brought back to the ICS Board in July.

Further detailed work was taking place in relation to future ways of working including identifying what success looks like for the LSC Health and Care Partnership; considering the scope of the Boards for NHS Lancashire and South Cumbria and the wider LSC Health and Care Partnership; and defining the functions of a LSC NHS organisation.

The LSC was also 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.

The expectation and uncertainty facing staff affected by the legislative changes was acknowledged and a HR group had been established, looking at principles to manage this process and regular staff briefings were being circulated including FAQs.

Peter Armer reported that he was hosting a workshop for VCFSE representatives on 15 June to ensure VCFSE organisations were prepared for the forthcoming changes. Currently the 5 ICS VCFSE teams were being prepared to ensure they could do business with ICPs.

RESOLVED: The ICS Board:-

- **Noted the requirements associated with the submission of a System Development Plan to NHS England/Improvement by 11 June 2021**

- **Noted the progress made across the Lancashire and South Cumbria Development Programme**
- **Approved the proposed approach to submission to be overseen by the ICS development Oversight Group.**

Outturn Reports for 2020/2021

10. Revenue and Capital Outturn 2020/21

Gary Raphael (GR) reported on the final outturn for 2020/21 including the financial performance for all Lancashire and South Cumbria partners in respect of both revenue and capital. It was noted that the figures were subject to audit, and not all audits had been completed at this stage.

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' amount for the annual leave accruals in trusts and loss of non-NHS income which, when excluded, gave a revised target of £20.2m deficit.

RESOLVED: The ICS Board noted the updated position on the 2020/21 final outturn.

11. Any Other Business

There was no other business raised.

Date and time of the next formal ICS Board meeting:
Wednesday, 7 July 2021, 10 am – 12.30 pm, MS Teams Videoconference

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Lancashire and South Cumbria Health and Care Partnership

ICS Board – Action/Decision Log (Updated 29 June 2021)

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
ICSB210206-04	**Workforce –** Discussion to take place at the next People's Board, reporting to the SCC.	Isla Wilson/Paula Roles / Karen Partington	Open	August 2021	
ICSB210206-06	**Health Inequalities –** Isla Wilson asked for urgent assurance as to the plan for health inequalities	ICS Execs	Open	July 2021	
ICSB210206-05	**Elective Recovery Accelerator Programme –** Key data on numbers, P1 and P2, cancellations, etc, to be provided at a future meeting.	Kevin McGee	Open	August 2021	
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	July 2021	2 June 2021 – Contract now in place. Discussion yet to take place.
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	Propose to close	May 2021	29 June 2021 - Executive team to action via agenda setting process. (eg, Elective Recovery for July meeting.)
ICSB210704 – 05b	**Elective Recovery Plan –** Refreshed trajectories to be reported to future meeting.	Kevin McGee	Propose to close	July 2021	On agenda for 7 July 2021.
ICSB201202	Ensure process for equality impact assessments	Talib Yaseen	Propose to close	July 2021	On agenda for 7 July 2021. 2 June 2021 – Update to be provided at the next meeting. • Exploratory work completed with Midlands and Lancashire CSU to explore the process for EIA that is in place across all 8

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

ICS Board

Date of meeting	**7th July 2021**
Title of paper	**System Reform: Progress Update**
Presented by	Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS
Author	Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS
Contributors	Sam Proffitt, Director of Provider Sustainability, ICS Steve Christian, Chief Integration Officer, Lancashire and South Cumbria NHS Foundation Trust Sarah Sheppard, Interim Director of HR and OD, ICS Victoria Ellarby, Programme Director – System Reform, LSC ICS
Agenda item	**5**

Executive summary

The purpose of this paper is to confirm that the ICS submitted its latest System Development Plan to the Regional team of NHS England & NHS Improvement (NHSEI) by the 30th June.

A national ICS Design Framework was published on the 16th June and offers additional guidance on the continued development of the Health and Care Partnership for Lancashire and South Cumbria and the actions required to establish a statutory NHS body for the same footprint.

The paper also provides a progress update on a number of key workstreams within the System Development Programme.

Recommendations

The ICS Board is asked to:

1. **Note** that a System Development Plan was submitted to NHSEI by 30th June 2021.

2. **Discuss** the progress made across the LSC System Development Programme.

Implications

If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Equality impact and risk assessment completed			✓	
Financial impact assessment completed			✓	

Patient and public engagement completed			✓	
Risks identified	✓			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, Lancashire and South Cumbria ICS

Lancashire and South Cumbria
Health and Care Partnership

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

ICS Board
Wednesday 7th July 2021

1. Introduction

The purpose of this paper is to confirm that the ICS submitted its latest System Development Plan to the Regional team of NHS England & NHS Improvement (NHSEI) by the 30th June.

A national ICS Design Framework was published on the 16th June and offers additional guidance on the continued development of the Health and Care Partnership for Lancashire and South Cumbria and the actions required to establish a statutory NHS body for the same footprint.

The paper also provides a progress update on a number of key workstreams within the System Development Programme.

2. LSC System Development Plan and Peer Review

Members of the Board will recall that the ICS was required to update and submit a System Development Plan to the Regional NHS team before the end of Quarter 1. A final draft of the Plan was signed off by the ICS development Oversight Group on 8th June and submitted on the 11th June. The final submission is shown below as an Appendix.

Regional colleagues then facilitated a helpful peer review session involving representatives from each of the three ICSs in the North West on Thursday 24th June. The session allowed colleagues to identify areas of common challenge and opportunities for peer support. Based on the discussions held, it is likely that there will be further contact between the 3 systems and Regional team on issues such as:

- The development of a financial framework which is able to support the development of effective integrated care arrangements in Lancashire and South Cumbria
- Supporting planning and risk mitigation during the process of CCG closedown
- Sharing good practice in relation to Equality, Diversity and Inclusion
- Tackling health inequalities

The System Development Plan was completed largely before the publication of the ICS Design Framework (see section below) although there was an opportunity for the ICS team to cross-check that there are no anomalies in expectations and timelines between the Lancashire and South Cumbria plan and national guidance.

It is expected that a further iteration of the Development Plan will be reviewed by the ICS Board during Quarter 2.

3. ICS Design Framework

This national document was published on 16th June and provides more information and guidance on the development of both the Health and Care Partnership and the NHS statutory body for Lancashire and South Cumbria. A link to the document is shown here:

https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/

The Framework identifies a number of areas where there will be clear expectations about the formation of the new partnerships and organisations, whilst also identifying issues which are open to local determination. The document also points to a number of areas e.g. relating to governance, accountability and financial frameworks where further guidance can be expected.

In general terms, the Framework document builds very positively on the development work which has already been undertaken in the ICS, the 5 place-based partnerships and in our provider collaborations.

Members are reminded that the guidance was published *subject to legislation* and it is therefore possible that changes may follow from the legislative process in Parliament.

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:

Considering the scope of the Boards for NHS Lancashire and South Cumbria and the wider LSC Health and Care Partnership: The ICS Design Framework sets out further information the distinct roles of these two Boards which are expected to be confirmed during the legislative process. At the request of the ICS development Oversight Group, interviews have taken place in early June with 30 senior leaders to discuss the purpose of the Health and Care Partnership Board and how this will need to be different from the way in which the LSC ICS Board has functioned to date.

It is clear from these early discussions that colleagues believe the Partnership Board should be established with a clear ambition as to what it might achieve in tackling issues such as:

- The wider determinants of health
- Persistent health inequalities
- Promoting and enabling integration of services

Colleagues added that the Board should ensure its approach is outward-looking, listening and accountable to communities and that there are very strong links to all of the place-based partnerships.

Further discussions are required to ensure that Board does not duplicate the roles of local Health and Wellbeing Boards.

4.2. **Commissioning reform**

The CCG Transition Board continues to oversee the necessary planning of activities which relate to the expected closedown of CCGs. Executive leads have been identified in each CCG and additional capacity for this programme of work is now being provided by Mersey Internal Audit Agency. Arrangements are now agreed to ensure an effective process of contracts novation from the 8 CCGs into the NHS statutory body from April 2022.

There is also a particular focus on the identification of the risks of transition so that these can be mitigated in each CCG's closedown plan.

4.3. **Development of Place-Based Partnerships (ICPs)**

LSC is continuing to undertake significant work in relation to future ways of working, overseen by the ICP Development Advisory Group (ICP DAG). Each place-based partnership is working through an action plan endorsed by the ICS Board at its meeting in May 2021. At its last meeting, the Group reviewed progress reports from each ICP and there are no significant delays.

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:

Provider Collaboration: All five Trusts in LSC are working with NHSEI to pilot a collaborative development framework that will subsequently be used nationally. The outputs from an initial workshop at the end of May has provided a clearer understanding of the current landscape and work is now being done to develop the Vision, Purpose and Key priorities to take the development of Collaborative forward.

A session is planned during July with the Provider Collaborative Board members, which includes all Provider Chairs and CEOs, to develop the Strategic Direction and key priorities. A common strategic narrative is being developed that

describes the future landscape for 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). A Strategic Coordination Group with executive membership from all Providers is now reporting to the Provider Collaborative Board and will oversee the delivery of the priorities. This Group is being supported by Aqua in its development as team.

Mental Health Lead Provider Collaborative: The System Transition Board established by the ICS to oversee the development of a lead provider collaboration for mental health, learning disability and autism services has now met for the second time, chaired by a Non Executive Director of the ICS Board. Members of this collaborative include Lancashire and South Cumbria NHS Foundation Trust as lead provider together with other NHS, local authority and voluntary sector partners.

The Board has endorsed a set of terms of reference and discussed a Programme Oversight Document which outlines the governance with work streams being scheduled from July onwards to support delivery. The System Transition Board will:

- Oversee the planning of the lead provider model as the future approach for NHS delivery of mental health, learning disability and autism services
- Make key recommendations to the ICS board to support system-wide transformation using collaborative opportunities across all sectors of health and care involved in the delivery of mental health, learning disability and autism services.

The next Board scheduled in early August will sign-off the Programme Plan (roadmap) which will outline the key milestones in line with what is in scope for the Board. A key focus over the summer will be to assess the requirements of the provider collaboration for MH, LD&A in line with the forthcoming legislation as well as current policy and guidance, to support the development of the Lead Provider model. A key focus will be undertaking due diligence and assurance processes, as determined by NHSEI.

As reported previously, to support service transformation, the Transition Board has endorsed the development of system-wide all age strategies for Mental Health, Learning Disability and Autism. Workshops to begin this process are planned to take place in July and August.

4.5. **Clinical and Professional Leadership**

Given the expected changes arising from the White Paper and the creation of new organisations and partnerships, it is now timely to consider how our models of clinical and professional leadership will evolve over the next 2-3 years. There

are several references to this in the ICS Design Framework and the issue of clinical and professional leadership has been raised during our ICP development programme and in the closedown of CCGs.

For these reasons, proposals for a time-limited programme to consider our future leadership models have been prepared for the ICS development Oversight Group to consider in July.

4.6. **Communications and Engagement**

A second staff briefing document was circulated during June to CCGs, CSU and ICS team members who are likely to be directly affected by the changes laid out in the White Paper. Arrangements are being made for a virtual briefing of these staff groups during July to ensure there are opportunities to explain the next stages of the system development plan and to encourage staff members to raise unresolved questions and concerns.

Scoping work has now begun to create Narratives explaining the purpose and contribution of our provider collaboratives. These will be presented to the ICS Board later in the summer.

4.7. **Workforce**

The focus of the Workforce workstream continues to be on three core areas of priority:

- Ensuring plans are in place to support the transition process for staff moving into the new organisational arrangements from April 2022;
- Considering the development of a Workforce function within the new NHS statutory body;
- Identifying the organisational development priorities for the new organisations and collaborative working arrangements across the system.

This work is expected to be guided by the imminent publication of national guidance which will supplement the details of the Employment Commitment towards NHS staff who are affected by the proposed changes.

5. Recommendations

The ICS Board is asked to:

- **Note** that a System Development Plan was submitted to NHSEI by 30th June 2021.
- **Discuss t**he progress made across the LSC System Development Programme.

Lancashire and South Cumbria Health and Care Partnership

System Development Plan

June 2021

Foreword

Our commitment to partnerships

Partners within the Lancashire and South Cumbria health and care system have been working together for a number of years to join up health and care. There are many examples of how this joint working has made a difference to the lives of local people. And yet many significant challenges remain.

The overarching aims of our plan are to improve the health and wellbeing of people living across Lancashire and South Cumbria and to reduce health inequalities.

We can only do this effectively and sustainably by taking action to improve the underlying issues which impact health, healthy behaviours, the lifestyle choices we make and the places and neighbourhoods we live in. Partnership working across many different sectors and organisations is vitally important in delivering on our key aims.

We are fully committed to further developing the breadth and depth of our partnerships. We recognise the valuable and varied perspectives that different partners bring to tackling our key challenges; we respect the ways in which different partners provide connections into our communities; and we understand that the knowledge and experiences of our communities themselves must be used in the planning and delivery of our services. Meaningful involvement of our communities and accountability to our residents must shape our future ways of working.

How we work together, being good partners to each other, is equally as important as what we do together.

The population of Lancashire and South Cumbria is diverse, with several factors contributing to inequalities across our health and care system. We recognise the importance of addressing these inequalities across the breadth of our services, for example through access to education, training and employment opportunities hosted by our 'anchor institutions' or through ensuring that health, wellbeing and care services are tailored to meet the specific needs of individuals and communities.

It is also important to us that our future leadership is fully reflective of the communities we work with.

An Equality Impact Risk Assessment will be undertaken across all of our system development workstreams.

Our System Development Plan

This System Development Plan is one of a suite of documents that Lancashire and South Cumbria partners are developing. Some documents are focused on our overarching aims of improving health and wellbeing and reducing health inequalities whilst others are more focused on our approach to building partnerships and structural changes to our ways of working that will deliver elements within the White Paper.

Several documents set out ***what*** we intend to do, for example:

- Our strategy, which describes our overarching aims and our key transformation programmes that are directly linked to health and wellbeing priorities and to key enablers such as developing our workforce and improving our use of digital solutions.

- A series of 'strategic narratives' that describe what the future looks like for our system, our place-based partnerships and our provider collaboratives. These are being used as the basis of our communications and engagement activities with staff and stakeholders.

Whilst others describe ***how*** we intend to deliver this, for example:

- This System Development Plan, which sets out our high-level plan for furthering our partnership working and delivering changes related to future ways of working. This plan identifies key outputs that will be delivered across the remainder of 2021/22.

We recognise that this plan will be iterative, linked to the outcome of the reading of the Bill in Parliament and the publication of national guidance. We will review the contents regularly and will continue to use this plan to drive delivery through our governance arrangements.

David Flory CBE
Independent Chair

Dr Amanda Doyle OBE
Chief Officer

Contents

Our health and care system

Partners within the Lancashire and South Cumbria system have been working together for a number of years to join up health and care. Our aim is to build on the work that we have started, and to use the opportunities presented in our System Development Plan to further increase our partnership working to improve the health and wellbeing of the people living across Lancashire and South Cumbria and reduce health inequalities.

Why we need to change

Our challenges are significant and well documented. They are not unique to Lancashire and South Cumbria, although some problems are worse for us locally.

Widening inequalities, staffing, funding, waiting times and pressures from an ageing population are all growing issues. Some of these issues have been exacerbated by the Covid-19 pandemic. We must be bold in our collective efforts to solve these problems with urgency.

Our purpose – together we can make things better

The partnership of health and care organisations working across the Lancashire and South Cumbria System have agreed a clear purpose for our work together. Our agreed vision, as described in our system strategy, is

"To empower and support healthy communities so that people have the best start in life and can live and age well.

We will do this by working together, as equal partners, to listen to the needs of our population, join up health and care services and address the challenges we face."

National context

In February 2021 the Government published a White Paper outlining how the NHS in England needs to change to enable health and care to work more closely together.

It has long been our aspiration to improve the way services work together and to be excellent partners to each other, but bureaucracy has sometimes got in the way. The reforms out lined in the White Paper therefore support our local ambitions by removing some of the current legal rules that can get in the way of joined up working and by accelerating our ambitions for increased integration and collective decision-making.

Lancashire and South Cumbria Health and Care Partnership

Our aims

Our Health and Care Partnership has commenced work on defining "what success looks like" in the context of:

- The nationally defined aims of a health and care system
- Our own vision and ambitions

It is important that success is considered from the perspective of all our partners, and that this success is described in a way that is meaningful to all and understandable by all. We have further work to do in understanding key drivers and in creating measures that sit behind these areas of focus

Our current themes

1. Improving the health and wellbeing of our residents
2. Improving the quality of our health and care services and the outcomes for our residents
3. Addressing the inequalities facing our residents
4. Ensuring good value for money
5. Actively contributing to social and economic development
6. Actively supporting the health, wellbeing and development of our workforce and ensuring the right skills and competencies
7. Listening to our communities and actively involving them in decision-making
8. Being good partners to each other in our Health and Care Partnership

What will the future look like for us?

We have already started to organise our work across different interconnected geographical footprints. The changes outlined in our System Development Plan will build on this.

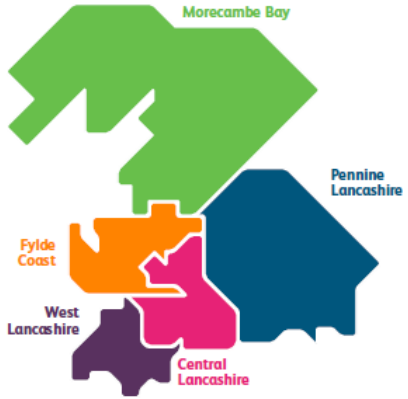
Our system

Our geographic footprint covers Lancashire and South Cumbria (districts of Barrow and South Lakeland), and we do not propose any changes to this. At a system level, our Lancashire and South Cumbria Health and Care Partnership provides strategic leadership for health and care. It includes local authorities; the NHS; voluntary, community, faith and social enterprise (VCFSE) organisations; academic institutions; other public sector organisations; and our communities.

Our places and neighbourhoods

We have five place-based partnerships within our system, which bring together planners and providers across health, local authority and the wider community to improve health and wellbeing. We do not propose any changes to these places.

Within our five places, we have 41 primary care networks around which we have established neighbourhood care teams which bring together primary and community health and care providers with wider public services and the VCFSE sector.



Our provider collaboratives across the system (acute and mental health)

Our NHS acute providers (four Trusts) are working together on the planning and delivery of acute healthcare services across the Lancashire and South Cumbria footprint to develop a provider collaborative model.

For mental health, learning disabilities and autism, partners are working together across the Lancashire and South Cumbria footprint to develop lead provider models for these services.

Changes to local government (Cumbria)

We are awaiting the outcome of a consultation on unitary authorities in Cumbria. Whichever option is selected, the Lancashire and South Cumbria Health and Care Partnership is fully committed to work with local government across Cumbria to ensure that the co-design required for the successful development and mobilisation of that option is delivered rapidly and effectively.

Lancashire and South Cumbria Health and Care Partnership

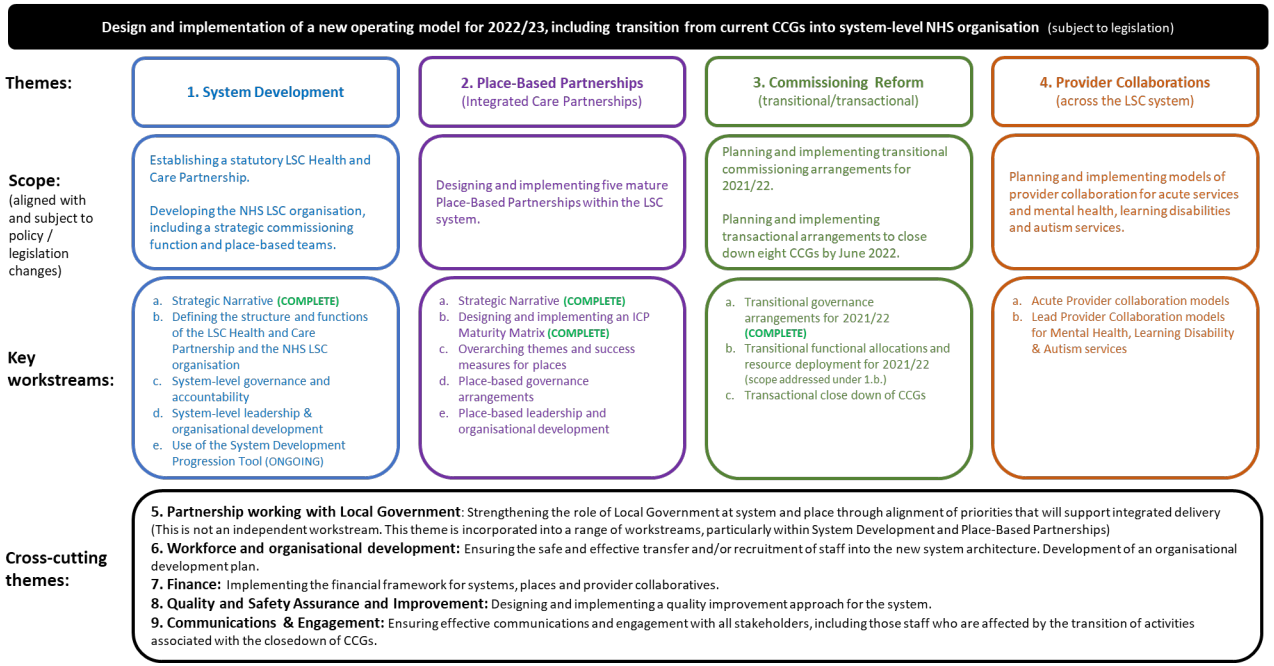
Our System Development Plan

Our System Development Plan builds on our initial thinking in autumn 2020, which was further enhanced in early 2020. It is structured across a number of key themes.

Our themes

1. System Development
2. Place-Based Partnerships
3. Commissioning Reform
4. Provider Collaborations
5. Partnership working with Local Government
6. Workforce and Organisational Development
7. Finance
8. Quality and Safety Assurance and Improvement
9. Communications and Engagement

Lancashire and South Cumbria System Development Plan (June 2021)



Themes and their workstreams – plan on a page

For each workstream within the themes, we have developed a plan on a page which sets out the key outputs across Q1 to Q4 of 2021/22 and the overarching deliverables for the start of 2022/23.

The timeframes within these plans have been informed by current insight on the timings for national legislative processes, the subsequent likely timings for the publication of national guidance, and local ambitions for new ways of working.

Risks

Each workstream has identified its own risks. Those risks with a score of 15 or higher are escalated through the relevant governance arrangements.

A key theme across several workstreams is the ongoing delay in the publication of national policy/guidance. This is resulting in a prolonged period of uncertainly for our workforce and the need to undertake a significant change programme in the second half of 2021/22.

Issues

Given the further delays to the progression of the Bill through Parliament and the subsequent delays to the publication of national guidance, we consider that one of our key risks has now become an issue:

- Delay in Bill having second reading in Parliament results in a further delay in the publication of national policy / guidance which ***RISKS*** a relatively short timeframe for implementation in the second half of 2021/22 which will coincide with operational pressures related to winter and the potential further pressures related to the prevalence of Covid-19

As a risk, this had been scored as **20** (Impact 4 x Probability 5).

We continue to undertake significant work on the design and implementation of our system, place-based partnerships and provider collaboratives, noting the “permissive” approach outlined by NHSEI in relation to much of the development activities, particularly at place. However, it is now inevitable that a significant amount of change will need to take place during Q3 and Q4 which will be challenging for the LSC Health and Care Partnership, particularly for NHS partners who will need to manage the transition of large numbers of staff.

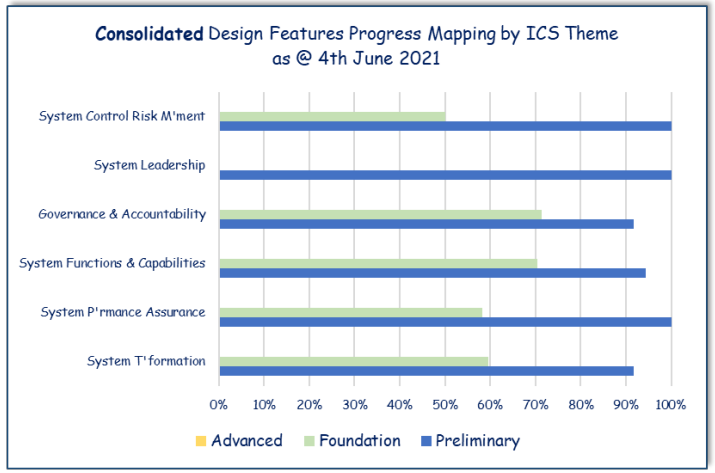
The System Development Progression Tool

Self-assessment

A final version of the SDPT is yet to be published by NHSEI. Therefore, a working draft version has been used to undertake a self-assessment of progress against the "Preliminary" and "Foundation" features of ICSs across a number of themes. Each theme has a series of statements, against which a rating is selected: "Significant progress", "Some progress", "Lots to do".

Significant progress can be demonstrated across all themes for the "Preliminary" features, as shown in the chart. As anticipated, further work is required around the "Foundation" features.

Assessment again the "Advanced" features has not been completed as these are areas that require longer term development and have a significant dependency on national guidance.



Areas of further development

The SDPT has highlighted key areas for further development. Many of these are already contained with the System Development Programme workstream plans for 2021/22 (indicated by a ✓).

However, it should be noted that several are not directly within the scope of the System Development Programme, but instead should be considered within the wider scope of the current ICS Board (of the future NHS LSC Board / LSC Health and Care Partnership Board).

1. System and digital transformation

- Review and refresh system transformation programmes post-Covid, ensuring they are appropriately resourced and clearly linked to delivery of priorities at system, place and neighbourhood
- Increase community involvement in designing / transforming health and care services, particularly for communities affected by inequalities *(✓ for place-based partnerships)*
- Strengthen enabling work programmes, including digital and data plans across the system; estate strategy; people plans across the health and care workforce

2. Leadership and people development

- Succession planning and people development across the system
- Development of future leadership teams at system, place, neighbourhood and in provider collaboratives, including clinical and professional leadership *(✓)*

3. System oversight and quality improvement

- Further development duties in relation to quality, performance and assurance, being clear on accountability and a collective approach to owning and addressing quality and performance challenges at system and in places *(✓)*
- Coproduction with staff and residents *(✓ for place-based partnerships)*
- Quality improvement priorities based on what matters to local people *(✓ for place-based partnerships)*

4. System roles and capabilities

- System stewardship to constructively challenge local health and well-being leaders to set higher collective ambitions than any single partner acting alone is able to do *(✓)*
- Nurture and deepen relationships between system partners *(✓)*
- System-wide clinical network development to address key clinical challenges prevalent across our system
- Involvement of residents in priority-setting, in associated decision-making and in holding the system to account for both the outcomes and value for money achieved *(✓)*
- Population based payment models *(✓)*
- An organisational development programme that is inclusive of all partners across the system *(✓)*

5. Financial framework and use of resources

- Greater collective work across NHS and non-NHS funding within the system *(✓)*
- A financial framework that includes processes, controls, interventions and governance arrangements designed to enable system partners to collectively accept and manage whole population capitation risk *(✓)*

6. System leadership, governance and accountability

- Partners are clear on the mission, benefits and added value of them working collaboratively at system, place and neighbourhood, and within the provider collaboratives *(✓)*
- Strengthen engagement of the wider non-executive community across the system and help them identify and proactively manage the interplay between system and organisational responsibilities within the system *(✓)*
- Clarity on governance and accountability at different levels of the system, that this reflective of the underpinning design principle of "subsidiarity" *(✓)*

Areas where we would appreciate peer support

Considering our System Development Plan and the themes within the SDPT, we have identified a number of areas where we would appreciate peer support, either within the NW Region or with connections across England. In some cases, these will also benefit from the publication of national guidance. We have reviewed this in the light of the NW Peer Review which took place on the 24th June.

- An approach to engaging residents in shaping what success looks like for a Health and Care Partnership, and in creating a tangible sense of accountability to residents
- Any recommended approaches / mechanisms / organisational development programmes that will further strengthen working relationships across the different sectors within partnerships
- An accountability framework across system, place, neighbourhoods and provider collaboratives
- A decision-making framework for system and for place, considering a scheme of delegation to support integrated working.
- An integrated approach to workforce planning across all sectors in the system
- An integrated approach to financial planning across all sectors in the system
- A financial framework, including how place-based allocations could be made within the future system, and how partners within the place will manage that allocation effectively
- An approach to equality, diversity and inclusion which draws on best practice across the NW region
- An opportunity to share peer learning from the involvement of Professor Michael Marmot in our health inequalities work

Our governance arrangements

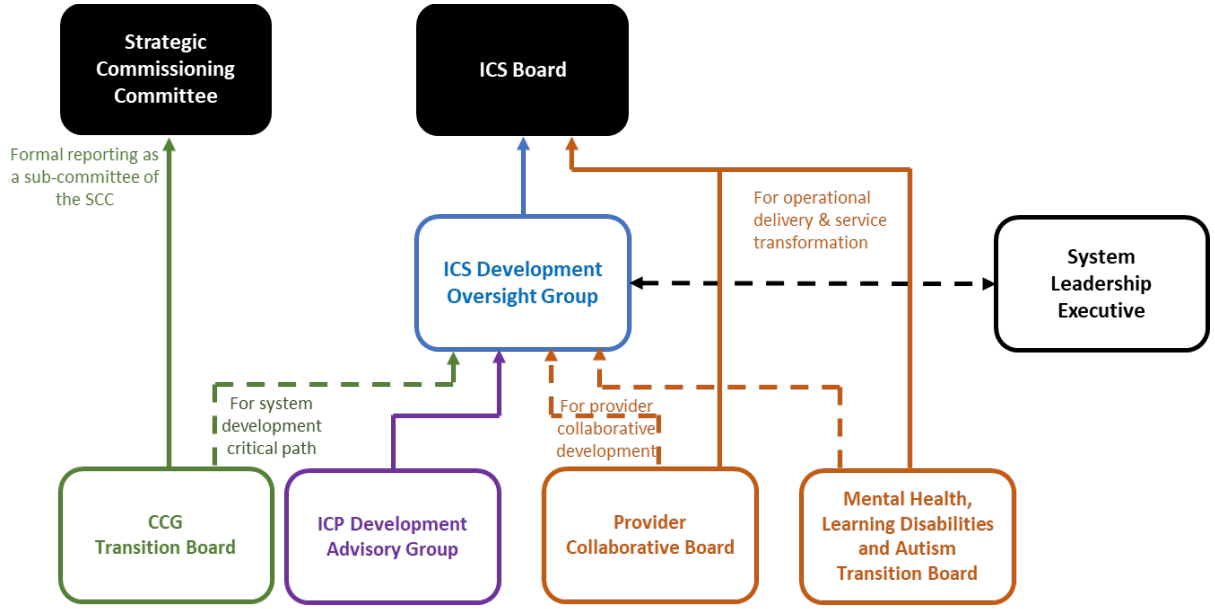
We have established a governance structure to oversee delivery of our System Development Plan, as outlined below

ICS Development Oversight Group

The ICS Development Oversight Group has oversight of the whole of the System Development Plan (delivery of key outputs in the plan on a page, interdependencies, key risks and issues, etc). This includes the four key themes of system development, place-based partnerships, commissioning reform and provider collaboration. The ICS Development Oversight Group has a lay / clinical chair, as do the CCG Transition Board, the ICP Development Advisory Group, the Provider Collaborative Board and the Mental Health, Learning Disabilities and Autism Transition Board.

Progress on cross-cutting workstreams is monitored by the ICS Development Oversight Group.

This ICS Development Oversight Group acts as the route in and out of the NW ICS Coordination Group.



Lancashire and South Cumbria System Development Plan (June 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 Collaborations (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 (scope addressed under 1.b.) 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 and Safety Assurance and 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.

National expectations as set out by NHSEI (June 2021)

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

These expectations have been mapped against the LSC themes and workstreams to ensure alignment with national expectations

2021/22 – Q1

Preparation phase

- Update System Development Plans (SDPs) against the key implementation requirements (functions, leadership, capabilities and governance) and identify key support requirements.
- Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.

2021/22 – Q2

Implementation phase

- Ensure all people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately.
- Carry out the agreed national recruitment and selection processes for the ICS NHS body chair and chief executive, in accordance with guidance on competencies and job descriptions issued by NHSEI. This will reflect the expected new accountabilities and responsibilities of ICS NHS bodies.
- Confirm appointments to ICS chair and chief executive. Subject to progress of the Bill after the second reading these roles will be confirmed as designate roles.
- Draft proposed new ICS NHS body MoU arrangements for 2022/23, including ICS operating model and governance arrangements, in line with NHSEI model constitution and guidance.
- Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint.
- Begin due diligence planning

2021/22 – Q3

Implementation phase

- Ensure people in impacted roles are well supported and consulted with appropriately.
- Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level roles in the NHS ICS body, using local filling of posts processes.
- Confirm designate appointments to ICS NHS body finance director, medical director, director of nursing and other board and senior level roles
- ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form.
- Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.

2021/22 – Q4

Transition phase

- Ensure people in affected roles are consulted and supported.
- Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes.
- Confirm designate appointments to any remaining senior ICS roles (in line with relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force).
- Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with NHSEI guidance.
- Commence engagement and consultation on the transfer with trade unions
- Complete preparations to shift NHSEI direct commissioning functions to ICS NHS body, where this is agreed from April 2022
- Ensure that revised digital, data and financial systems are in place ready for ‘go live’.
- Submit the ICS NHS Body Constitution for approval and agree the 2022/23 ICS MoU with NHSEI, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in future, in accordance with guidance to be issued.

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

Lancashire and South Cumbria Health and Care Partnership

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:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

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
• Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.	• Plan for CCG teams to only operate at sub-ICS level where the SDP confirms that the ICS plans to establish a significant place-based function at that footprint.		• Complete preparations to shift NHSEI direct commissioning functions to ICS NHS body, where this is agreed from April 2022

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

1. System Development

1. c. System-level governance and accountability

Executive Lead: Andrew Bennett
Workstream Lead(s): Various

External Support: Transformation Unit

Lancashire and South Cumbria Health and Care Partnership

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:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

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 planned governance and leadership models in place (linked to place-based partnerships development programme) • Draft proposed new ICS NHS body MoU arrangements for 2022/23, including ICS operating model and governance arrangements, in line with NHSEI model constitution and guidance.	• 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) • ICS NHS bodies and ICS Partnerships to be ready to operate in shadow form. • Engagement on local ICS Constitution and governance arrangements for ICS NHS body and ICS Partnership.	• 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 • Submit the ICS NHS Body Constitution for approval and agree the 2022/23 ICS MoU with NHSEI, setting out key elements of how the new ICS NHS body and ICS Partnership will operate in future, in accordance with guidance to be issued.

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:** TBC

Lancashire and South Cumbria Health and Care Partnership

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:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Scope requirements of organisational development programme	• Model for NHS LSC body 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 Chair of NHS LSC body and LSC Health and Care Partnership Board • Confirm designate appointment to Chair of NHS LSC organisation and LSC Health and Care Partnership Board • Process agreed for appointment of CEO, CFO and other key executives of NHS LSC organisation • Create model for organisational development programme • Carry out the agreed national recruitment and selection processes, and confirm designate appointments for the ICS NHS body chair and chief executive (subject to progress of Bill)	• Confirm designate appointments to CEO, CFO, Medical Director and Nursing Director roles of the NHS LSC organisation • Process agreed for appointment of other NHS LSC organisation Board roles • Organisational development programme commences • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level roles in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director, director of nursing and other board and senior level roles	• Confirm designate appointments to other NHS LSC organisation, inc. place-based leaders • All designate appointments formally ratified • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force).

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

2. Place-Based Partnerships
(Integrated Care Partnerships)

2. c. Overarching themes and success measures for places

Executive Lead: ICP Directors
Workstream Lead(s): Various

External Support: TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Ensuring common threads across the vision and aims for the five places, ensuring alignment with the ICP strategic narrative and the White Paper
- Creation of a local development programme to address gaps identified via the ICP Maturity Matrix (to dovetail with common development programme across the five places)
- Place-based communications and engagement plan re development of place-based partnerships (linked to cross cutting theme 9. Communications & Engagement)
- Development of success measures for place-based partnerships (linked to 1.c. System level governance and accountability), including creation of a balanced scorecard and an approach for engaging residents
- Developing an integrated approach to planning services across all partners in the place-based partnership

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Refreshed vision and aims for each place, with common elements across all • Local development programme for each place • Create local communications and engagement plan re development of place-based partnerships • Create plan for engaging residents in determining success measures of place-based partnerships	• Implementation of local communications and engagement plan re development of place-based partnerships • Create place-based balanced scorecard that aligns with system-level success measures and takes into account views of residents	• Implementation of local communications and engagement plan re development of place-based partnerships • Fully implemented place-based balanced scorecard that aligns with system-level success measures and takes into account views of residents. Must also link with NHS System Oversight Framework.	• Integrated plan for 2022/23 that includes all partners in the place-based partnership (inc. as a minimum operational delivery, workforce, quality, finance)

Overarching deliverables for 2022/23

- Measures of success agreed that take into account views of residents, aligns to system-level success measures and to NHS System Oversight Framework
- Integrated plan for 2022/23 that includes all partners in the place-based partnership (inc. as a minimum operational delivery, workforce, quality, finance)

2. Place-Based Partnerships
(Integrated Care Partnerships)

2. d. Place-based governance arrangements

Executive Lead: ICP Directors
Workstream Lead(s): Various

External Support: TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Ensuring meaningful involvement of all partners, and transparency across partner organisations
- Creating and implementing a partnership agreement which outlines the roles and responsibilities of each partner within the place and includes core principles / terms of engagement for integrated working
- Support the development of MoUs for 2022/23 – between the LSC Health and Care Partnership and place-based partnerships (linked to 1.c. System level governance and accountability)
- Ensure appropriate governance arrangements in place where partners can hold each other to account for delivering the core aims of a place-based partnership (inc. Place Based Partnership Board, formal place-based groups around key service areas, clinical and professional leadership body) and can feel a sense of accountability to residents.

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Partnership agreement in each place (with core common content across all five places) • Place Based Partnership Board established in all five places • Open-door policy deployed across organisational committees / groups	• Develop draft MoUs between LSC Health and Care Partnership and place-based partnerships • Formal place-based groups established with responsibility for planning and delivering using an integrated approach • Clinical and Professional Leadership body established in all five places	• Draft proposals on accountability and decision-making frameworks in places (linked to those operating at system level and with provider collaboratives)	• Agree MoUs between LSC Health and Care Partnership and place-based partnerships • Financial framework implemented, including place-based NHS allocations. • Place Based Partnership Board to ensure full sense of accountability to local residents. • Clarity on how Place Based Partnership Boards fit within wider system governance, including the LSC Health and Care Partnership Board and the NHS LSC Board, and HWBs

Overarching deliverables for 2022/23

- Governance arrangements for place-based partnerships fully implemented and aligned with system governance
- Accountability and decision-making frameworks implemented for places
- MoUs agreed - between the LSC Health and Care Partnership and place-based partnerships

2. Place-Based Partnerships
(Integrated Care Partnerships)

2. e. Place-based leadership and organisational development

Executive Lead: ICP Directors
Workstream Lead(s): Various

External Support: TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Design and implementation of a leadership model for place-based partnerships, including a Chair, Place Based Leader, executive leadership team (incorporating the "LSC place-based team"). This must also include appropriate non-executive / lay oversight and the role of elected members.
- Design and implementation of a clinical leadership model for place-based partnerships (linked to 1.d. System-level leadership and organisational development)
- Design and implement common behavioural principles / values
- Design and implementation of an organisational development programme to support senior leaders in the transition from organisational leadership to place-based leadership

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Interim Chair in post for all five places • Interim nominated senior leader in post for all five places • ICP Director in post for all five places • Common set of behavioural principles/values adopted across all five places • Scope requirements of organisational development programme	• Role description and model for Chair of the Place-Based Partnership from April 2022 onwards • Interim executive leadership team for the place, with members who hold lead director role responsibilities across the place for specific portfolios • Define place-based leader role and process for appointment • Model for clinical/professional leadership at place • Create model for organisational development programme • Organisational development programme commences	• Framework for ensuring appropriate non-executive / lay / elected members involvement and oversight	• Confirm designate appointments of place-based leaders • Designate place-based leader appointments formally ratified • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes.

Overarching deliverables for 2022/23

- Leadership model for place-based partnerships implemented
- Place-based leaders implemented
- Clinical/professional leadership model implemented
- Organisational development programme commenced and ongoing

3. Commissioning Reform	3. c. Transactions closedown of CCGs: Governance	**Executive Lead:** Denis Gizzi **Workstream Lead(s):** Helen Curtis / Sarah Mattocks	**External Support:** MIAA

Lancashire and South Cumbria Health and Care Partnership

Scope:

- To categorise all of the statutory and technical functions from the 8 x CCGs (senders) in order to enable safe and diligent transfer to the receiver statutory organisation (NHS LSC). This will include all functions, legal duties, people, assets & liabilities
- To ensure that all partners are aligned in these governance arrangements
- To socialise the transition arrangements for governance to ensure engagement and oversight from all partners

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Develop outline structure and close down plan, including a critical path showing key stage requirements, tasks and risks. Existing, well-grounded close down models will be employed in order for the programme to commence a due diligence process • All core functions expected to transfer from CCGs to NHS LSC will be categorised and risk assessed	• Consider external assurance contracts required for notice e.g. internal audit, external audit and counter fraud • Draft plan on how Information Governance arrangements can be 'sent' to NHS LSC • Consider any legacy arrangements, e.g. claims not closed at time of transition or lodged after transition • Develop risk register for closedown • Secure external support (from MIAA) and establish formal groups to deliver programme scope, ensure key functions will comply with closedown assurance requirements and are compatible with requirements of NHS LSC and the regulator. • Begin due diligence planning	• Review of plans against national guidance • Prepare first draft 'sender & receiver' portfolio pack • Formalise transfer process and 'clearance' duties in compliance with NHSE/I framework	• Prepare to stand down current CCG governance structures • Dedicated section in each CCG Annual report/Governance Statement reflecting work undertaken in 2021/22 • Full internal review of due diligence process • Testing of efficiency of process and compatibility with legal and technical requirements • Communicate formal transfer plan, date, time, receiving officer, sending officer • Confirm process and seek assurance from NHSE/I that the processes created are fit for purpose

Overarching deliverables for 2022/23

- Reporting and auditing of annual report and accounts
- Audit of closedown process
- Transfer of governance and functions from 8 x CCGs to NHS LSC organisation

3. Commissioning Reform	3. c. Transactional closedown of CCGs: Finance	**Executive Lead:** Denis Gizzi **Workstream Lead(s):** Kirsty Hollis	**External Support:** MIAA

Lancashire and South Cumbria Health and Care Partnership

Scope:

- To ensure the smooth financial closedown of 8 CCGs, complying with statutory duties including production of annual accounts and report for financial year 2021/22
- To utilise standard documentation for detailing and allocating financial balances and legacy issues
- To ensure a consistent approach to transfer of balances and all financial matters to the successor organisation

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Detailed project plan, referring to current national guidance and directions on closedown	• Draft working papers for use at month 09 interim closedown • Draft documents / letters to agencies informing of closedown ○ HMRC ○ Pensions agency • Comprehensive contracts listing to understand novation requirements • Agree interim and final accounts external audit plans • Begin due diligence planning	• Based on interim closedown, refine standardised working papers • Bring forward as much as possible for year end audit • Manage cash position in line with national guidance & prepare to transfer cash balances to legacy organisation • Month 09 interim closedown • Review capacity and support requirements to deliver annual accounts • Review of plans against national guidance	• Produce annual accounts • Engage with external audit for the audit of accounts • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with NHSEI guidance. • Ensure that revised digital, data and financial systems are in place ready for 'go live'.

Overarching deliverables for 2022/23

- 8 x sets of annual accounts and annual reports
- Standardised documentation of opening balances with appropriate narrative

3. Commissioning Reform

3. c. Transactional closedown of CCGs: CCG Functions

Executive Lead: Andrew Bennett / Denis Gizzi
Workstream Lead(s): Helen Curtis / Clare Thomason

External Support: MIAA

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Categorise all statutory and technical functions from the 8 x CCGs (senders) in order to enable safe and diligent transfer to the receiver statutory organisation (NHS LSC). This will include all functions, legal duties, people, assets & liabilities
- Arrangements for the close down or transfer of that function to an appropriate destination (linked to 1. b. Defining the structure and functions of the LSC Health and Care Partnership and the NHS LSC organisation)
- Agree functions to work differently during transition year, and support resource allocation, and those that will transition post March 2022 (linked to 1. b. Defining the structure and functions of the LSC Health and Care Partnership and the NHS LSC organisation)
- Assess and mitigate against risk to CCG statutory responsibilities during transition year

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Confirm all statutory and non statutory functions within each CCG • Confirm any gaps emerging across functions within CCGs	• Map all functions against their potential destination at system, place or neighbourhood (linked to 1.b.) • Risk assessments for functions in relation to close down and potential loss of workforce • Action plan for the close down/transfer of each function (linked to 1.b.) • Consider external system contracts required for notice e.g software packages • Begin due diligence planning	• Review functions against 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” (linked to 1.b.) • CCG teams only operating at sub-system level where LSC plans to establish a significant place-based function at that footprint (as described in 1.b.) • Continued risk assessment	• Review functions against agreed operating model for NHS LSC organisation to fulfil its functions at system level and at place level as part of an “LSC place-based teams” (linked to 1.b.) • Continued risk assessment • Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with NHSEI guidance.

Overarching deliverables for 2022/23

- Successful / effective closedown of LSC CCGs
- Functions transferred to system, place, neighbourhood
- All legacy issues resolved and satisfied

4. Provider Collaborations

4.a.Acute Provider collaboration models: Defining the vision and purpose

Executive Lead: Kevin McGee
Workstream Lead(s): Sam Proffitt / Gemma Stanion

External Support: NHSEI regional team

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Development of a strategic narrative to outline the purpose and intent of the acute provider collaborative (for staff and stakeholders across the LSC system)
- Creation of a single Clinical Strategy across acute services in LSC

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4

• Initial draft of strategic narrative to outline purpose and intent of the acute provider collaborative (for staff and stakeholders across the LSC system)
• Review of current clinical strategies across acute providers
	• Finalise strategic narrative
	• Agree common understanding of clinical and operational strategy
	• Ensure alignment with recovery programme
		• Develop shared financial strategy	• Agree collaborative work programme for the next 3-5 years
			  ○ Recovery and transformation
			  ○ Efficiency delivery
			  ○ Quality improvement
			  ○ Operational standardisation

Overarching deliverables for 2022/23

- Vision and purpose for acute provider collaborative as part of LSC Health and Care Partnership
- Clinical and operational strategy
- Financial strategy

4. Provider Collaborations	4.a.Acute Provider collaboration models: Governance, accountability and leadership	**Executive Lead:** Kevin McGee **Workstream Lead(s):** Sam Proffitt / Gemma Stanion	**External Support:** NHSEI regional team

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Governance arrangements for the acute provider collaborative in relation to the LSC Health and Care Partnership and organisations
- Decision-making framework that will support collective decision-making across the system
- Development sessions with NHSEI to support future models of governance, accountability and leadership
- Design and implementation of a leadership model for the acute provider collaborative
- Design and implementation of an organisational development programme to support senior leaders in a system leadership model
- Development of improvement approach and delivery model

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Proposals for reporting structure and decision making framework • Ensure alignment with wider LSC workstreams including Out of Hospital, Primary Care and Mental Health • Design development programme for Strategic Co-ordination Group	• Implement reporting structure and decision making framework • Developmental programme with NHSEI to support future models of governance, accountability and leadership • Commence development workshops with Strategic Co-ordination Group • Agree single approach to improvement methodology and programme management	• Review and refresh governance and accountability in alignment with national guidance and developing NHS LSC Board and LSC Health and Care Partnership Board • Implementation of outputs of developmental programme with NHSEI to support future models of governance, accountability and leadership • Implement agreed improvement methodology and programme management approach	• Acute provider collaborative governance, accountability and leadership embedded

Overarching deliverables for 2022/23

- Acute provider collaborative in place with governance, accountability and leadership embedded
- Agreed improvement methodology and programme management approach in place

4. Provider Collaborations

4.b. Lead Provider Collaboration models for Mental Health, Learning Disability & Autism services

Executive Lead: Caroline Donovan
Workstream Lead(s): Steve Christian / Fleur Carney

External Support: Moorhouse

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Workforce transition: Ensure strategic and placed based commissioning, support impacted workforce through transition.
- Due diligence: Ensure clarity and consistency in commissioning approach, through further development of a governance framework
- Planning & service development: Development of collaborative commissioning intentions underpinned by aligned strategies, e.g. MH, LD & A, carers and community health and social care services.
- Strategy and communication: Lead, develop and finalise a system-wide all age strategy for MH LD&A and communication and engagement plans
- Governance and Integration: Develop and implement governance structures that support joint decision making, manage conflicts of interest, prevent further fragmentation of service delivery.
- NHS E LPC Oversight: Transition of NHSE/I specialist commissioning functions into the Provider Collaborative model by 1st October 2022

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Establish Programme Approach and System Transition Board Governance • Mobilise six work streams that will support the overarching deliverables of the System Transition Board • Commence system-wide all age strategy for MH, LD&A	• Clear understanding and mapping of available commissioning resources / infrastructure • Workforce plan to support transition Review current commissioning and quality contracts arrangements. Identify risks and mitigating actions. Assess existing quality assurance processes. • Finalise a system-wide all age strategy for MH LD&A • Develop communication and engagement plan • Propose roadmap to progress to shadow form of provider collaborative model hosted by LSCFT • Formal transition of NHSE specialist commissioning programmes into LSCFT provider collaborative – CAHMS tier 4 and Adult secure	• Co-ordinate change management HR communications to ensure clarity and assurance is provided to staff regularly • Ensure staff are involved in the process and support this involvement through a series of workshops and regular updates • Implement governance structures that support joint decision making, manage conflicts of interest, prevent further fragmentation of service delivery. • Develop business case for delegating responsibilities supported by delivery on Q2 outputs.	• Confirm high level plans in line with commissioning intentions for pathways across mental health, and learning disability and autism services • Formal sign-off business case for transition

Overarching deliverables for 2022/23

- Implement provider collaboration arrangement which will take on additional accountability on behalf of the ICS, working with partners to agree a shared vision and establish governance structures for mental health, and learning disability and autism services.
- Provider collaboration model (hosted by LSCFT) will work with other providers to collectively determine how services are funded and delivered, and how different bodies involved in providing care work together

6. Workforce and Organisational Development	a. CCG closedown/disestablishment (inc. transfer of workforce and relevant HR systems)	**Executive Lead:** Sarah Sheppard **Workstream Lead(s):** Cath Owen	**External Support:** TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Closedown and disestablishment of 8 x CCGs across LSC, including safe and effective transfer of affected workforce to new NHS LSC organisation
- Ensure all LSC CCG statutory roles are disestablished and determine / address any risk in relation to any employment liability
- Implementation of required HR systems and termination of unrequired legacy systems

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Confirm closedown activities and process via project plan • Ensure CCG provider services are considered in terms of transfer to new ICS organisation and/or notice (e.g. payroll) and consideration of transfer requirement to new service provisions for new NHS LSC organisation • Confirm contractual arrangements for non-employed CCG Governing Body members • Consider legacy issues (for potential non-transferring roles) and any actions required prior to closedown (e.g. GP Pensions issue)	• Review LSC plans against national guidance • Confirm transfer mechanism and intended formal process • Establish Data Sharing Agreement between CCGs (and NHS LSC organisation once established) • Consider current organisations individual ESR/payroll databased (VPDs*) in terms of requirement by NHS LSC organisation and the management of any subsequent legacy ESR/payroll systems (VPDs) • Identify single payroll provider for NHS LSC organisation and agree implementation plan *Virtual Private Database	• Review LSC plans against national guidance • Formal confirmation of arrangements for current CCG GB members and non-employed post holders up until 31/3/2022. • Confirm requirements for retention of closure team into new NHS LSC organisation for any outstanding actions/issues • Commence formal consultation with transferring staff • Identify Occupational Health provider for new NHS LSC organisation • Identify and implement recruitment system (e.g. NHS jobs, TRAC)	• Confirm requirements for Governing Body roles as part of disestablishment and closure team requirements • Prepare Employee Liability Information (ELI) for transfer to new NHS LSC organisation • Disable access to CCG systems such as TRAC, NHS Jobs etc. • Transfer of Statutory and Mandatory training records for transferring staff • Agree provision of job evaluation for new NHS LSC organisation • Transfer of Special Class Status records • Formal payroll transfer • Complete preparations to shift NHSEI direct commissioning functions to ICS NHS body, where this is agreed from April 2022 • Ensure that revised digital, data and financial systems are in place ready for ‘go live’.

Overarching deliverables for 2022/23

- Effective CCG closedown and disestablishment
- Relevant staff transfer completed, with staff employed by NHS LSC organisation
- New arrangements in place for HR, payroll and occupational health services implemented

6. Workforce and Organisational Development	b. Recruitment into NHS LSC senior leadership team and associated governance arrangements	**Executive Lead:** Sarah Sheppard **Workstream Lead(s):** Cath Owen	**External Support:** TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Recruitment to NHS LSC senior leadership team, including lay/non-executive, clinical and executive appointments (linked to 1.d. System leadership and organisational development)
- Recruitment to place-based leader roles (in conjunction with place-based partnerships) (linked to 1.d. System leadership and organisational development and 2.e. Place-based leadership and organisational development)
- Establishment of governance arrangements for determination of non-AfC remuneration (as part of initial recruitment and ongoing)

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
	• Model for NHS LSC body leadership and terms (via appropriate Remuneration Committees) • Determine process for senior NHS LSC appointments & impact of employment commitment • Determine affected CCG roles / staff • Agree process for Chair, CEO & CFO of NHS LSC body and place-based leaders • Confirm designate appointment to Chair • Remuneration consideration re staff potentially displaced via local Remuneration Committees • Remuneration Committee to determine remuneration for non-AfC roles for NHS LSC Board (linked to national guidance) • Carry out the agreed national recruitment and selection processes, and confirm designate appointments for the ICS NHS body chair and chief executive (subject to progress of Bill)	• Confirm designate appointments to CEO, CFO, Medical Director and Nursing Director roles of the NHS LSC body and place-based leaders • Process agreed for other NHS LSC body Board roles (inc. potential alternative roles for displaced staff(in line with Employment Commitment) • Formal consultation with staff potentially impacted by national guidance and LSC implementation plan • Recruit NHS LSC senior leadership team • Carry out the recruitment and selection processes for designate finance director, medical director, director of nursing and other board level roles in the NHS ICS body, using local filling of posts processes. • Confirm designate appointments to ICS NHS body finance director, medical director, director of nursing and other board and senior level roles	• Agree shadow Remuneration Committee TOR for new NHS LSC organisation • Continue the recruitment and selection processes for all other designate ICS NHS body senior roles, including place-level leaders and non-executive roles, using local filling of posts processes. • Confirm designate appointments to any remaining senior ICS roles (in line with relevant guidance) so that as much of the ICS NHS executive board and other senior leadership is ready (subject to formal decisions on appointments after the legislation is in place/in force).

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
- Governance arrangements for NHS LSC determination of non-AfC remuneration

6. Workforce and Organisational Development	c. Organisational development	**Executive Lead:** Sarah Sheppard **Workstream Lead(s):** Cath Owen	**External Support:** TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Design and implementation of an organisational development programme to support senior leaders in the transition from organisational leadership to system leadership (linked to 1. d. System-level leadership and organisational development and 2. e. Place-based leadership and organisational development)

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Scope requirements of organisational development programme (system and place)	• Draft HR & OD Strategy and Implementation Plan • Create model for organisational development programme • Organisational development programme commences	• Develop single set of HR policies for new NHS LSC organisation • Develop appropriate Board level policies e.g. Suspension & Removal, Fit & Proper persons, Conflicts of Interest	• HR & OD Strategy and Implementation Plan with HR programme of work as enabler for new NHS LSC organisation • Provision of support for affected post holders as part of transition / closedown of 8 x CCGs • Induction development and plan for new NHS LSC organisation • People Plan for new NHS LSC organisation

Overarching deliverables for 2022/23

- HR & OD Strategy and Implementation Plan
- People Plan for NHS LSC organisation
- Organisational development programme commenced and ongoing

6. Workforce and Organisational Development	c. Staff engagement and consultation	**Executive Lead:** Sarah Sheppard **Workstream Lead(s):** Cath Owen	**External Support:** TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Engagement and consultation with staff involved in transition from 8 x CCGs to NHS LSC organisation
- Support offers for staff affected by transition

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Engagement with Staff Side on plans to disestablish CCGs from 01 April 22 and create new ICS organisation • People Transition Principles • FAQs for regular update • Resource and Recruitment Protocol to support staff during transition period	• Identify Change Ambassadors to support transition • Develop ongoing programme of health and wellbeing support for colleagues	• Commence delivery of programme of health and wellbeing support for colleagues	• Ongoing delivery of programme of health and wellbeing support for colleagues • Agree mechanism and ToR for new NHS LSC organisation's Staff Partnership arrangements
• Develop plans in preparation for managing organisational and people transition, taking into account the anticipated process and timetable, any potential changes to ICS boundaries and the need to transform functions to support recovery and delivery across the ICS.	• Ensure all people currently in ICS Chair, ICS lead or AO roles are well supported and consulted with appropriately.	• Ensure all people in impacted roles are well supported and consulted with appropriately.	• Ensure people in affected roles are consulted and supported. • Commence engagement and consultation on the transfer with trade unions

Overarching deliverables for 2022/23

- Relevant staff transfer completed, with staff employed by NHS LSC organisation
- Staff Partnership arrangements established for NHS LSC organisation

7. Finance

Executive Lead: Gary Raphael
Workstream Lead(s): TBC

External Support: TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Influence and understand the design of the system-level financial framework and the implications for the financial regime
- Develop the system-level Financial Planning Framework in response to national guidance
- Implement transitional arrangements

Key outputs required from this workstream:

The outputs expected in every ICS over the course of the transition period in 2021/22 as set out by NHSEI

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
Key tasks • Understand emerging thinking – place development, provider collaboratives, timescales for transfer of NHSE directly commissioned services, system functions and capabilities • Build knowledge and understanding of the implications of changes for CFOs / FDs and cultures, values and behaviours needed to support system working and accountability at system, place and statutory organisations • High level thinking about how funding will flow within the system and the financial governance and oversight arrangements needed. This will feed in, inform and shape the thinking and work in other system development groups	**Key Tasks:** • Design financial planning principles and mechanisms to operate at system / place • Map how finance functions and support need to be organised and the implications of this • Review finance structures and support required through the transition process	**Key Tasks:** • Timescales and plans for transition to new arrangements • Shadow arrangements • Transfer of NHSE commissioned functions • Maintaining BAU and closing down 8 x CCGs • Creating new NHS LSC organisation	• Complete due diligence and preparations for staff and property (assets and liabilities, including contracts) transfers from CCGs and other NHS staff transfers to new ICS NHS body in line with NHSEI guidance. • Ensure that revised digital, data and financial systems are in place ready for 'go live'.

Overarching deliverables for 2022/23

- Financial Framework for system, place and provider collaboratives

8. Quality and Safety Assurance and Improvement

Executive Lead: Julie Higgins
Workstream Lead(s): Helen Curtis / Kathryn Lord

External Support: TBC

Lancashire and South Cumbria Health and Care Partnership

Scope:

- Ensure that quality and safety is managed during the transition phase of the system reform in accordance with national guidance
- Ensure that quality and safety legacy issues are captured as part of the closedown of CCGs and transfer to the new statutory body
- Implement guidance from the National Quality Board which will determine the oversight of quality from April 2022 onwards
- Adopt and implement the relevant guidance from the NHS System Oversight Framework
- Ensure that issues arising as the NHS emerges from the pandemic are given direct and appropriate attention and are not lost due to organisational change

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
• Establish a Quality and Performance Committee as a sub committee of the Strategic Commissioning Committee • Continue with local CCG Committees and have membership that links into the above • Develop quality reports to the Quality and Performance Committee and escalation process to the Strategic Commissioning Committee • Commence work to agree portfolios across Chief Nurses and Quality Leads so that wherever possible things are done once on behalf of us all • Appoint an interim Director of Nursing and Quality for the system	• Complete portfolio work and identify individual leads and any gaps given current position in CCG nursing and quality teams that need to be addressed • Agree further programme of deep dives in relation to areas of concern across quality and performance • Agree composition of teams at system and place level in accordance with guidance from the National Quality Board • Assess the risk to quality and safety during the transition period and identify mitigation plans • Receive and implement the NQB Quality Toolkit • Plan for and support the transition of NHSEI roles and workforce into the ICS	• Review Terms of Reference of Quality and Performance Committee based on statutory guidance • Define Nursing and Quality structure at system and place in accordance with legislative guidance and HR framework and commence appointment process • Undertake capture of legacy issues within each CCG and cataloguing system to ensure easy retrieval of the same • Build upon the portfolio work to identify leads and teams to support Quality Improvement, influence on investment decisions at place and at system for health care and population health gain	• New statutory Quality Committee to commence meeting in shadow form • Shadow Nursing and Quality Structure in place • Describe vision for ICS 3-5 year plan for Quality and Nursing

Overarching deliverables for 2022/23

- External assurance of the Nursing and Quality function at system and place reviewed to ensure that there are neither gaps nor overlap
- Constant review of emerging quality and safety issues to ensure that nothing has been lost during the transition period.
- Adopt and implement consistent metrics and reporting using best practice benchmarks including the NQB Quality Toolkit
- Preparation for any Covid19 public inquiry, quality issues, harms, defensible decisions and actions during pandemic response.

9. Communications and Engagement

Executive Lead: Andrew Bennett
Workstream Lead(s): Neil Greaves / Hannah Brooks

External Support: Kate Hurry

Lancashire and South Cumbria Health and Care Partnership

Scope:

This workstream will support all component parts of the system reform programme through the development of:

- Strategic narrative documents and toolkits for use by senior leaders to set out language and messaging and to shape communications, engagement, involvement with all stakeholders
- Co-ordinating communications and engagement plans for all stakeholders at system and place levels, including those staff who are affected by the transition of activities associated with the closedown of CCGs
- Oversight, planning and direction to support communications and engagement of system reform across LSC
- Consistent key messages for staff, providers, partners and public

Key outputs required from this workstream:

2021/22 – Q1	2021/22 – Q2	2021/22 – Q3	2021/22 – Q4
Laying foundations • Develop high-level CE plan • Strategic narrative toolkit agreed by ICS Board • Regular staff briefings established for those affected by system reform • Single feedback mechanism launched for staff • Regular stakeholder briefings established for providers, partners, MPs and public • Initial case studies identified • Narrative documents approved to be shared with stakeholders (including delivering integrated care summary, ICP common narrative and clinical strategy) • Integrated care section on website developed	**Wider socialisation with partners** • Monthly briefings for staff affected and wider stakeholders • Embed messages and language across partners and organisations using the strategic narrative toolkit • Support common narrative for Provider Collaborative • MP/political engagement fronted by LSC Independent Chair and Chief Officer • Workshops held with ICPs to develop their local messages ready for wider public engagement in Q3 • Further case studies from all system partners developed and shared in a variety of formats such as blogs, news and videos • LSC engagement calendar produced to cover all workstream plans	**Wider public engagement** • Monthly briefings for staff affected and wider stakeholders including updates on national legislation • Oversight of a programme of engagement working across the ICPs to ensure a consistent approach to key messages, timing and ways of capturing feedback • Outcomes from public engagement fed into decision-making bodies • Review narrative toolkit messages in line with national guidance • Further case studies developed and shared • Set out products and channels which need to be in place for 22/23 for a new organisation and wider partnership such as websites etc.	**Preparing groundwork for 2022/23** • Monthly briefings for staff affected and wider stakeholders • Broader MP/political engagement to show how we have listened to feedback, fronted by LSC Independent Chair and Chief Officer • Feedback loop established to show how we have listened to feedback • Branding and identity guidelines agreed and shared ahead of 22/23 • Products and channels in place for a new NHS organisation and wider partnership such as websites and social media etc. • Oversight of systems and resources ready to transfer to new organisation following CCG closedown

Overarching deliverables for 2022/23

- Consistency of language, messaging and system level ambitions at all levels of the system
- Evidence of transparent and open engagement with staff, partners and members of the public in each area of LSC which contributes to system development
- Established communications channels and products in place for NHS 'Lancashire and South Cumbria' organisation and the wider LSC Health and Care Partnership
- Confidence and enthusiasm in the benefits of working in partnership for the population and local people and the opportunities this provides for staff and partners

Lancashire and South Cumbria
Health and Care Partnership

ICS Board

Date of Meeting	7th July 2021
Title of Paper	Greater Lancashire Plan
Presented By	Phil Green, Director Growth Environment and Planning, Lancashire County Council
Authors	Phil Green (on behalf of 'Team Lancashire')
Agenda Item	6
Confidential	No

Purpose of the Paper

A presentation to introduce work on the robust evidence base being prepared to inform the development of the Greater Lancashire Plan and to update with progress.

Executive summary

Lancashire has a major and unique contribution to make to the UK yet does not have a single, place-based strategy and risks falling behind other regions. Lancashire also has its challenges and Covid-19 has hit its people, businesses and communities hard.

Seeking to adopt a strong partnership approach, Lancashire Leaders have demonstrated a commitment and ambition to speak with one voice through the development of the Greater Lancashire Plan that will set out the overarching vision and place and people based strategy and action plan for Lancashire.

A robust, granular evidence is being prepared including an Independent Economic Review and Environment commissions, aligned with other research, forming the ingredients to underpin the strategic decision making of Lancashire Leaders in consultation with key stakeholders including as we recover together from the global pandemic. The evidence base includes inter alias consideration of early years, health, the economy, place making, environment and climate change.

The Greater Lancashire Plan will set out a consistent, compelling and coherent narrative as a foundation from which all our plans in Lancashire can be rooted. In doing so it will provide the essential policy framework for determining policies and priorities and promote a strengthened place leadership utilising our shared assets to help create the conditions for a sustained and consistent approach to prioritisation and delivery.

This will amplify Lancashire's voice to help maximise the potential of its distinct and diverse urban, rural and coastal geography, its 1.5m resident population, 55,000 businesses and the associated communities, coastline and countryside.

Lancashire and South Cumbria
Health and Care Partnership

The presentation will introduce the evidence base being developed and overseen by an Independent panel of experts prior to describing the next steps towards the development of the Greater Lancashire Plan itself.

Recommendations

It is recommended that the presentation be noted and that the Board consider how it can support the development of the Greater Lancashire Plan.

Governance and Reporting

(List Other Forums that have Discussed this Paper)

Meeting	Date	Outcome

Conflicts of Interest Identified

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

The Greater Lancashire Plan

Lancashire defining People and Place

Progress Briefing: ICS Board

7th July 2021

Invest in Lancashire

NORTHERN POWERHOUSE

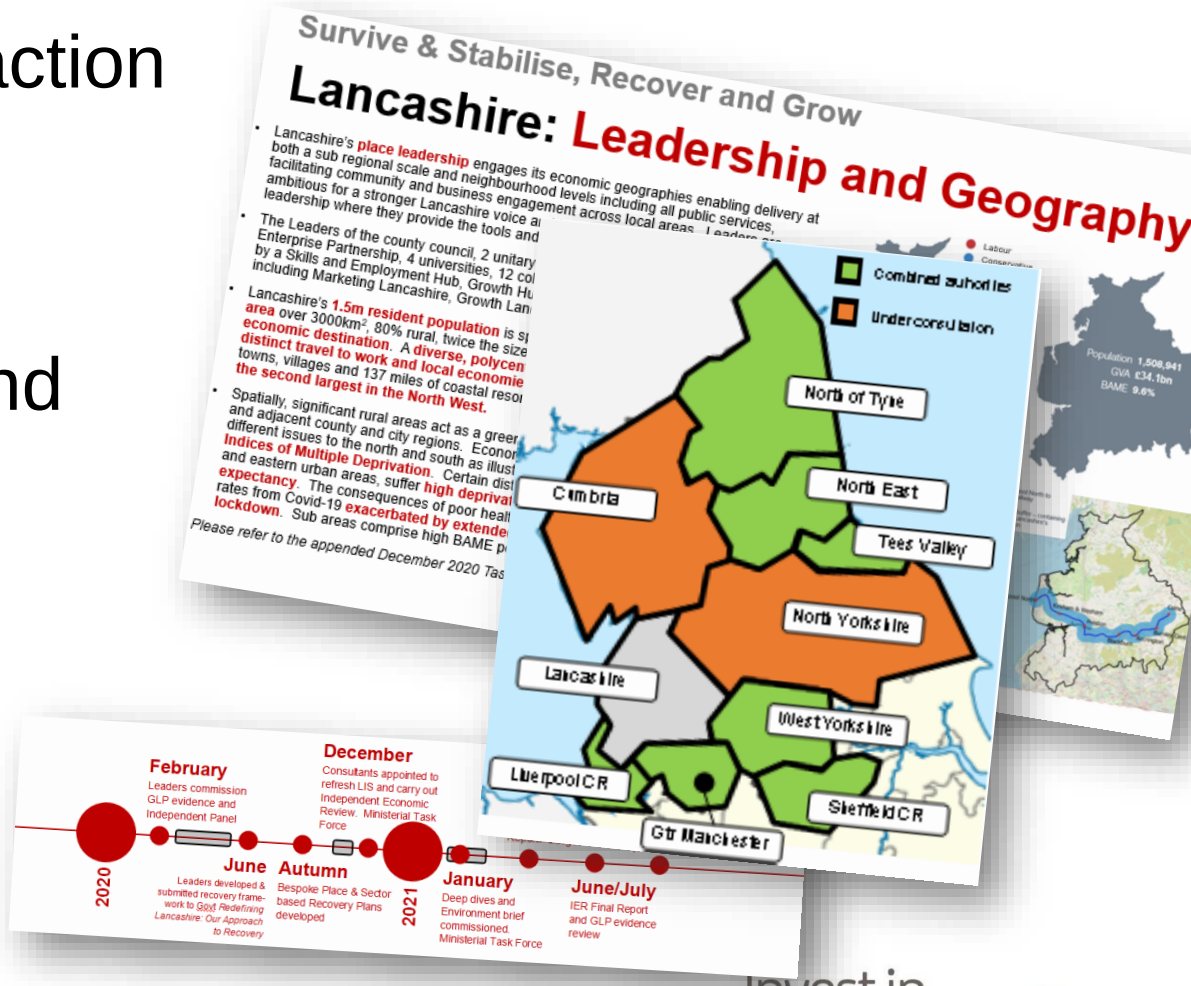
We are Lancashire The place for growth

Lancashire Enterprise Partnership

Lancashire Authorities

Why a Greater Lancashire Plan?

- Place leadership / vision / ambition / action
- Overarching people and place-based strategy built on robust evidence
- Framework for determining policies and priorities
- Compelling, consistent narrative
- Amplified, stronger and unified voice
- Advocate for Lancashire residents, businesses and communities with authority and influence.

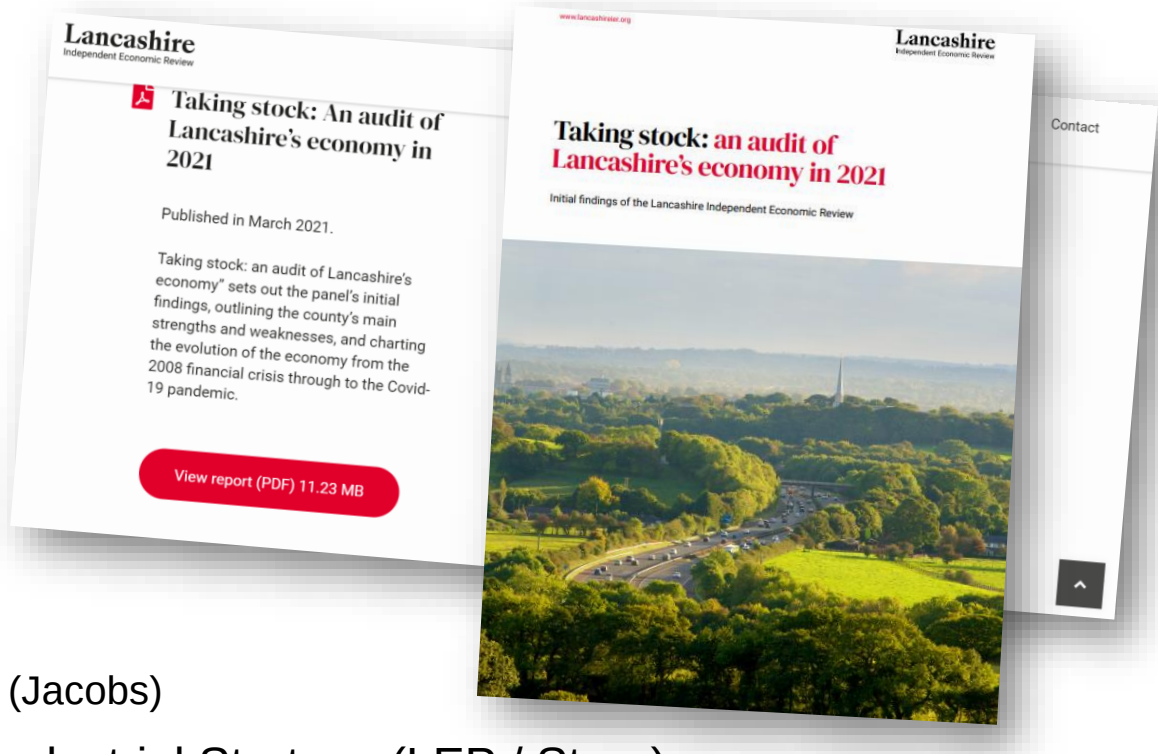


Invest in Lancashire

Survive & Stabilise, Recover and Grow

Informed by a Robust Evidence Base

- Overseen by Independent Panel making recommendations to Lancashire's place leadership
- Each piece of evidence will inform and **underpin decisions Leaders make** in putting together the Greater Lancashire Plan:
- Independent Economic Review (IER) (Metro-Dynamics):
  - Future of Manufacturing
  - Health, Wealth and Wellbeing
  - Infrastructure in Lancashire
  - The Future of Towns
  - Internationalisation (LEP / OCO Consulting)
- Environment Commission:
  - Lancashire Net Zero Pathway Options (Atkins)
  - Lancashire Climate Resilience Study (Atkins)
  - State of the Environment Report for Lancashire 2021 (Jacobs)
  - Decennial Review of the Lancashire Sustainable Energy Study (Jacobs)
- Build on a solid foundation including the refreshed Local Industrial Strategy (LEP / Steer) evidence; mini deep dives prepared for Minister Scully; sector plans and other evidence
- Government White Paper Levelling Up (TBC)



Invest in Lancashire

Survive & Stabilise, Recover and Grow

Lancashire's Independent Panel

Rowena Burns (Chair)
Health Innovation

Sir Howard Bernstein
Economy and Reform

Graham Biggs
Rural Services Network

Prof. Rachel Cooper OBE
Lancaster University

Louise Marix Evans
Environment, Sustainability & Climate

Neil McInroy
Centre for Local Economic Strategies

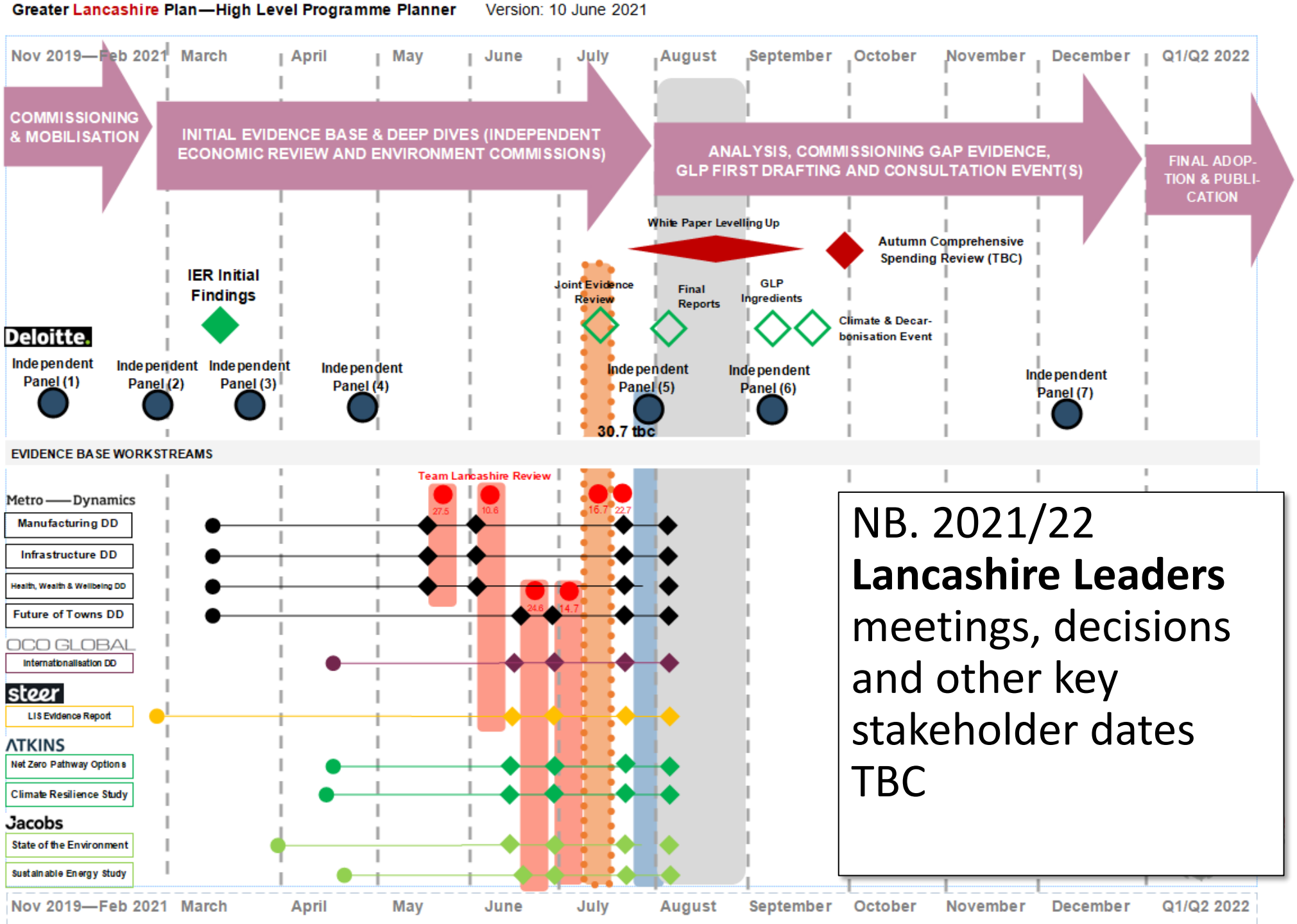
Henry Murison
Northern Powerhouse Partnership

David Taylor CBE
University of Central Lancashire

John Holden
Productivity

Invest in Lancashire

GLP. Project Plan



NB. 2021/22 **Lancashire Leaders** meetings, decisions and other key stakeholder dates TBC

GLP. Key Milestones

March ‘21:	IER Initial Findings Report; Deep Dives commenced; Call for Evidence and public website launched
April:	Environment commission & internationalisation deep dive launched
May-July:	Initial reports emerge and draft findings tested
Summer:	Independent Panel and final reports / key findings due. Panel recommendations, response and Government alignment. Commissioning of any gap research
Autumn:	Issues and Options Analysis. Potential decarbonisation event. Levelling Up White Paper and Government Spending Review due
Winter:	Potential GLP Conference. Drafting, consultation, final drafting
Spring ’22:	Publication and adoption of **Greater Lancashire Plan**

Invest in Lancashire

ICS Board

Date of Meeting	**7th July 2021**
Title of Paper	**Anchor Collaboratives**
Presented By	Claire Muir, Transformation and Change Lead for Morecambe Bay CCG Dr Andy Knox, Director of Population Health for Bay Health and Care Partners
Authors	Claire Muir
Agenda Item	**7**
Confidential	No

Purpose of the Paper

The purpose of this paper and slide set is to introduce and explore the role of the NHS as an Anchor Institution within the Lancashire and South Cumbria Integrated Care System.

Executive summary

This agenda item will provide an opportunity for board members to hear a proposed approach for the ICS to use its anchor status to improve population health and reduce health inequalities.

The proposed approach will include the use of a charter which can be used by the ICS to self-evaluate their anchor status, identify cross cutting opportunities to make anchor practices embedded within the NHS and measure progress over time. This can provide a starting point for institutional and partnership discussions, outlining the different domains in which the ICS could direct their efforts, along with a scoring system to demonstrate commitment and opportunities.

The proposed approach also includes the roll out of the Anchor Charter within each ICP through local leads.

Recommendations

The Board is asked to:

1) Note the contents of this paper and presentation slides
2) Comment on the contents of this paper and presentation slides
3) Commit to and mobile the NHS Anchor Charter/ approach across the ICS/ HCP

Lancashire and South Cumbria
Health and Care Partnership

Governance and Reporting (List Other Forums that have Discussed this Paper)		
Meeting	**Date**	**Outcome**
ICS Exec meeting	10/05/2021	Support for the proposed approach. Request to present the paper and slides at ICS System Leaders Meeting and ICS Board
System Leaders Executive Meeting	16/06/2021	Support for the document/ approach.

Conflicts of Interest Identified
N/A

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

The NHS Anchor Collaborative Charter

The purpose of this paper is to provide information on the NHS as an Anchor Institution, and to outline a charter which can be used by organisations to self-evaluate their anchor status, identify cross cutting opportunities to make anchor practices embedded within the NHS and measure progress over time.

This document can provide a starting point for institutional and partnership discussions, outlining the different domains in which anchor organisations can direct their efforts, along with a scoring system to demonstrate commitment and opportunities.

Section One: Introduction to Anchor Institutions

This section will introduce the role of the NHS as an Anchor Institution within the Lancashire and South Cumbria Integrated Care System.

Background

Anchor Institutions are large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area. (1)

Anchors have sizable assets that can be used to support local community wealth building and development, through procurement and spending power, workforce and training, and assets such as buildings and land. Anchors have a mission to advance the welfare of the populations they serve. They tend to receive (or are significant stewards of) public resources, and often have a responsibility to meet certain standards on impact of value.

The NHS as an Anchor Institution

Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. As an anchor institution, the NHS influences the health and wellbeing of communities and impacts on the wider social, economic and environmental factors that make us healthy.

The Health Foundation - Building healthier communities: the role of the NHS as an anchor institution (1) recognises the potential difference to local people by:

1. Purchasing more locally and for social benefit: In England the NHS spends £27bn every year on goods and services
2. Using buildings and spaces to support communities: The NHS occupies 8,253 sites across England on 6,500 hectares of land
3. Working more closely with local partners: The NHS can learn from others, spread good ideas and model civic responsibility
4. Reducing its environmental impact: The NHS is responsible for 40% of the public sector's carbon footprint

5. Widening access to quality work: The NHS is the UKs biggest employer, with 1.6 million staff

In addition to boosting economic growth and supporting a healthy population, the NHS, along with other Anchor Institutions have the potential to create the conditions needed to help tackle inequalities. The CPP (Centre for Progressive Policy) analysis shows that, on average, the health and care sector accounts for a larger share of local area output in deprived places, so its role in terms of employment and procurement will be particularly important in economically-disadvantaged areas.

Further detail on the Facets of an Anchor Institution and the associated components are outlined within section two of this document.

Section Two: The NHS Anchor Charter

This section outlines the different domains within the Lancashire and South Cumbria Anchor Charter. This can be used to determine where NHS organisations direct their efforts.

The Facets of an Anchor Institution (1)

Domain One: Widening access to quality work

1. **Widening workforce participation**
   - Using data to understand local demographics and opportunities
   - Where possible aiming to employ a staff mix that is drawn from, and broadly representative of, the local population it serves, including areas of deprivation, race, ethnicity etc.
   - Employing locally by targeting positions for local people and recognising and supporting people to overcome barriers to work
   - Actively engaging with communities to identify jobs and services required within a place to meet local needs (2)

2. **Building the future workforce**
   - Engaging young people and supporting career development
   - Creating pre-employment programmes, work placements and voluntary experience to help people acquire the skills needed for specific jobs
   - Working with local Academies/ Schools, Further Education Colleges and Higher Education Intuitions to offer apprenticeship programmes and develop these programmes effectively to ensure local jobs for local people and retain a workforce

3. **Being a Good Employer**
   - Supporting fair pay and conditions of employment including paying a living wage and providing stable employment
   - Remunerating staff fairly, measuring and addressing the ethnic and gender pay gaps
   - Offering fair working conditions whilst promoting a work life balance
   - Supporting professional development and career progression to staff at all levels

- Supporting health and wellbeing of staff, for example offering workplace wellness schemes that are accessible to all
- Ensuring and measuring the uptake of staff support programmes by different staff groups and population characteristics (including grade / seniority, gender and ethnicity etc.) and taking action to reduce any identified inequalities
- Implementation of the NHS People Plan which focuses on improving staff wellbeing, creating good working cultures including ensuring equality and diversity, implementing new ways of working and delivering care, and growing for the future workforce. Additionally, it is recommended that each of these key aspects are to be explored through strong partnership working. (3)

Domain two: Purchasing and Commissioning for Social Value

1. **Shifting spend more locally**
   - A clear understanding of current purchasing practices- identifying opportunities where a greater proportion of the budget could be reallocated to local organisations
   - Finding ways to prioritise local employers
   - Providing training and clarity to purchasing teams on what is legally possible and how to enforce social value
   - Supporting the capacity and capability of the local supplier market by ensuring that local businesses, social enterprises and SMEs can compete for and secure NHS contracts
   - Offering toolkits and guidance for suppliers to help organisations understand the required criteria and improve the quality of applications.

2. **Embedding social value into purchasing decisions**
   - Considering public and social value when commissioning or purchasing services, for example commissioning a service that has a wider community or public benefit that extends beyond the primary contract delivery
   - Embedding social value into procurement processes, for example designing a core contract specification so that suppliers must meet specific conditions for example paying a living wage
   - Providing training and capability building for those in charge of procurement
   - Purchasing teams given the time and space to build skills and knowledge on social value and permission to integrate these outcomes into contracting decisions
   - Considering the possibility of having a designated sustainability or social value lead who can oversee local purchasing initiatives
   - A designated board member to lead on social value and sustainability to help join up efforts as part of a more centralised organisational approach

Domain three: Expanding community access to NHS property

1. **Using buildings and spaces to support local communities**
   - Enabling local groups and businesses to use estates- the NHS often has facilities that are not used at certain times such as weekends which means it can offer the space to community group or charities at little or no cost
   - Considering leasing retail space to local community businesses, thereby encouraging patients, staff and visitors to spend locally

2. **Converting and selling estate for community benefit**
    - Considering social value and the impact on the community when selling surplus land or redeveloping land or buildings, for example supporting access to affordable housing or housing for key workers using NHS estate
    - Pursuing alternatives to open market sales and enter into joint ventures with housing associations or councils who may be able to help attract upfront investment for the development of community spaces or housing

3. **Working in partnership across a place to maximise the wider value of NHS estates**
    - Beyond the sale of surplus assets, working proactively with other anchors to help improve the local built environment to support community health and wellbeing
    - Carrying out meaningful public engagement during planning of opportunities to use estates for public good

4. **Developing accessible community green spaces**
    - Creating more accessible community parks which provide a habitat for wildlife, a space for physical activity and contribute to improved health and wellbeing, particularly for people who otherwise would not have access
    - Opening up existing green space owned by the NHS to the local community to increase its positive impact on health and wellbeing
    - Working to develop good quality, accessible green spaces on unused land

Domain four: Reducing environmental impact

1. **Adopting sustainable practices within the NHS**
    - Clear leadership and staff buy in for environmental sustainability
    - Commitment from senior leaders to change organisational behaviours to support environmental sustainability
    - Developing and implementing strategies to improve energy efficiency, supporting more sustainable/ active travel and reducing waste and water consumption
    - Embedding environmental sustainability into organisation wide strategies
    - Providing teams with the tools and resources they need to feel empowered to implement solutions and measure impact for supporting environmental sustainability
    - Building a sense of shared motivated responsibility and ownership over sustainability solutions, for example recruiting champions and running campaigns

2. **Influencing sustainable practices in the community**
    - Influencing local suppliers to develop practices for developments that support the environmental health of local communities, for example recycling
    - Advocating for more public transport routes and cycle lanes into NHS hospitals and premises
    - Purchasing and commissioning decisions to influence sustainability practices within the community, for example working with local suppliers to reduce carbon output

Domain five: Working with local partners

1. **Partnering with other anchor institutions across a place**
   - Developing an anchor collaborative and networks to support shared approaches locally
   - Working with other anchor Institutions to combine influence and scale impact on local communities
   - Supporting a place based vision, commitment and shared objectives
   - Working towards an anchor mission underpinned by extensive engagement with local people to ensure that resources are invested in the areas that could bring the greatest community benefit
   - Working as part of an anchor collaborative that enables flexibility, allowing each organisation to determine the most appropriate steps to implement shared objectives
   - Creating and engaging in opportunities to foster good working relationships with anchor organisations, for example setting up new forums or mechanisms for collaboration.

2. **Developing networks to support, shared learning and spread good practice**
   - Working with partner organisations to develop collective identity as anchor institutions to tackle common issues
   - Facilitating shared learning, provide expertise and develop skills around local economic development an social sustainability, for example collaborative networks and communities of practice

Domain six: Tackling Health Inequalities

1. **Listening to and working with communities**
   - Leadership and staff buy in for listening to and working with communities to improve health and wellbeing and tackle health inequalities
   - Creating a Poverty Truth Commission to engage in deep listening with communities and breaking down stigma
   - Actively working with data to understand where community health inequalities are within a place
   - Working with identified communities to understand needs, experiences and assets to drive down health inequalities
   - Co-producing services with communities with increased levels of health inequalities and those identified as harder to reach
   - Creating and facilitating learning environments around health inequalities
   - Providing access to resources to reduce inequalities such as translators

2. **Taking a targeted approach to where and how resources are spent**
   - Using a weighted approach to calculate resource allocation line with inequalities within the population, for example the Index of Multiple Deprivation (IMD)
   - Using a targeted approach to ensure resource distribution and allocation in line with inequalities
   - Using innovative methods to measure the success of interventions and services that considers the impact on health inequalities

3. **Encouraging continuous learning and development around health inequalities**
    - Visible leadership support for learning and development opportunities focused on reducing health inequalities
    - Providing staff training and opportunities for learning about health inequalities
    - Providing teams with the tools and resources they need to feel empowered to address health inequalities as part of their work
    - Recruitment of champions to support the workforce in addressing health inequalities

Cross cutting principles

The below identifies six cross cutting steps that should be taken as part of each domain identified within the charter (1)

1. Build a baseline understanding of current practice to know where to prioritise action and establish informed goals.
2. Develop metrics and evaluate the impact of interventions.
3. Establish clear and visible leadership to embed anchor practices within organisational and system strategies.
4. Enable staff to act on a collective vision for enhancing community health and wellbeing.
5. Support the sharing and spread of ideas through networks.
6. Engage proactively with communities to ensure that anchor strategies meet the needs of local people and to maximise impact on narrowing inequalities.

Section Three: Implementation of the NHS Anchor Charter

This section outlines how NHS organisations can utilise the Anchor Charter within a place.

Priorities

NHS organisations will be responsible for identifying their own priorities and areas of focus highlighted within the charter. Organisations may prioritise initial activities in line with local priorities, involving the community and other partners.

Although organisations will have individual priorities, a placed based approach to rolling out the anchor charter will provide an opportunity for organisations to work in partnership where appropriate to maximise the wider impact.

Measurement

The following scoring system can be used by NHS organisations to demonstrate their commitment and progress against the facets outlined in section two of this document. This scoring system is broken down into four status levels; bronze, silver, gold and platinum.

Bronze: Fulfil one component (numbered) in each domain section

Silver: Fulfil two components in each domain section

Gold: Fulfil over half of the components in each domain section

Platinum: Fulfil all components in each domain section

It is recommended that organisations self-evaluate their individual anchor status, using the reporting sheet which can be found in Appendix A. This activity can be carried out to assess an organisations baseline level anchor practices, identify cross cutting opportunities to embed anchor practices and measure progress over time. Individual organisations can evidence their efforts and demonstrate progress through their own data sources which can be both quantitative and qualitative to show different ways of working. The reporting sheet also provides space for organisations to identify opportunities to further develop their anchor status.

Conclusion

As highlighted in this document there are a range of opportunities for the NHS to harness its considerable influence to have a greater impact on health and wellbeing of communities. It is essential that all activities pursued as part of an anchor collaborative are joined up and embedded as a part of central, local system or organisational strategies to ensure sustainable transformation. Rather than applying anchor practices from one independent domain, the greatest impact will come from pursing changes in each domain of anchor influence, whilst working in partnership with other anchors across a place.

References

(1) https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution

(2) https://www.hilarycottam.com/radical-help/

(3) https://www.england.nhs.uk/wp-content/uploads/2020/07/We_Are_The_NHS_Action_For_All_Of_Us_FINAL_24_08_20.pdf

Appendix A. Anchor Collaborative Reporting Sheet

Table 1. A reporting sheet to be used by individual organisations to evidence their efforts in relation to the different domains of the anchor collaborative criteria and identify opportunities for progression.

Domain One: Widening access to quality work			
Component	**Status**	**Evidence**	**Opportunities for progression**
Widening workforce participation • Using data to understand local demographics and opportunities • Where possible aiming to employ a staff mix that is drawn from, and broadly representative of, the local population it serves, including areas of deprivation, race, ethnicity etc. • Employing locally by targeting positions for local people and recognising and supporting people to overcome barriers to work • Actively engaging with communities to identify jobs and services required within a place to meet local needs (2)			

Building the future workforce • Engaging young people and supporting career development • Creating pre-employment programmes, work placements and voluntary experience to help people acquire the skills needed for specific jobs • Working with local Academies/ Schools, Further Education Colleges and Higher Education Intuitions to offer apprenticeship programmes and develop these programmes effectively to ensure local jobs for local people and retain a workforce			
Being a Good Employer • Supporting fair pay and conditions of employment including paying a living wage and providing stable employment • Remunerating staff fairly, measuring and addressing the ethnic and gender pay gaps • Offering fair working conditions whilst			

promoting a work life balance • Supporting professional development and career progression to staff at all levels • Supporting health and wellbeing of staff, for example offering workplace wellness schemes that are accessible to all • Ensuring and measuring the uptake of staff support programmes by different staff groups and population characteristics (including grade / seniority, gender and ethnicity etc.) and taking action to reduce any identified inequalities • Implementation of the NHS People Plan which focuses on improving staff wellbeing, creating good working cultures including ensuring equality and diversity, implementing new ways of working and delivering care, and growing for the future workforce. Additionally, it is			

recommended that each of these key aspects are to be explored through strong partnership working. (3)			
Domain two: Purchasing and Commissioning for Social Value			
Component	**Status**	**Evidence**	**Opportunities for progression**
Shifting spend more locally • A clear understanding of current purchasing practices- identifying opportunities where a greater proportion of the budget could be reallocated to local organisations • Finding ways to prioritise local employers • Providing training and clarity to purchasing teams on what is legally possible and how to enforce social value • Supporting the capacity and capability of the local supplier market by ensuring that local businesses, social enterprises and SMEs can compete for and secure NHS contracts			

• Offering toolkits and guidance for suppliers to help organisations understand the required criteria and improve the quality of applications.			
Embedding social value into purchasing decisions • Considering public and social value when commissioning or purchasing services, for example commissioning a service that has a wider community or public benefit that extends beyond the primary contract delivery • Embedding social value into procurement processes, for example designing a core contract specification so that suppliers must meet specific conditions for example paying a living wage • Providing training and capability building for those in charge of procurement • Purchasing teams given the time and space to			

build skills and knowledge on social value and permission to integrate these outcomes into contracting decisions • Considering the possibility of having a designated sustainability or social value lead who can oversee local purchasing initiatives • A designated board member to lead on social value and sustainability to help join up efforts as part of a more centralised organisational approach			
Domain three: Expanding community access to NHS property			
Component	**Status**	**Evidence**	**Opportunities for progression**
Using buildings and spaces to support local communities • Enabling local groups and businesses to use estates- the NHS often has facilities that are not used at certain times such as weekends which means it can offer the space to community group or charities at little or no cost			

• Considering leasing retail space to local community businesses, thereby encouraging patients, staff and visitors to spend locally			
Converting and selling estate for community benefit • Considering social value and the impact on the community when selling surplus land or redeveloping land or buildings, for example supporting access to affordable housing or housing for key workers using NHS estate • Pursuing alternatives to open market sales and enter into joint ventures with housing associations or councils who may be able to help attract upfront investment for the development of community spaces or housing			

Working in partnership across a place to maximise the wider value of NHS estates • Beyond the sale of surplus assets, working proactively with other anchors to help improve the local built environment to support community health and wellbeing • Carrying out meaningful public engagement during planning of opportunities to use estates for public good			
Developing accessible community green spaces • Creating more accessible community parks which provide a habitat for wildlife, a space for physical activity and contribute to improved health and wellbeing, particularly for people who otherwise would not have access • Opening up existing green space owned by the NHS to the local community to increase its			

positive impact on health and wellbeing • Working to develop good quality, accessible green spaces on unused land			
Domain four: Reducing environmental impact			
Component	**Status**	**Evidence**	**Opportunities for progression**
Adopting sustainable practices within the NHS • Clear leadership and staff buy in for environmental sustainability • Commitment from senior leaders to change organisational behaviours to support environmental sustainability • Developing and implementing strategies to improve energy efficiency, supporting more sustainable/ active travel and reducing waste and water consumption • Embedding environmental sustainability into organisation wide strategies • Providing teams with the tools and resources they			

need to feel empowered to implement solutions and measure impact for supporting environmental sustainability • Building a sense of shared motivated responsibility and ownership over sustainability solutions, for example recruiting champions and running campaigns			
Influencing sustainable practices in the community • Influencing local suppliers to develop practices for developments that support the environmental health of local communities, for example recycling • Advocating for more public transport routes and cycle lanes into NHS hospitals and premises • Purchasing and commissioning decisions to influence sustainability practices within the community, for example working with local			

suppliers to reduce carbon output			
Domain five: Working with local partners			
Component	**Status**	**Evidence**	**Opportunities for progression**
Partnering with other anchor institutions across a place • Developing an anchor collaborative and networks to support shared approaches locally • Working with other anchor Institutions to combine influence and scale impact on local communities • Supporting a place based vision, commitment and shared objectives • Working towards an anchor mission underpinned by extensive engagement with local people to ensure that resources are invested in the areas that could bring the greatest community benefit • Working as part of an anchor collaborative that enables flexibility,			

allowing each organisation to determine the most appropriate steps to implement shared objectives • Creating and engaging in opportunities to foster good working relationships with anchor organisations, for example setting up new forums or mechanisms for collaboration.			
Developing networks to support, shared learning and spread good practice • Working with partner organisations to develop collective identity as anchor institutions to tackle common issues • Facilitating shared learning, provide expertise and develop skills around local economic development an social sustainability, for example collaborative networks and communities of practice			

Domain six: Tackling Health Inequalities			
Component	**Status**	**Evidence**	**Opportunities for progression**
Listening to and working with communities • Leadership and staff buy in for listening to and working with communities to improve health and wellbeing and tackle health inequalities • Creating a Poverty Truth Commission to engage in deep listening with communities and breaking down stigma • Actively working with data to understand where community health inequalities are within a place • Working with identified communities to understand needs, experiences and assets to drive down health inequalities • Co-producing services with communities with increased levels of health inequalities and those identified as harder to reach			

• Creating and facilitating learning environments around health inequalities • Providing access to resources to reduce inequalities such as translators			
Taking a targeted approach to where and how resources are spent • Using a weighted approach to calculate resource allocation line with inequalities within the population, for example the Index of Multiple Deprivation (IMD) • Using a targeted approach to ensure resource distribution and allocation in line with inequalities • Using innovative methods to measure the success of interventions and services that considers the impact on health inequalities			

Encouraging continuous learning and development around health inequalities • Visible leadership support for learning and development opportunities focused on reducing health inequalities • Providing staff training and opportunities for learning about health inequalities • Providing teams with the tools and resources they need to feel empowered to address health inequalities as part of their work • Recruitment of champions to support the workforce in addressing health inequalities			

Bay Health & Care Partners delivering

bettercare together

NHS

NHS Anchor Collaborative

Anchor Institutions

'Anchor institutions' are large public sector organisations rooted in and connected to their local communities

- Sizable assets that can be used to support local community wealth building and development
- A mission to advance the welfare of the populations they serve
- Receive (or are significant stewards of) public resources
- A responsibility to meet certain standards on impact of value.

What makes the NHS an anchor institution?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit
In England alone, the NHS spends £27bn every year on goods and services.

Using buildings and spaces to support communities
The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners
The NHS can learn from others, spread good ideas and model civic responsibility.

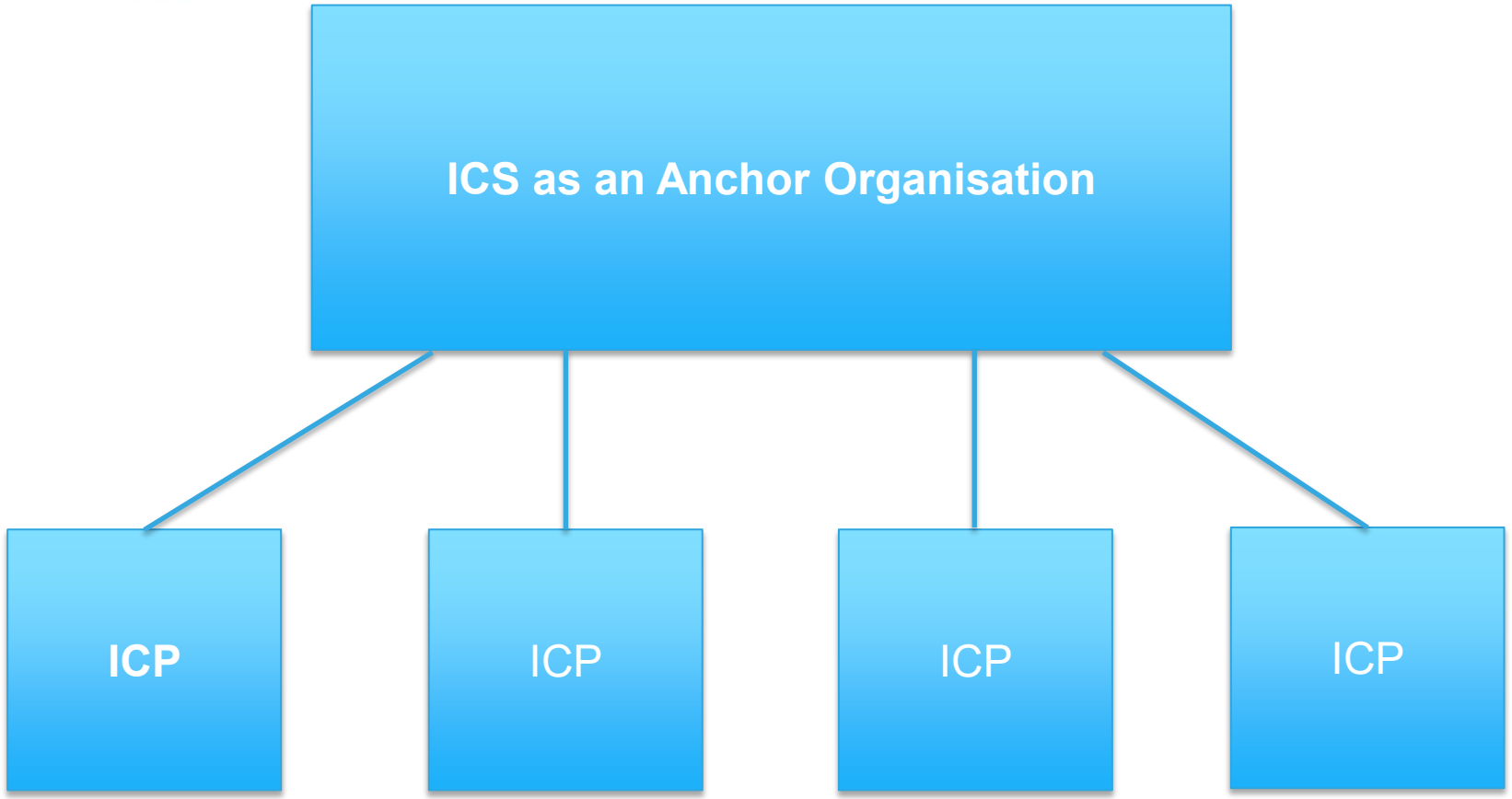
Widening access to quality work
The NHS is the UK's biggest employer, with 1.6 million staff.

Reducing its environmental impact
The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.

Anchor Charter

1. **Widening access to quality work**
2. **Purchasing and Commissioning for Social Value**
3. **Expanding community access to Anchor property**
4. **Reduce environmental impact**
5. **Work with local partners**
6. **Tackling Health Inequalities**


ICS as an Anchor Organisation
ICP
ICP
ICP
ICP

Morecambe Bay Anchor Collaborative

- Led by NHS and District Councils
- A group of organizations who ‘sign up’ to key anchor practices
- The collaborative aims to identify, develop and share how organizations can positively contribute to the Bay area by influencing the health and wellbeing of communities and impacts on the wider social, economic and environmental factors that make us healthy.
- Current organisations involved: Morecambe Bay CCG, UHMBT, Lancaster District Council, Barrow Borough Council and South Lakeland District Council.

Local Approach

1. Organizational ‘sign up/
2. Identification of an organizational representative/ Champion
3. Monthly Steering group meetings
4. Progress updates and shared learning
5. Ongoing support/ learning

Wider Engagement

Lancaster University
University of Cumbria
Colleges
BAE
EDF

Governance

- Monthly updates provided by organisational champions
- Annual report to the Population Health Strategy Group
- Annual report to the BHCP Leadership Team
- Ad hoc updates into the Population Health Programme Plan

Outcomes

Widening access to quality work
% Staff are paid above the living wage

Purchasing and Commissioning for Social Value
Targeted local procurement including a target of 5-10% shift over 3 years

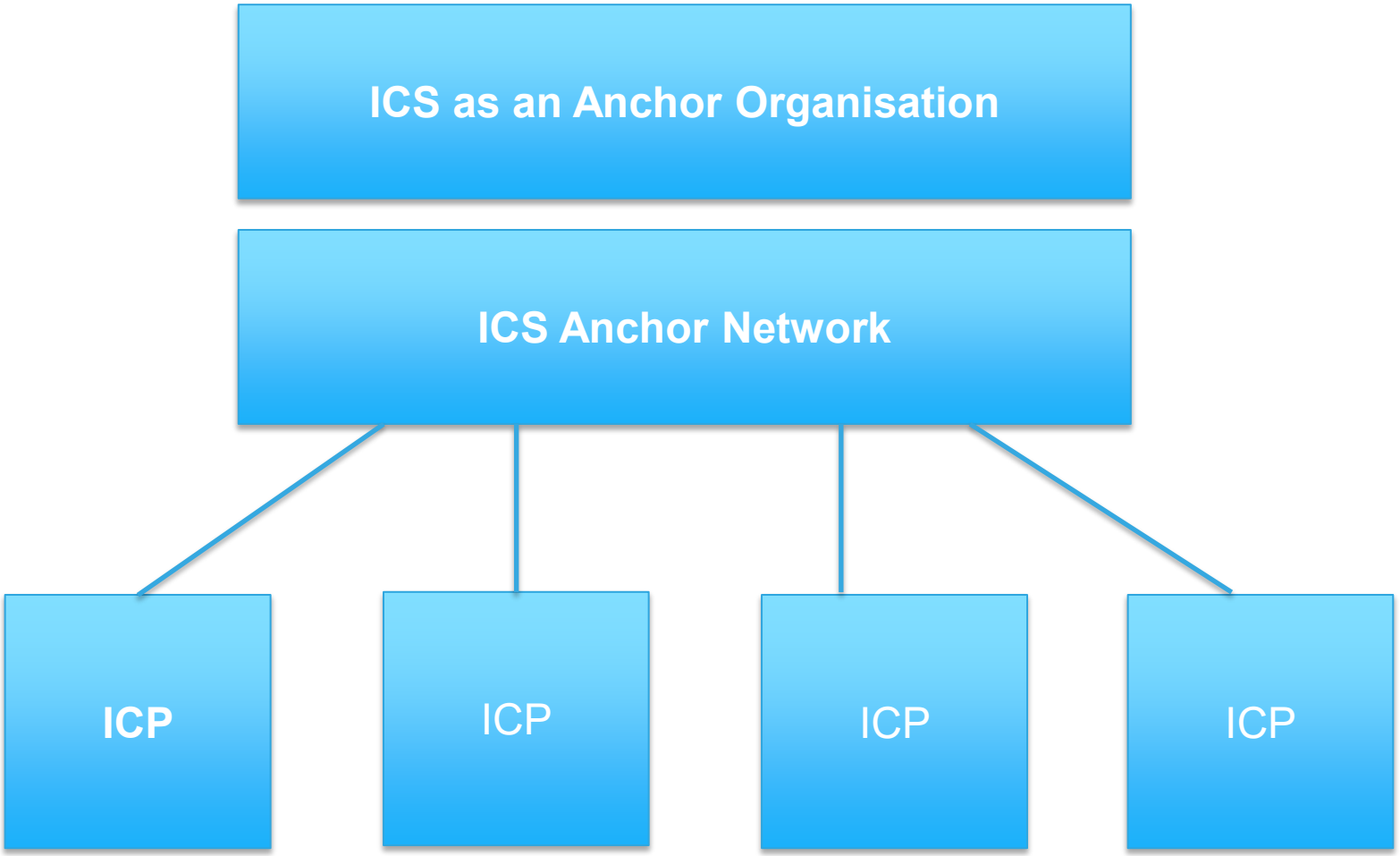
Expanding community access to anchor property
Increase % of affordable housing

Reducing environmental impact
Reduced carbon output % (increased recycling, increase in active travel by anchor employees)

Working with local partners
Increased spread and scale of good practice

Tackling Health Inequalities
Overall reduction in health inequalities across Morecambe Bay

A System Approach



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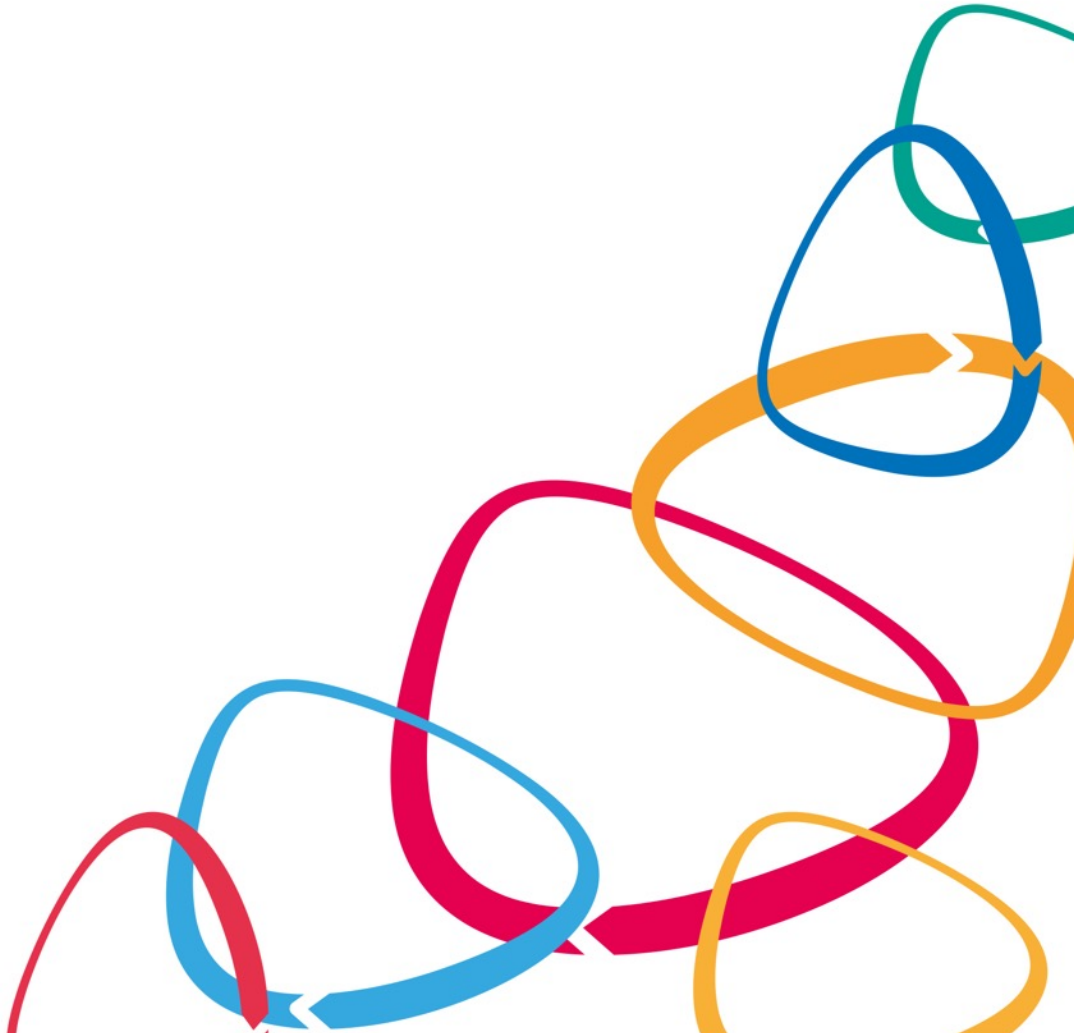
NHS

Thank you ☺



ICS Board

Date of meeting	**7th July 2021**
Title of paper	**New Hospitals Programme**
Presented by	Jerry Hawker, ICS Executive Director and SRO
Author	Jerry Hawker, ICS Executive Director and SRO
Contributors	Rebecca Malin, Programme Director
Agenda item	**8**

Purpose of the paper
Update
Executive summary
The New Hospitals Programme is a key strategic priority and sits within the integrated care system's wider strategic vision, with the central aim of delivering world-class hospital infrastructure from which high-quality services can be provided This paper provides an update on current progress of the programme and also explores areas where the Health and Care Partnership (ICS) Board can help drive imagination and innovation to create opportunities for much greater additional benefits for the region.
Recommendations
The Board is asked to note the progress of the New Hospitals Programme and consider the opportunities the programme presents to be used as a catalyst for wider partnership working.
Next Steps
In line with the programme plan the next steps are: Publish the approved Case for Change Develop proposals to respond to the Case for Change
Implications

If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Equality impact assessment completed		✓		
Patient and public engagement completed		✓		
Financial impact assessment completed		✓		
Associated risks		✓		

Report authorised by:	Jerry Hawker

Lancashire and South Cumbria
Health and Care Partnership

NEW HOSPITALS PROGRAMME – HIGHLIGHTS AND ENABLING SYSTEM WORKING

1. Introduction

1.2 This paper provides the Lancashire and South Cumbria Health and Care Partnership (ICS) Board with an update on current progress of the New Hospitals Programme and explores some of the areas where the Health and Care Partnership (ICS) Board can help drive the health and care system's imagination and innovation to create opportunities for much greater additional benefits for the region.

2 Background

2.1 The New Hospitals Programme is a key strategic priority for the Lancashire and South Cumbria Health and Care Partnership. It sits within the integrated care system's wider strategic vision, with the central aim of delivering world-class hospital infrastructure from which high-quality services can be provided.

2.2 The New Hospitals Programme offers Lancashire and South Cumbria a once-in-a-generation opportunity to transform our ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 Investment in Lancashire and South Cumbria's NHS hospital infrastructure will enable us to provide state of the art facilities and technology, strengthening our position as a centre of excellence for research, education and specialised care. This will significantly boost the attractiveness of the area to potential recruits and the highest calibre of clinicians.

2.4 The programme is committed to ensuring new hospitals fully embrace the benefits of digital technologies to create an agile network of care, allowing us to optimise the size of our physical footprint and minimise environmental impact. This will, in turn, enable us to provide more specialised services in our hospitals and deliver more care closer to home as part of the wider ambitions of the Lancashire and South Cumbria Health and Care Partnership.

2.5 However, our ambitions could and should extend much further than hospital facilities. Through the strength of the Health and Care Partnership, the New Hospitals programme should be a catalyst to delivering wider socio-economic benefits and play a key part in revitalising the regional economy, building the workforce of the future, and cutting carbon emissions to protect the environment.

3 Programme highlights

Programme scope

3.1 System partners have been integral to refining the scope of the New Hospitals Programme. In particular, it is worth noting the programme is focused on hospital facilities/sites, with the integrated care system's clinical strategy determining the clinical model, including configuration of services. This work will continue in parallel to, and aligned with, the New Hospitals Programme.

Lancashire and South Cumbria
Health and Care Partnership

Stage 1 assurance

3.2 In line with the NHS England and NHS Improvement (NHSE/I) process for assuring service change, the New Hospitals Programme presented the draft Case for Change and Communications and Engagement Strategy to a regional NHSE/I stage 1 assurance panel. This was well-received and, with minor amendments, the panel supported the programme continuing to develop proposals to respond to the Case for Change.

Case for Change

3.3 The New Hospitals Programme Case for Change seeks to demonstrate a compelling case for why Lancashire and South Cumbria needs new hospital facilities. Using input from the programme's Case for Change workshops and stakeholder input including staff and patient representatives, a strong rationale has been set out, clearly demonstrating the challenges around the condition of hospital estate at the Royal Lancaster Infirmary, Royal Preston Hospital and Furness General Hospital.

3.4 Following feedback from NHSE/I and system partners, the Case for Change has been updated and will be presented for final approval to the Lancashire and South Cumbria Strategic Commissioning Committee on 15 July. The Case for Change will then be made available to the public through the New Hospitals Programme website and social media channels. Public-facing engagement events are planned as soon as COVID guidelines permit them to safely take place.

Developing proposals

3.5 It is important to note no decisions have yet been made and all options are on the table. A variety of factors will influence proposals, such as:

- Patient accessibility
- Clinical outcomes
- Affordability
- Sustainability.

3.6 System wide work is underway to develop proposals which deliver against the challenges detailed in the Case for Change. The key milestones are:

- Agreement of demand and capacity modelling and associated assumptions – the output of this will determine the size and cost of hospital facilities for 2030 and beyond
- Development of the longlist of proposals
- Assessment criteria (critical success factors)
- Appraisal of the longlist to shortlist.

3.7 Agreement of the assumptions for our demand and capacity modelling is a critical milestone. Whilst the modelling and assumptions will be refined throughout subsequent business cases, it is key that system partners are comfortable and supportive of the assumptions being applied.

3.8 Proposals for new hospital facilities will be led by data, research and clinical expertise and they will be reviewed and guided by NHS partners and local authorities. Throughout this process, the programme is seeking the input of our people (staff and patient representatives) to emerging proposals and also the assessment criteria. This

will be carried out through the communications and engagement activities detailed in sections 3.11 to 3.14 below.

Programme timeline

3.9 The programme remains on track to deliver the final business case by mid-2024 and to start building in 2025, with new hospital facilities opening by 2030.

3.10 The programme will be subject to a series of checks and balances, including scrutiny and agreement from decision makers within the NHS, the Government and local authorities. As our proposals develop, there will be greater clarity regarding the scope of any public consultation.

Communications and engagement

3.11 As members will be aware, the New Hospitals Programme is committed to involving and engaging our workforce, patients and population. Over the last period, the programme has launched a Lancashire and South Cumbria New Hospitals Programme website and initial social media channels: New Hospitals Programme Twitter and New Hospitals Programme Facebook accounts.

3.12 The New Hospitals Programme Big Chat online conversation is now live, with active engagement from staff across Lancashire and South Cumbria, with all NHS colleagues encouraged to register and join in the conversation. Plans are underway to invite Trust Members from LTHTr and UHMBT Members by the end of June and arrangements for sending direct invites to our other hospital Trusts and North West Ambulance Service staff are progressing.

3.13 Since launching, the Big Chat online conversation has received 6,176 visits with 15,838 interactions - with contributions focused on hopes and desires, fears and concerns and specific clinical benefits of new hospital facilities.

3.14 In addition, work has begun with HealthWatch, to encourage local people to get involved in sharing their views about what new hospital facilities would mean to them. Preparations are underway for six focus group/workshop sessions in July/August, with a focus on outreach to people who are digitally excluded.

4 The New Hospitals Programme as an enabler to system partnership working

4.1 The following sections set-out some key areas of the New Hospitals Programme that have significant potential for wider partnership working across Lancashire and South Cumbria. It highlights some initial actions taken, but is primarily intended to encourage wider debate about how the Lancashire and South Cumbria integrated care system partners and the Partnership Board can play a significant part in maximising benefits for the region.

Infrastructure development

4.2 Our hospitals are some of Lancashire and South Cumbria's most significant community assets: they are anchor institutions providing healthcare to our population and employment to around 40,000 people.

4.3 New hospital facilities present exciting possibilities with regard to joint working with local research and academic institutions as well as connecting NHS health research to the growth sector of applied health technology, pharmacological and medical device manufacture. This sector is expanding rapidly and brings with it high-quality jobs and opportunities for local people.

4.4 The New Hospitals Programme has already started working with Lancashire County Council and the Local Enterprise Partnerships(s) to explore opportunities with respect to infrastructure planning. The programme is also working with the Steering Group, who are developing a new Lancashire Economic Strategy.

4.5 Whilst no decisions have been made with regard to proposals for new or existing sites for the New Hospitals Programme, there is a huge opportunity to work closely with partners to maximise opportunities.

4.6 The role of the NHS as an anchor institution is also an important consideration, as well as how the New Hospitals Programme can be used to maximise opportunities for local businesses and enterprises. The Programme team are exploring this with the national NHS team, but may have far greater impact through leveraging the wider influence of the Partnership Board

4.7 The Health and Care Partnership Board is asked to note the progress above and consider how it can take a leading role in exploring and maximising opportunities.

Digital Technologies

4.8 Digital technology is already identified by the Lancashire and South Cumbria Health and Care Partnership as a key enabler to realising the integrated care system ambitions. It is also a foundation for the success of the New Hospitals Programme and is vital for the delivery of sustainable, high quality, accessible acute care.

4.9 The Government has set clear requirements and ambitions that the business cases for new hospital facilities need to demonstrate far reaching and innovative approaches to using digital technologies.

4.10 New infrastructure will provide adaptable space for evolving technology. Embedding the expected impact of digital technology into the fabric of the estate will ensure that the New Hospitals Programme infrastructure is right-sized and enable the smart building specification to be included from the outset. It will be a crucial enabler for delivering our ambitions as an integrated care system and for a digitally networked system of Lancashire and South Cumbria hospitals, which can deliver care closer to home.

4.11 Therefore for the New Hospitals Programme to be successful, it is reliant on the successful delivery of the integrated care system's wider ambitious digital strategy, with a focus on making information and data easy to use across the health and care system, and providing functional infrastructure that supports integration across our system.

4.12 The Health and Care Partnership Board is asked to note the interdependency between the New Hospitals Programme and the Integrated Care System digital ambitions and consider how the Partnership can maximise the potential for joint working.

Workforce

4.13 Our hospitals employ 40,000 staff across Lancashire and South Cumbria, with LTHTr and UHMBT employing 7,000 and 7,500 people respectively.

4.14 Like many healthcare systems, we face significant issues with workforce supply and retention. Regionally, our vacancy gap is 9% - this is above the national average of 6.9%. More than 20% of the workforce are over 55 years of age, which provides an added retirement risk. Some of these challenges are national shortages, however poor working environments are a significant contributor to this issue. Alongside wellbeing, staff feedback tells us that they want a working environment where they can care for patients and operate with the space and facilities they need to perform their roles to the standard that they and patients expect. This is often not the case in the ageing buildings we are asking them to work within.

4.15 Forward-thinking organisations are focusing their efforts on the design of workforce environments that offer healthier, more comfortable and more effective places to work – indeed this is a key consideration for most people seeking employment.

4.16 Although new hospital facilities will take up to 2030 to plan and build, the programme believes that the prospect of better, more agile hospital facilities, designed to accommodate the region's changing population demographics, will support the delivery of these goals in the short term by increasing staff morale, recruitment and retention. The development of new hospital facilities will also indirectly but significantly, impact on the wider determinants of health and wellbeing by attracting investment into the region and contributing to the number of high quality jobs available in the local community.

4.17 The recently published Integrated Care Systems: design framework (NHS, June 2020) highlights the key role of the NHS ICS Body and the ICS Partnership has in making the local area a great place to work and live, bringing partners together to develop and support the 'one workforce' which contributes to providing care across the system. This includes supporting the expansion of primary care and integrated teams in the community and closer collaboration on workforce development across the health and care sector, and with local government, the third sector and volunteers.

4.18 Whilst the New Hospitals Programme can be a key enabler in developing new hospital facilities that are more attractive to our current and future workforce, it will only be successful if embedded within a much wider and ambitious integrated care system workforce plan with a “one workforce” ambition.

Research, education and training

4.19 There are ground-breaking innovations taking place in research and education in Lancashire and South Cumbria. The New Hospitals Programme has emphasised the need to stay at the forefront of this work in its ambitions, building for the future for the benefit of our patients and to secure our position as a centre of excellence in acute and specialist care.

4.20 Our strong reputation is evident from the NHS in Lancashire and South Cumbria’s significant contributions to the National Institute of Health Research (NIHR). LTHTr and UHMBT are key contributors to the NIHR portfolio studies, with two of the North West coast clinical leads working in both Trusts. LTHTr is also home to the NIHR Lancashire Clinical Research Facility and the Health Academy. Since its establishment in 2015, the Health Academy has won a number of prestigious awards.

4.21 Despite the strength of our reputation, the outdated condition of our estate and tired education and research facilities mean that UHMBT and LTHTr are not an attractive proposition for trainees embarking on their career. There is a large student body at all sites and, with the expansion of medical student places, there should be an opportunity to attract more medical students from Lancaster University, the University of Central Lancashire (UCLan), Edge Hill University and the University of Manchester. However, to help with recruitment and support the teaching of these students, new infrastructure will be paramount.

4.22 Investment in our infrastructure to provide state of the art facilities and technology will strengthen our position as a centre of excellence for research, education, training and specialised care.

4.23 Lancashire and South Cumbria health and care system partners already work with a range of external academic and business partners, at both a regional and national level. Links with the university sector are strong and there is a shared ambition to drive research, education and innovation across the region. There is a significant opportunity to increase our attractiveness as a partner of choice.

4.24 The New Hospitals Programme offers a significant opportunity to enable and encourage the people of Lancashire and South Cumbria to train and work in our healthcare system, both within our anchor institutions and through additional investment and economic growth opportunities brought to the region by this development. However the opportunity cannot be delivered through the New Hospitals Programme itself, it must be driven by maximising our partnership arrangements. The Lancashire and South Cumbria Health and Care Partnership Board provides a great opportunity to make this happen.

Net Zero Carbon

4.25 The NHS has set an ambitious plan to reach net zero carbon by 2040 for the emissions the NHS control directly (the NHS Carbon Footprint), with an ambition to reach an 80%

reduction by 2028 to 2032. Many of health and care system partners have committed to similar ambitions in their environment plans.

4.26 The New Hospitals Programme will present a significant opportunity to help the Lancashire and South Cumbria Health and Care Partnership deliver on its net zero carbon ambition.

4.27 Whilst it is expected that significant national guidance will be published determining some aspects of the New Hospitals Programme construction, it should not diminish the opportunity to explore broader opportunities to work as a partnership in Lancashire and South Cumbria, including shared policies around use of office space (the NHP aims to halve non-clinical space), supporting use of electric cars, and working with local experts/utility companies on low carbon energy generation.

4.28 The Board is asked to note the future significant impact the New Hospitals Programme will have on the NHS net zero carbon ambition and the potential for significant partnership working, with associated socio-economic benefits.

5. Recommendations

5.1 The Board is asked to note the progress of the New Hospitals Programme and consider the opportunities the programme presents to be used as a catalyst for wider partnership working.

Jerry Hawker, SRO and ICS Executive Director
Rebecca Malin, Programme Director
June 2021

ICS Board

Date of meeting	**7th July 2021**
Title of paper	**Equality, Health Inequality Impact Assessments and Quality Impact Assessments**
Presented by	Talib Yaseen, Director of Transformation
Author	Talib Yaseen, Director of Transformation & Tim Waldron, Head of Equality, Diversity & Human Rights Peoples Services, MLCSU
Agenda item	**9**
Confidential	**No**

Purpose of the paper

To inform the ICS Board about the need to adopt and develop an approach to equality and health inequality impact assessments in 2021/22 and as part of the work required to support the establishment of the proposed statutory NHS body for Lancashire and South Cumbria.

Executive summary

This paper sets out an ambitious approach to delivering equality, diversity and inclusion. The approach proposed begins with the necessary application and use of Equality and Health Inequality Impact Risk Assessments (EHIIRA) which arise from the Equality Act of 2010, in order that the ICS can measurably address equality and health inequality deficits that affect individuals and communities across L&SC, but recognises that we will need to go beyond these in order to achieve our aims around unequal outcomes and health inequality.

The NHS Long term plan outlines a far stronger and comprehensive commitment to redressing equality and health inequality issues both within the NHS workforce and Services. This is further reinforced within the recent Integrated Care Systems: design framework with an expectation that ICS bodies will be very ambitious in dealing with inequalities in access to and outcomes from healthcare services and will be able to demonstrate how they are driving the equality, diversity and inclusion agenda forward.

Recommendations

1. The ICS Board is recommended to adopt and develop the existing EHIIRA service and process in place for the L&SC CCG's.

2. The ICS Board is recommended to support the establishment of a working group, Chaired by a Non-Executive Director, to operationalise the approach for meeting the equality and health inequality requirements for the ICS, and developing recommendations for the policy and direction on this matter for the new L&SC NHS Body, in order that we can measurably address equality and health inequality deficits that affect individuals and communities across L&SC.

3. The Board to confirm that it is their intention is to create an Equality, Diversity and Inclusion policy and process which makes an impact on reducing health inequality.

4. The approach to the development and application of Quality Impact Assessments is also undertaken by the proposed working group.

Governance and reporting (list other forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
ICS Executive Meeting	21/06/2021	Amendments to the paper

Conflicts of interest identified
MLCSU are the current Provider of EHIIRA services across L&SC CCG's and have supported the development of this paper.

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			X	
Equality impact assessment completed			X	
Privacy impact assessment completed		X		
Financial impact assessment completed		X		
Associated risks	X			
Are associated risks detailed on the ICS Risk Register?		X		

Report authorised by:	Talib Yaseen, Director of Transformation

EQUALITY, HEALTH INEQUALITY and QUALITY IMPACT ASSESSMENTS

7th July 2021

1 Introduction

This paper makes proposals for the use of Equality and Health Inequality Impact Risk Assessments (EHIIRA) which arise from the Equality Act of 2010, and there use in the Integrated Care System. There is a minimum legal requirement to comply with the legislation and guidance and introducing EHIIRA will assist us to meet this requirement, however if the ICS wants to make measureable improvements in equality and health inequality deficits and tackle the challenges for individuals and communities we need to take a measureable and proactive action oriented approach.

There are two separate but interconnected processes that will be considered in this paper, firstly undertaking Equality and Health Inequality Impact Risk Assessments(EHIIRA) and secondly undertaking Quality Impact Assessments (QIA) where required. These two processes are often conflated but they are different and important for specific reasons, which will be explained in this paper.

The purpose of this paper is to:

1. Provide the background to the Equality, Diversity and Human Rights (EDHR) responsibilities which will be transferred to the L&SC NHS statutory body on the 1st of April 2022, subject to legislation.
2. Briefly outline how the ICS and the Clinical Commissioning Groups (CCGs) currently use Equality, Health Inequality Impact and Risk Assessments (EHIIRA) as a fundamental part of responding to these responsibilities.
3. Discuss the requirement for Quality Impact Assessments that arise from guidance issued by the National Quality Board and there application with regards to the ICS.
4. Make recommendations to the ICS Board to ensure it not only follows the spirit and minimum requirements set out in legislation, but aspires to a greater standard and one that is in keeping with its core purpose to address inequalities.

2 Equality and Health Inequality Impact Risk Assessments as A tool for transformation – Our Aspiration

The NHS Long term plan outlines a far stronger and comprehensive commitment to redressing equality and health inequality issues both within the NHS workforce and Services, this is further reinforced within the recent Integrated Care Systems: design framework with an expectation that ICS bodies will be very ambitious in dealing with inequalities in access to and outcomes from healthcare services and will be able to demonstrate how they are driving the equality, diversity and inclusion agenda forward.

Whilst EHIIRAs were born as a tool to measure legal and mandated duty compliance, those organisations who use them in a more aspirational and transformative way understand the quality thinking they bring to the table in providing a holistic understanding of the local equality/health inequality issues and how these can be used as a vehicle to strategically develop approaches to redress them through strategy, service review, planning and commissioning activities.

The useable intelligence they provide is fundamental to good population health management in that they help organisations to understand not only population and user rates, but which

communities live where, what health issues are across communities and those that are different in different communities, why some communities use health services the way they do at a regional, sub regional and neighbourhood level.

This holistic understanding would allow the ICS to plan partnership wide approaches to redressing health inequality and help to focus finances and activity to areas where it will have the most impact. Planning to redress health inequality is not a one size fits all approach. For example, nationally it is known there is low uptake of cancer screening services amongst women from black and minority ethnic communities and because they are often diagnosed later they experience worse outcomes from healthcare. A good EHIIRA would recognise this, help to plan redress, and rationalise why funding and activity should be greater in one sub region as opposed to another.

The “Status Quo” is simply not working for many communities and the whole community focus EHIIRAs bring, with useable intelligence feeding into planning and commissioning, can and should play a major part into transforming services and how we work for the better.

This means actively using this intelligence to shape how we procure and commission services at every level of activity in the ICS and ICP’s, for example through social value contracts and employment opportunities via NHS anchor organisations. Importantly as the L&SC statutory body is formed in April 2022 we need to ensure we also take positive action to ensure the membership reflects the population we serve and we address equality and diversity opportunities for the staff we employ and the population we serve.

There is a separate program of work underway in the ICS to develop the population health intelligence system for L&SC and EHIIRA’s are not a substitute or replacement for this whole population approach, but they do allow analysis of the impact of policy or service changes on key groups of the population. The proposed approach to the use of EHIIRA’s needs to be connected to the wider work on population health intelligence being led by Dr Julie Higgins.

An improved approach to equality, diversity and inclusion will need to be supported by place-level data and business intelligence which can inform EHIRAs and wider decision making.

Our aspiration however should be to use this intelligence, whole system and specific, to ensure we take every opportunity to understand and address equality and health inequalities across our population and demonstrate why there is a need for differential action and/or investment to address such differences. This approach needs to be embedded at every level of our Integrated Care System if we want to measurably address inequalities and social determinants of ill health.

If we are ambitious about our approach there is also an opportunity to explore a single EHIIRA service across L&SC, that includes NHS Providers, the ICS, ICP’s and Primary Care Networks. This is something the Board may want to include in the proposed development work in this area.

3 Background

3.1 Local Review

Concerns were raised by non-executive directors that the ICS appears to have an inconsistent approach to EHIIRA’s. The ICS Director of Transformation, and the interim ICS, Business Affairs Lead, undertook a review in the spring of 2021 of what currently happens in practice.

This review identified that the current ICS Board Cover Sheet, which indicates the status of a program with regards to EHIIRA, was adopted from one of the CCG's in Lancashire and South Cumbria. As part of this review it was identified that the ICS does not have an underpinning policy that details, when and how this section of the template should be utilised, the timing and requirement to undertake an assessment, and the information required to support such an assessment in support of relevant decision(s) made by the ICS Board. There is also the potential for duplication, for example if the Strategic Commissioning Committee or one of the CCG's has conducted an EHIIRA to support a specific policy/work programme there ought to be no need to undertake a further assessment for the ICS if we are considering the same matter. However that assessment needs to be referenced and made available to Board members.

3.2 Current practice within CCGs

Currently the CCGs in Lancashire and South Cumbria have all agreed their chosen methodology for capturing and demonstrating how "Due Regard" has been taken to conduct Equality, Health Inequality Impact and Risk Assessments (EHIIRA). Whilst there is no specific duty to conduct them, they are widely recognised to be the best practice approach. They provide a process which ensures that we make (and can evidence) decisions which take account of how the consequences and unintended consequences of decisions may impact on inequality and accessibility.

3.3 Governance and assurance route within CCG's

The current Equality, Diversity and Human Rights (EDHR) function, provided by MLCSU, works closely with the CCG Project Management Office (PMO), Commissioning Teams and others to recognise where new policy, strategy, procedures, programmes of work or service re-designs will need to undertake an EHIIRA.

The person leading on the policy or work programme will be informed an EHIIRA is required and tasked to produce one with support from the EDHR function. Covering notes of reports going to decision making bodies ask the following, a) has an EHIIA been carried out b) if not why C) if yes, what are the key issues. The EHIIRA is made available where decisions are made. Where EHIIRA are not completed, delayed or any other related problems, this will be recorded as a potential risk on the respective risk register. As a minimum the ICS needs to adopt this approach for the remaining part of 2021/22.

At present NHS Midlands and Lancashire CSU provide EDHR support to the CCGs and as part of this support use the Uassure online EHIIRA software platform to record, retain and reproduce the EHIIRA if required.

3.4 Options for the continued use of the EHIIRA process and legacy documents

Whilst conducting of EHIIRAs is no longer a specific requirement in law, it is clear Government Departments and the Judiciary prescribe them as a means to demonstrate legal compliance and would expect them to be conducted and produced as evidence. We would not advocate any other option than to continue with some form of EHIIRA to recognise and manage risk.

There are several options available for consideration by the ICS Board.

1. The ICS could choose to continue to use the existing EHIIRA toolkit as either a paper based approach or as part of the Uassure system.

a. The paper based toolkit including templates and guidance would be provided free of charge (Any access to the online toolkit on Uassure would come with an appropriate charge).
b. If the ICS chose to continue to contract with the MLCSU Equality and Inclusion Team, as a successor body to the existing CCG's, all the above would be included in the service offer.

2. The ICS could choose to source another toolkit from elsewhere, there are plenty to choose from across the country, including online versions but all will come with unique intellectual/copy rights.

3. The ICS could choose to establish its own specialist team to take this work forward as part of a new statutory body.

*(Note- It would be reasonable to expect any commissioned EDHR service to provide such a toolkit as part of its service specification, but it would be advisable to ensure the requirement is contained within any service specification).

Whichever option is settled upon the governance and assurance route above should be embedded within the ICS Governance regimes to ensure compliance is considered and dealt with at appropriate times.

3.5 Legacy EHIIRAs and supporting documentation

There are approximately 300 EHIIRAs sitting in the Uassure online platform belonging to the eight CCGs that would require transfer to the new ICS Body. Most are in an historical complete stage but some remain as live documents whilst programmes of work emerge. It is likely some of these will overhang the transition from CCG to ICS responsibility.

The recently published Integrated Care Systems: design framework confirms that all CCG assets and liabilities will transfer to an ICS NHS Body. There are two options that can be considered with regard to handing over these legacy documents.

1. The ICS can choose to purchase the use of the Uassure system (either separately or as part of MLSCU service provision). On the 1st of April 2022, the ICS can be set up as a new customer and given the permission to share all relevant previous entries or;

2. The Uassure system has the ability to generate a Portable Document Format (PDF) report for each EHIIRA these can be produced and handed over to the new organisation.

It is recommended that the ICS Board support the establishment of a working group, Chaired by a Non-Executive Director, to operationalise the approach for meeting the equality and health inequality requirements for the ICS, and make recommendations for the policy and direction on this matter for the new L&SC NHS Body.

3.6 National Picture

National scoping of ICS Board papers in England identified varied approaches to EHIIRA and QIA, ranging from a minimal one side of information on this topic, to multiple pages containing in depth detail, with some reporting no information on EHIIRA's and others reporting at a high level.

Our local review identified that we can be assured that EHIIRA's are captured for programmes of work that are managed through the ICS PMO office, with detailed discussions held at the ICS Programme Delivery Board. The EHIIRA process is included in the program management documentation of the ICS PMO..

Further action needs to be taken to ensure the requirement to conduct EHIIRA and Quality Impact Assessments is undertaken for areas that fall outside the PMO Office i.e. Board policy or decisions. This will provide the minimum assurance for the Board that consideration of EHIIRA and/or a QIA is documented, utilised to inform decision making and retained and available for review. The Uassure online EHIIRA software platform could be adapted to capture both types of review.

The detail about the legislation on this matter and further background is set out in Appendix 1 of this paper.

4 Quality Impact Assessments

The NHS National Quality Board (NQB) issued guidance in 2012 outlining how quality of care should be assessed during the development of and implementation of Cost Improvement Plans (CIPs) to ensure proper scrutiny by provider boards and commissioning authorities. In practice this led to the local adoption of Quality Impact Assessments to support the scrutiny of changes in local services or cost reduction plans, the objective here being to ensure an assessment was made that there would be no adverse impact on service delivery or staff from the cost improvement plans. They are used alongside the financial and business case for any proposed change, and are usually reviewed and approved by the Medical Director and Chief Nurse on behalf of the respective organisation.

As there is a system transition process underway we need to ensure plans approved by the Financial Recovery Board, for example, are quality and equality impact assessed, where required, but this need only happen once in the system. It is recommended that an approach to the development and application of Quality Impact Assessments is considered as part of this wider work, which could include a panel or named individuals undertaking this assessment. Further work will be needed to agree a process with the Director of Nursing and Medical Director of the ICS.

5 Discussion - Implications for the ICS on the way forward

This paper has identified a range of issues that need to be considered and the experience and input of the Board into determining and agreeing a way forward would be appreciated. A number of recommendations have been made that flow from the analysis and assessment undertaken in this paper to help support the Board determine a way forward.

Going forward the ICS will require an underpinning policy and an assessment process to ensure EHIIRA and QIA are undertaken and implemented effectively. Such a policy and process will need to be in place (amongst many) no later than April 2022.

As a legally constituted body the L&SC NHS Body will have a whole raft of EDHR Legal and NHSEI mandated duties to adhere to, without going into the whole spectrum, the basic premise is the same across them all, the ICS must be able to demonstrate it has taken "Due Regard" to the needs of the whole community in everything it does, this includes planning, commissioning, service design, delivery and decision making.

These requirements have a particular focus on what considerations were taken leading up to and at the time a decision is made. Where an ICS chooses to delegate powers to make decision on its behalf, for example delegating powers to make decisions to bodies within Integrated Care Partnership (ICP) or sub decision making groups the responsibility for meeting the legal requirement remains with the constituted body and cannot be transferred.

A number of questions are framed here to support a conversation with Board members about this important area of work:

- Do colleagues understand the requirement for EHIIRA and QIA assessments?

- Do colleagues want to go beyond the minimum legislative requirements to be being an exemplar organisation utilising the intelligence within Equality and Health Inequality and Impact Risk Assessments?

- Do colleagues support the transition and development of the current process utilised by CCG's to the ICS and the wider aspiration to be an exemplar for the application and use of Equality and Health Inequality and Impact Risk Assessments as described in this paper?

- Does the board support the establishment of a small working group, Chaired by a Non-Executive Director, to operationalise the approach for meeting the equality and health inequality requirements for the ICS, and for this group to make recommendations for the policy and direction on this matter for the new L&SC NHS Body, including education and training?

6 Recommendations

1. The ICS Board is recommended to adopt and develop the existing EHIIRA service and process in place for the L&SC CCG's.

2. The ICS Board is recommended to support the establishment of a working group, Chaired by a Non-Executive Director, to operationalise the approach for meeting the equality and health inequality requirements for the ICS, and developing recommendations for the policy and direction on this matter for the new L&SC NHS Body, in order that we can measurably address equality and health inequality deficits that affect individuals and communities across L&SC.

3. The Board to confirm that it is their intention is to create an Equality, Diversity and Inclusion policy and process which makes an impact on reducing health inequality.

4. The approach to the development and application of Quality Impact Assessments is also undertaken by the proposed working group.

Talib Yaseen
Executive Director of Transformation

Tim Waldron
Head of Equality, Diversity & Human Rights,
Peoples Services
NHS Midlands and Lancashire CSU

References

1. House of Commons Briefing Paper, Number 06591, 8th July 2020, The Public Sector Equality Duty and Equality Impact Assessments
2. Securing Equality, A guide to using the public sector equality duty to fight local cuts, UNISON, September 2017
3. Equality Information and the Equality Act; A guide for Public Authorities, Equality and Human Rights Commission, updated 2014
4. Meeting the Equality Duty in Policy and Decision Making, Equality and Human Rights Commission, updated 2014

Appendix 1 Legislation and Guidance on Equality and Quality Impact Assessments

1 The Legal Framework

From 1st April 2022 the Equality, Diversity and Human Rights duties currently held by CCGs will transfer to the ICS, assuming legislation is passed, these include.

1.1 Legal Duties

- The Human Rights Act 1998
- The Equality Act 2010
- The Public Sector Equality Duty 2011
- The Health and Social Care Act 2012 (currently under review/refresh)
- The Social Value Act 2012
- The Modern Slavery Act 2015

1.2 NHSEI Mandated Duties

- The Equality Delivery System (EDS (currently under review/refresh))
- The Workforce Race Equality Standard (WRES)
- The Workforce Disability Equality Standard (WDES)
- The Accessible Information Standard (AIS) and
- The NHS Standard Contract – Service Conditions 2021/2022

2 Equality Act of 2010 and the Public Sector Equality Duty

The Public Sector Equality Duty (PSED) contained in section 149 of the Equality Act 2010, requires public authorities to have due regard to several equality considerations when exercising their functions. Section 149 replaced pre-existing duties concerning race, disability and sex. It extended coverage to the additional “protected characteristics” of age, gender reassignment, religion or belief, pregnancy and maternity, sexual orientation and, in certain circumstances, marriage and civil partnership.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

These requirements apply to the organisation itself in terms of employment of staff and the decisions it makes that could have an impact on quality and equality in terms of service provision and delivery.

Public authorities often carry out Equality Impact Assessments (EIA) prior to implementing policies, with a view to predicting their impact on equality. The Equality Act 2010 does not

specifically require them to be carried out, although they are a way of facilitating and evidencing compliance with the Public Sector Equality Duty.

Having due regard to the aims of the general equality duty is about using good equality information and analysis, at the right time, as part of the decision-making processes.

An Equality Impact Assessment (EIA) is an analysis of a proposed organisational policy, or a change to an existing one, which assesses whether the policy has a disparate impact on persons with protected characteristics. They are carried out primarily by public authorities to assist compliance with equality duties.

3 Equality Impact Assessments and the Law

The Equality Act 2010 does not require public authorities to carry out EIAs.

The current legal position is that EIAs are one way - but not the only way - for a public authority to demonstrate compliance with the PSED. However, the case law indicates that some form of documentary evidence of compliance with the PSED is valuable to public authorities.

Thus, although the law does not require public authorities to carry out EIAs, the courts place significant weight on the existence of some form of documentary evidence of compliance with the PSED when determining judicial review cases.

The general duty states that: ‘A public authority must, in the exercise of its functions, have due regard to the need to

(a) Eliminate all forms of discrimination, harassment and victimisation that are prohibited by or under this act;

(b) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it;

The Public Sector Equality Duty goes beyond simply outlawing discrimination. It places an obligation on public bodies to consider positive steps to promote equality and good relations. This includes thinking about ways to reduce disadvantage and meet the different needs of different groups. So public bodies should think about how they can promote equality at all stages of their work, from developing policy to ongoing service delivery.

4 Consequences of Non Compliance

Enforcement Section 156 of the Act states: A failure in respect of a performance of a duty imposed by or under this Chapter does not confer a cause of action at private law. This means that an aggrieved party who feels a public authority has not complied with the PSED can only bring their claim by way of judicial review (public law).

Judicial review is a process whereby the High Court (and more senior courts) determines whether the actions of a public body are lawful. Only the Equality and Human Rights Commission (EHRC) or individuals/organisations affected by a failure of a public authority to comply with the PSED may issue a claim for judicial review.

The Equality and Human Rights Commission (EHRC) has a statutory power to institute judicial review proceedings where a public authority may have failed to comply with the PSED. Further, if the EHRC suspects that an authority is not complying with the PSED it

has a power to conduct an assessment and, if necessary, serve a compliance notice on the authority requiring it to set out in writing steps it proposes to take to address the non-compliance. The authority must give this written information to the Commission within 28 days of its receipt of the compliance notice.

The EHRC provides the following guidance: Assessing the impact on equality of proposed changes to policies, procedures and practices is not just something the law requires, it is a positive opportunity for public authorities to ensure they make better decisions based on robust evidence. The assessment does not necessarily have to take the form of a document called an Equality Impact Assessment (EIA) but you can choose to do so if it is helpful.

It will help you to demonstrate compliance if you:

- Ensure you have a written record of the equality considerations you have taken into account
- Ensure that your decision-making includes a consideration of the actions that would help to avoid or mitigate any negative impacts on particular protected groups.
- Make your decisions based on evidence
- Make your decision-making process more transparent.

The practice of carrying out EIAs is widespread. While they have been described as a valuable “tool to encourage service managers to consider the equality issues within their service and to act upon the findings of the assessments” they have also been described as overly bureaucratic.

5 Quality Impact Assessments

The NHS National Quality Board (NQB) issued guidance in 2012 outlining how quality of care should be assessed during the development of and implementation of Cost Improvement Plans (CIPs) to ensure proper scrutiny by provider boards and commissioning authorities. In practice this led to the local adoption of Quality Impact Assessments to support the change in local services or cost reduction plans. They are used alongside the financial and business case for any proposed change.

In many places these two requirements have been conflated into a single process known as Quality and Equality Impact Assessments (QEIA), but are borne out of very different requirements.

End

ICS Board

Date of meeting	**7th July 2021**
Title of paper	**System Financial Recovery Programme and terms of reference**
Presented by	**Gary Raphael, Executive Director of Finance and Investment**
Author	**Gary Raphael**
Agenda item	**11**
Confidential	**No**

Purpose of the paper
To explain to the ICS Board the different strands of the recovery programme, providing the context for what is acknowledged as a complex programme within the overall planning framework for the System. Hopefully it will assist ICS Board members in framing the progress reports that will flow from the System Financial Recovery Board on delivery of our programme objectives. To obtain approval for the draft terms of reference agreed at the June meeting of the System Financial Recovery Board.
Executive summary
The attached cover report (excluding appendices) for a series of appendices and spreadsheets detailing the System's organisational and system-wide savings plans for 2021/22 was used to introduce our system financial recovery submission to the regional and national CFOs earlier in June. The full submission plus further detail on schemes was also presented to the System Financial Recovery Board on 28th June. The SFRB confirmed its commitment to the development of the system-wide schemes reported. The cover report explains the background on: • Organisational savings plans • System-wide programme • Run rate exercise • System diagnostic • Governance and resources Although the System's H1 plan has been accepted, the regional and national CFOs want assurance that our longer term recovery programme will deliver the results we have signalled. They have not yet indicated confidence in our programme and work is on-going to prepare for a second call with the national and regional CFOs in early August. The System Financial Recovery Board will ensure that the PMO arrangements for the programme are effective, savings schemes are developed and implemented and will oversee preparations for the upcoming call with Julian Kelly and regional colleagues.
Recommendations
The ICS Board is asked to **note** the contents of the cover paper, to expect future reports on progress in all the areas highlighted in it and to **approve** the attached

terms of reference for the System Financial Recovery Board.				
Governance and reporting (list other forums that have discussed this paper)				
Meeting	**Date**			**Outcomes**
System Financial Recovery Board	**28th June 2021**			**ToR agreed for submission to the ICS Board for approval**
Conflicts of interest identified				
None identified.				
Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			√	N/A at this stage
Equality impact assessment completed			√	N/A at this stage
Privacy impact assessment completed			√	
Financial impact assessment completed	√			Outlined within reports to SFRB
Associated risks	√			Identified in reports to SFRB, but yet to be fully scoped for each system-wide scheme
Are associated risks detailed on the ICS Risk Register?		√		ICS Risk register to be developed.

Report authorised by:	Gary Raphael

Lancashire and South Cumbria
Health and Care Partnership

Lancashire and South Cumbria ICS

System Financial Recovery Programme

Introduction

1. Lancashire and South Cumbria (L&SC) ICS Board approved the establishment of a System Financial Recovery Board at its March 2021 meeting, building on a report in the previous month that outlined the approach to system recovery that had been discussed and agreed by CCG CFOs and trust finance directors. This Board is chaired by the ICS Chief Officer and meets monthly, starting in April 2021.

2. The ICS Board agreed to a twin track approach to savings in 2021/22:
    - A pragmatic set of cost improvement schemes for 2021/22 to enable the System to gain momentum on savings while we investigated a more strategic approach for later years
    - Development of a 'system diagnostic' to enable the root causes of the deficit to be identified and set the foundations for a strategic approach to service reform, building on the clinical strategy to enable delivery of more cost effective services over a number of years

3. Our original intentions for 2021/22 required adaptation to take account of national priorities signalled as part of the H1 planning round, which elevated elective recovery, mental health, on-going Covid responses and other requirements within a continuing Covid financial framework. National requirements were to spend more money to reduce the backlog on elective waiting lists, financed through the Elective Recovery Fund (ERF) and on-going national priorities, like cancer services, were to be delivered through the application of the Strategic Development Funds (SDF).

4. H1 compliant plans for L&SC have been developed and submitted to ensure implementation of national and local priorities while the System stays within its financial envelope of £1.79bn. A major part of the System's financial plan is the requirement for providers to deliver a 3% CIP and CCGs to deliver 3% CIP on influenceable spending. The total CIP planned for H1 amounts to £56m with an assumption of an equivalent amount in H2 = total of £112m for the year, with a similar recurrent impact.

5. In order to meet the ICS Board's ambitious £200m savings target in the context of the H1 plans, the system-wide savings schemes required to supplement organisational CIPs have been re-scoped to ensure delivery of £88m recurring savings, with as large a part year effect in 2021/22 as it is possible to achieve above and beyond the £112m already in trust and CCG plans.

6. The diagnostic work, development of the financial strategy along with clarity on future planning guidance will continue to build on this work to ensure ongoing financial sustainability in future years

Organisational savings plans

7. Appendix 1 is a summary of the organisational CIPs developed to enable the System to operate within its financial envelope during H1 in 2021/22. It should be noted that CCGs and trusts have identified £45.1m out of a total of £56.7m required at the time of this report, with £10.6m outstanding. A significant focus is being placed on the CIP plans and the final programme will need to be fully developed within the next few weeks. A risk based assessment is also in place and requires system-wide moderation to ensure consistency across the organisations, which will be undertaken shortly. Overall, the current level of risk is in line with expectations at this early stage of H1 plan implementation. The PMO will work with organisations to ensure that existing and any further plans deliver recurring savings.

8. Any duplication in organisational and system-wide schemes has already been assessed and taken into account in making the estimates for the system-wide schemes.

9. In addition to these CIPs, the System's provider collaborative is developing contingency schemes that will either supplement existing plans or, as a minimum, substitute for those that do not deliver our original estimates. The specific schemes include a review of asset valuation methodology being used across the patch to move to a more consistent valuation approach based on modern equivalent asset valuation and a number of GIRFT review areas agreed by the Provider Collaborative Board (which are already being scoped).

System-wide programmes

10. A range of system-wide programmes have and are being established to supplement organisational schemes, with the objective of delivering at least £88m in recurring terms with a target of £30m or more being delivered in 2021/22. The main programmes are:
    i. Medicines management refresh across secondary and primary care - £10m in 2021/22 and £15m in recurring terms
    ii. System approach to procurement in estates and digital functions - £3m in 2021/22 with £11m recurrently
    iii. System approach to procurement of drugs and dressings across the ICS - £2m in 2021/22 with £4m recurrently
    iv. Agency and locum staffing – implementation of common rates across L&SC and development of a system approach to use of temporary staffing - £9m in 2021/22 (excluding use of temporary staff to deliver elective targets) and £29m recurrently
    v. Continuing Health Care – investigation of unwarranted variation across L&SC; benchmarking suggests that alignment with national average conversion rates would deliver a significant level of savings of circa £10m to £15m in recurring terms with a target of £5m in 2021/22
    vi. Evidence based interventions – enforcement of extant policy, £5m in a full year and £3m target in 2021/22 (non-cash releasing)

vii. Pathology collaborative – this has developed and achieved national approval for a business case to support £31m capital investment as part of wave 4 national schemes. Savings of £0.5m per annum are scheduled from 2022/23 building incrementally up to £7.2m by 2030/31

viii. Driving out duplication of provision for developments and other services across the ICS e.g. extra capacity versus admission avoidance schemes, review of BCF - £5m in 2021/22

ix. Corporate services across L&SC – a major programme to rationalise services, with the objective of delivering savings from 2022/23 onwards. Model hospital data suggests the maximum savings could be in the order of £67m, but the potential has yet to be scoped

Run rate exercise

11. CCG and trust finance directors are working with an external senior finance director to undertake a peer review of costs incurred since the 2019/20 outturn through to H1 2021/22 plans. The objective is to ensure that there is a thorough, collective understanding of all material components of each organisation's run rate bridge analysis.

12. The peer review will ensure that organisations in each of the 5 separate places in L&SC, as well as the mental health trust and NWAS, have the opportunity to scrutinise primary care, secondary care and other spending decisions, with a further peer review process undertaken across the separate places, to enable us to compare and contrast our individual responses to Covid and other spending decisions.

13. Understanding and joint ownership of all major spending decisions enables any duplication of intent (e.g. between primary and secondary care) to be identified and rectified. It will also enable finance directors to gain insights into the impact that their organisations' spending decisions have had on the whole system and build the commitment required to enable future decisions to be better informed and agreed on a system basis.

14. A potential outcome of the run rate exercise is to drive out duplication and make better use of the resources already applied to historic issues. This has been referred to in point viii in paragraph 10 above; the amount is indicative at this stage.

System diagnostic

15. A specification for the system diagnostic has been developed to enable procurement during June 2021 and early outputs by the end of the summer.

16. The intention of the diagnostic is to identify the underlying causes of the System deficit of circa £340m (estimated as current run rates, less Covid spending and the usual level of CIPs, compared to notified total place-based allocations) in order to be able to design a series of interventions to resolve the separate issues identified. The system will look to deal with the matters most easily resolved from late 2021/22 and

schedule the work programmes to deliver more difficult issues from 2022/23 onwards.

17. A potential risk of the diagnostic is that it points to issues that cannot be easily resolved or which feel that they are not within the control of system partners. There is absolute clarity within the System that having identified the problems we will move to resolve them. Being able to stratify the reasons for the deficit ensures that we will develop solutions for the specific issues, rather than try to deal with them in the same way.

Governance and resources

18. As mentioned above in paragraph 1, the System has established a Financial Recovery Board. It comprises a range of very senior clinical (e.g. MD, DoN) and managerial colleagues from across the trusts and CCGs in L&SC, with support provided by the Finance Advisory Committee, which comprises the NHS DoFs and CFOs from across the system as well as NHSEI regional team members.

19. The Provider Collaborative has a Director of Provider Sustainability in post, whose job is to coordinate and drive more cost effective service provision across the five trusts in L&SC and who is building on system PMO resources to be able to deliver the whole programme of work. This director has executive level experience as a director of finance in provider organisations, was previously the finance lead in the neighbouring ICS to L&SC and has the remit to move quickly to drive sustainability in the provider collaborative. She is also a member of the ICS executive team to ensure that the ICS and provider collaborative works together effectively on this part of our collective agenda. ICS sourced funding has been made available to enable the PMO to be scaled up to meet the substantial challenge faced by the system.

20. The provider collaborative is a well-established part of the whole L&SC system comprising the CEOs and Chairs of the trusts and it is itself chaired by David Flory, the ICS' independent chairman.

21. Attached to this paper as appendix 2 is the system savings tracker that is being used by the System Financial Recovery Board to monitor delivery of savings and progress on the savings pipeline.

Conclusion

22. L&SC ICS has delivered a compliant H1 plan, upon which it expects to be monitored for successful delivery by NHSEI. The final Plan was submitted on time on 3rd June, following the submission of compliant finance plans on 6th May, 2021.

23. The System has also been asked by the national and regional CFOs to demonstrate that the ICS Board's ambition to deliver £200m recurring savings by the end of 2021/22 is adequately scoped and can be monitored throughout the year.

24. This report provides the information about organisational CIPs (£112m) which are necessary for a compliant H1 plan and also shows where the system is looking to deliver another £88m savings in recurring terms, with an in-year financial target of £30m. The governance arrangements established to assure delivery have also been outlined in this report.

Gary Raphael
Executive Director of Finance and Investment
7rd June 2021

Lancashire and South Cumbria
Health and Care Partnership

SYSTEM FINANCIAL RECOVERY BOARD (SFRB) TERMS OF REFERENCE

Document Control			
Title	Lancashire and South Cumbria Integrated Care System (LSC ICS): Terms of Reference (TORs) : System Financial Recovery Board (SFRB)		
Responsible Person	System Financial Recovery Board Chair		
Date of Approval			
Approved By	Lancashire and South Cumbria ICS Board		
Author	Gary Raphael		
Date Created	18th June 2021		
Date Last Amended	29th June 2021		
Version	2		
Review Date	October 2021		
Publish on Public Website		**Yes** ☑	**No**
The version of the policy posted on the intranet must be a PDF copy of the approved version			
Constitutional Document		**Yes** ☑	**No**
Requires an Equality Impact Assessment		**Yes**	**No** ☑

Amendment History		
Version	**Date**	**Changes**
1	18 06 21	Initial draft
2	29 06 21	To incorporate the need for a vice chair
3		
4		

1.	The Propose of the System Financial Improvement Board
1.1	The Lancashire and South Cumbria ICS Board has established a group to be known as the System Financial Recovery Board (SFRB) to lead the collaborative work required across Lancashire and south Cumbria ICS to ensure robust, deliverable plans for more financially sustainable services over the strategic timeframe. Financial recovery means our ability as partners in the system to be able to deliver health services within the resources made available by NHSEI.
1.2	The SFRB will lead the programme of work to ensure that the system delivers cost effective healthcare for all patients across the ICS.
1.3	The SFRB will be responsible for: • Gaining assurance from all organisations in their ICPs and via the Provider Collaboratives, that improvement programmes will deliver more cost effective healthcare. • Reviewing potential system-wide cost improvement schemes and selecting those that align with the strategic direction of the system and fit within the programme developed as part of the system diagnostic. • Ensuring that system-wide schemes are scoped, initiated quickly and the necessary PMO arrangements are in place and operating effectively to assure delivery at organisational level. • In the short term to investigate the learning and innovation gains made during the response to Covid, determining the potential further gains that could be obtained by adopting the same approach in other areas.

2.	Authority, Accountability and Governance
2.1	The SFRB is established by the ICS Board and will oversee progress in the delivery of agreed plans, ensure the necessary resources are deployed to achieve them, provide advice and support to those tasked to deliver agreed changes and report on progress on a regular basis to the ICS Board.
2.2	The SFRB will have the authority to confirm SROs and finance leads for each system-wide scheme and hold them to account for delivery.
2.3	The SFRB will authorise deployment of the staffing, financial and advisory resources necessary to develop and implement plans under its purview.
2.4	The SFRB will advise the ICS and Provider Collaborative boards on the feasibility of system-wide schemes and the level of ambition that is warranted, given our financial circumstances.
2.5	Members of the Board will ensure that their host organisations and ICPs are apprised of the main aspects of the financial recovery programme and promote its objectives.

3.	Key Functions and Objectives
3.1	Obtain assurance from organisations, ICPs or PCB that their CIP and QIPP programmes are delivering the expected cost improvements, in order to maintain an overview of the overall level of cost improvement being achieved.
3.2	Using available data sources, system learnings and horizon scanning to develop and assure implementation of a list of potential schemes for healthcare improvement/cost effective delivery that aligns to ICS strategic imperatives and the system diagnostic.
3.3	Advise on the list of schemes, review Project Initiation Documents (PIDs) and confirm the system-wide schemes necessary for healthcare improvement/cost effective delivery in the short, medium and longer term, taking into account the governance arrangements within the PCB and ICPs.
3.4	Advise on and ensure that the ICS Board's ambitions for improved cost effectiveness are met through the programme of work developed for financial recovery and that a pipeline of schemes is produced covering current and future years.
3.5	Ensure the delivery of the system diagnostic, to inform the system's collective understanding of the drivers of our deficits and assist us in directing the different approaches and solutions we must take to the different aspects of our deficit, over the strategic timeframe.
3.6	Monitor achievement of the various stages of system-wide scheme development and implementation (using the savings tracker) ensuring that the expected level of cost improvement is achieved within our organisations.
3.7	Make recommendations to the Investment Committee for healthcare improvement schemes that may arise in the course of the Board's deliberations.
3.8	Keep track of lessons learned and scheme effectiveness and stop any schemes that do not meet the objective of improving cost effectiveness.

4.	Membership
4.1	The Board comprises representatives of the health organisations, with a preponderance of clinical and operational senior leaders.
4.2	Membership of SFRB will be made up of the following members, plus any other representatives that are required to attend as determined: • CEO/chair • Vice chair • An ICS non-executive director • CCG AO • Medical Director • Nursing Director

	• Operations Director • Human Resources Director • GP • Finance Director • Director of Sustainability for the PCB • ICS Finance Lead • ICS Head of Cost Improvement
4.3	In the event of a member not being available, a nominated alternative senior officer should attend who is able to represent the perspective of the absent professional e.g. a MD for the usual MD delegate.

5.	Quoracy
5.1	A minimum of: • 50% of the membership • The Chair or Vice Chair of the SFRB
5.2	Members are not expected to miss more than two meetings in a row.

6.	**Decision Making**
6.1	Decision making will usually be by the consensus.
6.2	In the event of a highly controversial item, the SFRB will vote with the decisions passed by simple majority.

7.	**Declarations of Interest**
7.1	Individuals contracted to work with or appointed to the SFRB will comply with the standard of business conduct policy including the requirements for declaring any conflicts of interest.
7.2	In order to facilitate this process, "Declaration of Interests" will be a standing item on all agendas.
7.3	All new declarations of interest must be notified to the Chair within 28 days of a member taking office of any interests requiring registration, or within 28 days of a change to a member's registered interests. Copies of these notifications should be sent to the Programme Office.

8.	**Access and Attendance**
8.1	The meetings are not held in public.
8.2	Other CCG/Provider Directors and staff, representatives from partner organisations may be required to attend meetings to speak on specific matters.
8.3	Access to meeting may be granted to other professional colleagues with the permission of the Chair.

9.	**Agenda and Minutes**
9.1	The agenda and support papers will be circulated by email no later than 3 working days prior to the meeting.
9.2	Papers may not be tabled without the agreement of the Chair.
9.3	Minutes will be taken by the support officer and distributed to the members within 10 working days after the meeting.
9.4	Given the mixture of policy development, option appraisal and the incomplete nature of much of the portfolio of work undertaken by the Board, minutes are deemed to be confidential and will not go into the public domain.
9.5	Agenda and papers to be finalised with the Chairman before seven working days in advance of the meeting.
9.6	All papers agreed by the Chairman should be received by the Business Support Team seven working days in advance of the meeting.

10.	Meeting Arrangements
10.1	The SFRB will initially be held monthly or as otherwise required by the programme.
10.2	Meetings will be approximately 90 minutes in duration (or as determined by the Group).
10.3	The Chair may at any time convene extraordinary meetings to consider business that requires urgent attention or when required to manage significant risks.
10.4	A workstream report will be produced following each meeting for submission to the LSC ICS Board.

11.	Review
11.1	The SFRB will review its purpose, function, terms of reference and performance annually or at the discretion on the Chair.

Lancashire and South Cumbria
Health and Care Partnership

ICS Board

Date of meeting	**7th July 2021**
Title of paper	**ICS Financial Report**
Presented by	Gary Raphael, ICS Executive Director of Finance and Investment
Author	Elaine Collier, ICS Head of Finance
Agenda item	**12**
Confidential	No

Purpose of the paper
For noting.
Executive summary
This paper reports on the month 2 financial performance for the L&SC system. It covers the revenue and capital positions of all L&SC partners and the position on ICS central functions.
Recommendations
The Board is asked to **note** the report.

Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
None		

Conflicts of interest identified
Not applicable

Implications

If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			X	
Equality impact assessment completed			X	
Privacy impact assessment completed			X	
Financial impact assessment completed	X			
Associated risks	X			
Are associated risks detailed on the ICS Risk Register?		X		

Report authorised by:	Gary Raphael, ICS Executive Director of Finance and Investment

Lancashire and South Cumbria
Health and Care Partnership

ICS Financial Report

1. Introduction

1.1 This paper reports on the month 2 financial performance for L&SC partners and ICS central functions.

2. Financial Performance

2.1 As previously reported, 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. The only exception being a £2m technical deficit which relates to delayed funding for NWAS 111First, which is still being followed up with national team.

2.2 Table 1 below shows a summary of the plan position, showing a net system deficit of £22.4m offset by ERF income of £20.4m

Table 1 – L&SC system planning overview for H1 (April to September 2021):

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)**

2.3 At month 2, we are reporting a position that is slightly ahead of the £22.4m plan, £0.3m year-to-date and £2.7m for H1 forecast outturn. However this reported position is affected by the ERF income assumptions made by providers. The reporting guidance for month 2 was not clear and with this being the first month of reporting, it resulted in some inconsistencies that we hope will be clarified for month 3. We are also awaiting activity information to confirm that we are on track to achieve the planned ERF income. Table 2 below shows a summary of the position for CCGs, providers and the system financial performance for month 2.

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

Financial Position Overview - M02						
Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan £m	Actual £m	Variance to Plan £m	Plan £m	FOT £m	Variance to Plan £m
CCGs	(0.0)	(0.3)	(0.3)	0.0	0.7	0.7
NHS Providers	(7.5)	(6.9)	0.6	(22.4)	(20.4)	2.0
System Financial Performance	**(7.5)**	**(7.2)**	**0.3**	**(22.4)**	**(19.7)**	**2.7**

2.4 Appendix 1 shows a more detailed overview of the financial performance by CCG and provider sector.

2.5 Table 3 below reports on the ICP performance against the plan.

Table 3 – L&SC ICP summary financial position as at the end of month 2, May 2021:

System performance Surplus / (Deficit) - M02						
By ICP	Year to Date			Forecast Outturn		
	Plan £m	Actual £m	Variance to Plan £m	Plan £m	Forecast £m	Variance to Plan £m
Central Lancashire ICP	(1.4)	(1.0)	0.3	(6.6)	(4.0)	2.6
Fylde Coast ICP	(2.2)	(2.1)	0.1	(6.9)	(6.9)	(0.0)
Pennine Lancashire ICP	(2.1)	(2.0)	0.1	(6.9)	(6.9)	0.0
Morecambe Bay ICP	(1.7)	(2.1)	(0.3)	0.0	0.0	0.0
West Lancashire MCP	0.0	0.0	0.0	0.0	0.1	0.1
North West Ambulance Service NHS Trust	0.0	0.1	0.0	(2.0)	(2.0)	0.0
Lancashire and South Cumbria NHS FT	(0.1)	(0.1)	(0.0)	0.0	(0.0)	(0.0)
ICP Financial Performance	**(7.5)**	**(7.2)**	**0.3**	**(22.4)**	**(19.7)**	**2.7**

3. Efficiencies

3.1 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.

3.2 At month 2, we are reporting actual savings of £6.9m which is £1.5m behind plan. There is still a level of unidentified savings totaling £10.7m, but we are working with these respective organisations and expect this to reduce to near zero at month 3. Table 4 below shows a summary of the current position by ICP.

Table 4 – L&SC ICP efficiency delivery as at the end of month 2, May 2021:

Efficiencies : CIPS / QIPPS - M02						
ICP	H1	Year-to-date			H1	
	CIP Plan £m	Plan £m	Actual £m	Variance to Plan £m	Unidentified CIP £m	% of CIP plan
Central Lancashire ICP	13.0	0.7	0.9	0.2	7.6	58%
Fylde Coast ICP	12.6	2.9	2.9	0.0	(0.0)	0%
Pennine Lancashire ICP	13.1	1.7	0.1	(1.7)	1.3	10%
Morecambe Bay ICP	9.4	1.7	1.6	(0.0)	0.0	0%
West Lancashire MCP	2.1	0.1	0.1	0.0	0.0	0%
North West Ambulance Service NHS Trust	3.6	0.7	0.9	0.3	1.8	50%
Lancashire and South Cumbria NHS FT	2.0	0.6	0.4	(0.2)	(0.1)	0%
ICP Performance	**55.8**	**8.4**	**6.9**	**(1.5)**	**10.7**	

Lancashire and South Cumbria
Health and Care Partnership

4. Capital Performance

4.1 L&SC have submitted a capital plan totalling £156.9m for 2021/22. This is made up of our capital envelope of £112m and a further £44.9m for additional allocations and other items.

4.2 At month 2, we are reporting that we are broadly in line with the plan and we will be undertaking a more detailed exercise at the end of quarter 1 to review any potential slippage, which may allow us to bring forward schemes from our prioritised waiting list.

4.3 The ICS has a duty to ensure that the envelope is spent in full as any underspend represents lost resource. The ICS is committed to achieving this at year end. Table 5 below shows the current position.

Table 5 – L&SC summary capital position as at the end of month 2, May 2021:

Capital Overview - M02						
Capital	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance to Plan	Plan	FOT	Variance to Plan
	£m	£m	£m	£m	£m	£m
Charge against Capital Envelope	**15.2**	**8.4**	**6.8**	**112.0**	**109.9**	**2.1**
National allocations plus other items charged to CDEL	7.2	4.0	3.2	44.9	44.9	0.0
Capital DEL	**22.4**	**12.4**	**10.0**	**156.9**	**154.8**	**2.1**

5. ICS Central Functions

5.1 Table 6 below provides an update on the financial position for central functions. These are draft budgets are in the process of being finalised as we get confirmation of the different funding streams.

Table 6 – ICS central functions draft position for month 2, May 2021:

ICS Central Functions : DRAFT Budgets - M02							
ICS Central Functions		Year-to-date			Full Year Forecast		
		Budget	Actual	Under / (over) spend	Annual Budget	Forecast Outturn	Under / (over) spend
		£000	£000	£000	£000	£000	£000
ICS Core Budgets							
	Clinical Portfolios	72	45	27	429	429	0
	Enabling Functions	206	190	16	1,237	1,237	0
	Executive Functions	416	390	26	2,494	2,494	0
	Other Support Functions	47	47	0	284	284	0
		741	672	69	4,444	4,444	0
Nationally Funded Budgets		4,189	4,189	0	25,134	25,134	0
System Funded Budgets		137	137	0	823	823	0
TOTAL		**5,067**	**4,998**	**69**	**30,401**	**30,401**	**0**

6. Recommendation

6.1 The ICS Board is requested to **note** the contents of the report;

Gary Raphael
ICS Executive Director of Finance and Investment
29 June 2021

Lancashire and South Cumbria
Health and Care Partnership

Appendix 1

Detailed overview of financial performance by CCG and provider sector.

Financial Position Overview - M02						
Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan	Actual	Under / (over) spend	Plan	FOT	Under / (over) spend
	£m	£m	£m	£m	£m	£m
Acute Services	331.6	331.2	(0.4)	1,006.7	1,006.5	(0.2)
Mental Health Services	63.5	63.8	0.3	195.7	196.1	0.4
Community Health Services	49.7	50.7	0.9	149.6	150.4	0.7
Continuing Care Services	27.8	29.7	2.0	79.9	82.5	2.6
Primary Care Services	64.3	64.3	(0.1)	197.7	196.4	(1.4)
Primary Care Co-Commissioning	45.8	45.6	(0.1)	137.3	137.2	(0.0)
Other Programme Services	14.2	14.8	0.7	36.8	40.1	3.4
Running Costs	5.3	5.2	(0.1)	16.0	15.9	(0.1)
Hosted Services	0.0	0.0	0.0	0.0	0.0	0.0
COVID Outside Env & ERF Unvalidated	2.9		(2.9)	6.2		(6.2)
Total CCG Net Expenditure	605.1	605.4	0.3	1,825.9	1,825.2	(0.7)
In-Year Allocation	605.1	605.1	0.0	1,825.9	1,825.9	0.0
CCG Total	**(0.0)**	**(0.3)**	**(0.3)**	**0.0**	**0.7**	**0.7**
Income Excl Reimbursements	529.7	525.1	(4.7)	1,587.2	1,606.2	18.9
COVID-19 Reimbursements	1.8	7.3	5.5	5.1	21.6	16.5
Total Income	531.6	532.4	0.8	1,592.4	1,627.8	35.4
Pay	(356.0)	(361.2)	(5.2)	(1,063.6)	(1,083.1)	(19.4)
Non Pay	(176.1)	(171.1)	5.0	(530.2)	(544.1)	(13.9)
Non Operating Items (exc gains on disposal)	(7.0)	(6.9)	0.1	(21.0)	(21.0)	(0.0)
Total Expenditure	(539.0)	(539.2)	(0.2)	(1,614.8)	(1,648.2)	(33.4)
NHS Providers	**(7.5)**	**(6.9)**	**0.6**	**(22.4)**	**(20.4)**	**2.0**
System Financial Performance	**(7.5)**	**(7.2)**	**0.3**	**(22.4)**	**(19.7)**	**2.7**

Lancashire and South Cumbria
Health and Care Partnership

ICS Board

Date of meeting	**7th July 2021**
Title of paper	**System Performance**
Presented by	Andrew Bennett, Executive Director- Commissioning
Author	Andrew Bennett, Executive Director- Commissioning
Agenda item	**13**
Confidential	**No**

Purpose of the paper

This paper is to confirm that the Strategic Commissioning Committee has taken oversight for the development of a consolidated approach to the reporting of System Performance.

Executive summary

The Strategic Commissioning Committee (SCC) was formed in April 2021 and builds on the previous work of the Joint Committee of CCGs. In order for the Committee to perform more of the functions traditionally undertaken by CCG Governing Bodies, it was agreed to form a number of sub-committees, including a Quality and Performance sub Committee.

The Quality and Performance Sub Committee has subsequently supported the consolidation of quality and performance reports from each CCG/ICP area. This is still a developmental process which has already been helpful in enabling the SCC to understand a broad view of system performance. In its first meetings, the sub committee has also employed a "deep dive" approach to review a number of quality/performance issues in relation to Safeguarding services, Elective Recovery and Mental Health.

Board members may be aware that Kevin McGee now attends the SCC (on behalf of the Provider Collaborative) and has indicated support for the development of consolidated system-based quality and performance reports. As these are refined, they should be capable of being used in a number of our key governance groups, rather than maintaining multiple reporting processes. In future, this approach will also enable the ICS to be clear how accountability for performance improvement will be demonstrated across the system.

Recommendations

The ICS Board is asked to:

1) note the development of consolidated performance reporting through the Strategic Commissioning Committee.

2) agree to receive a more detailed report on system performance at its meeting in September 2021.

Governance and reporting (list other forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**

Conflicts of interest identified
N/A

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			x	
Equality impact assessment completed			x	
Privacy impact assessment completed			x	
Financial impact assessment completed			x	
Associated risks			x	
Are associated risks detailed on the ICS Risk Register?			x	

Report authorised by:	Andrew Bennett

ICS Board

Date of meeting	**7th July 2021**
Title of paper	**Lancashire and South Cumbria System Development Programme – Highlight Report**
Presented by	Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS
Author	Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS
Agenda item	**15**

Purpose of the paper
For information.
Recommendations
Item for information only.

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			✓	
Equality impact assessment completed			✓	
Privacy impact assessment completed			✓	
Financial impact assessment completed			✓	
Associated risks			✓	
Are associated risks detailed on the ICS Risk Register?				

Report authorised by:	Andrew Bennett, Executive Director of Commissioning, Lancashire and South Cumbria ICS

L&SC ICS System Reform Programme
Monthly Highlight Report

Lancashire and South Cumbria Health and Care Partnership

Workstream Summary

Worksream	ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Programme Status
ICS Development	A	*Develop a statutory ICS, including a strategic commissioning function and place-based functions, in line with national publications and local thinking*	Chair = David Flory	Programme On Track
ICP Development	B	*Design and implement five mature ICPs within the ICS, in line with national publications and L&SC ICP strategic narrative*	Chair = Geoff Jolliffe	Programme On Track
Commissioning Reform	C	*Plan and implement the transitional commissioning arrangements for 2021/22 and the transactional arrangements to close down eight CCGs by June 2022*	Chair = Roy Fisher	Programme On Track
Acute Provider Collaborative	D	*Planning and implementing models of provider collaboration for acute services*	Chair = David Flory	Programme On Track
Mental Health Lead Provider Collaborative	D	*Planning and implementing models of provider collaboration for Mental Health, Learning Disabilities and Autism services*	Chair = Isla Wilson	Programme On Track
Workforce	E	*Closedown and disestablishment of 8 x CCGs across LSC, including safe and effective transfer of affected workforce to new NHS L&SC organisation*	Exec Lead = Sarah Sheppard	Programme On Track
Finance	F	*Plan and Implement a Financial Framework for system, place and provider collaboratives*	Exec Lead = Gary Raphael	Programme Not Started
Communications & Engagement	G	*Ensuring effective communication and engagement with all stakeholders, including those staff who are affected by the transition of activities associated with the closedown of CCGs*	Exec Lead = Andrew Bennett	Programme On Track

ICS Development - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
A01	**Produce an agreed Strategic Narrative which describes what it means to be an ICS in L&SC**	Andrew Bennett	A toolkit has been developed to support leaders in their conversations with staff and a broad range of stakeholders when explaining the changes that are ongoing to deliver integrated care and the NHS reforms. The toolkit was endorsed at ICS OG on 13.04.21 and was fully approved at the ICS Board on 5th May 2021. It is now being cascaded as the beginning of regular communications with staff. The content will be reviewed following publication of national guidance.	31/03/22	In Progress no issues/delays
A02	**Define the ICS structure**	Andrew Bennett	Awaiting national guidance, although some elements from other work streams will inform the structure of the ICS	30/06/22	Not Started
A03	**Define the Functions of an ICS (e.g. workforce, finance)**	Andrew Bennett	Three key pieces of work are underway: 1. Strategic commissioning functions (next workshop scheduled for 2nd June) 2. Corporate functions 3. 'Accelerator' areas (next workshop scheduled for 9th June) - Primary/community services integration – Peter Tinson - Population health management – Julie Higgins, Dr Andy Knox - Quality and performance improvement – Helen Curtis, Kathryn Lord, Julie Higgins - Communications and engagement – Neil Greaves A check and challenge session across the various perspectives is planned (likely early July)	30/06/22	In Progress but with minor issues/delays
A04	**Define the future ICS Governance**	Andrew Bennett	The ICS OG has started to reflect on the scope and purpose of these two Boards, linked to the work on success measures. A short piece of work has been commissioned to consider the Health and Care Partnership Board in greater detail. Outputs from this will be reported to the ICS OG in July 2021.	30/06/22	In Progress but with minor issues/delays
A05	**Develop and agree ICS Leadership model & OD programme**	Amanda Doyle Sarah Sheppard	Initial scoping work underway and will be informed by further national guidance	31/03/22	In Progress no issues/delays
A06	**System Development Progression - provide assurance to NHSEI & Region**	Andrew Bennett	Initial assessment against draft national System Development Progression Tool completed. Awaiting release of the final version of the Tool	30/06/22	In Progress no issues/delays
A07	**Develop and agree arrangements for Partnership working with Local Government (LGA Support Offer)**	Andrew Bennett	Working group established. Scoping activities have identified two possible areas of focus: Intermediate care for adults and children's complex packages linked to transition. Work is underway with the LGA to scope in greater detail.	30/06/21	In Progress no issues/delays

ICP Development - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
B01	**Develop and agree the ICP Strategic Narrative**	Vicki Ellarby	Common ICP Strategic Narrative was approved by the ICS Board in December 2020. This was cross referenced with the White Paper, publish in February 2021, to ensure alignment with National direction of travel. Any further updates will be made i/when further guidance is received	30/06/21	Complete
B02	**Develop and agree the ICP Maturity Matrix**	Sarah James	ICP Maturity Matrix was designed, and endorsed by AQuA in December 2020. Self-assessments against the L&SC ICP maturity matrix were completed by each ICP in January 2021 and peer-to-peer reviews completed in March 2021. Together, these have identified common areas for development, opportunities to share learning between ICPs, and individual development needs within each place. The findings will be used to shape the overall development programme for 2021/22.	31/03/22	Complete
B03	**Scope the ICP Development Programme**	ICP Programme Directors	Findings from the ICP Maturity Matrix and the 3 externally facilitated workshops have been used to create a number of proposals for ICP Development in 2021/22. The proposals were tested at a System Wide workshop on 21 April 2021. These proposals were fully approved by the ICS Board on 5 May 2021.	02/05/22	Complete
B04	**Overarching Themes - immediate actions**	ICP Programme Directors	A 1st draft of the refreshed vision and aims for place are in development and will be shared across the ICP PDs late May. Local development Plans are in progress across all 5 ICPs, along with local Comms and Engagement Plans	31/03/22	In Progress no issues/delays
B05	**Overarching themes - broader development programme**	ICP Programme Directors	No updates at present	31/03/22	Not Started
			Development of local balanced scorecards are in varying stages of progress		

			Development of local balanced scorecards are in varying stages of progress across all 5 ICPs.		
B06	**Success measures for place-based partnerships - immediate actions**	ICP Programme Directors	A small working group is planned for July to review and consider possible metrics. ICPs are also reviewing local engagement plans. Good practice will be shared across the ICPs as part of the collective work	31/03/22	In Progress no issues/delays
B07	**Success measures for place-based partnerships - broader development programme**	ICP Programme Directors	No updates at present	31/03/22	Not Started
B08	**How we will organise ourselves to work together as partners - immediate actions**	ICP Programme Directors	ICPs have partners actively engaged within current Place based Boards and Forums - further work to explore and revise TOR and memberships is underway to ensure meaningful involvement. Place based Partnership Boards if not already established will be in place June/July for all ICPs Partnerships will be formalised through Partnership agreements/MOUs which are also being developed locally.	31/08/21	In Progress no issues/delays
B09	**How we will organise ourselves to work together as partners - broader development programme**	ICP Programme Directors	No updates at present	31/08/21	Not Started
B10	**Place-based leadership and implementation - immediate actions**	ICP Programme Directors	All ICPs have identified and experienced and trusted Chair for the Place-based Partnership. Discussion scheduled for CCG/Trust Chairs meeting on 2nd June 2021 on Independent/NED leadership and involvement in place-based partnerships. Executive Leadership teams are in development across the ICPs and 4 ICPs have identified a Senior Leader for Place (Pennine are currently seeking expressions of interest)	31/08/21	In Progress no issues/delays
B11	**Place-based leadership and implementation - immediate actions**	ICP Programme Directors	No updates at present	31/08/21	Not Started

Commissioning Reform - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
C01	**Define transitional Commissioning governance arrangements**	Andrew Bennett	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.	31/03/22	Complete
C02	**Develop and agree transitional functional allocation of resources**	Andrew Bennett	Three key pieces of work are underway: 1. Strategic commissioning functions (next workshop scheduled for 2nd June) 2. Corporate functions 3. 'Accelerator' areas (next wrokshop scheduled for 9th June) - Primary/community services integration – Peter Tinson - Population health management – Julie Higgins, Dr Andy Knox - Quality and performance improvement – Helen Curtis, Kathryn Lord, Julie Higgins - Communications and engagement – Neil Greaves A check and challenge session across the various perspectives is planned (likely early July)	30/06/22	In Progress but with minor issues/delays
C03	**Agree plan for transactional close-down of CCGs**	Denis Gizzi Helen Curtis	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.	30/06/22	In Progress no issues/delays

Provider Collaborative - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
D01	**Acute Provider collaboration models: Defining the vision and purpose**	Sam Proffitt Gemma Stanion		30/06/21	
D02	**Acute Provider collaboration models: Governance, accountability and leadership**	Sam Proffitt Gemma Stanion			

MH Lead Provider Collaborative - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
D03	**Workforce transition: Ensure strategic and placed based commissioning, support impacted workforce through transition .**	Steve Christian Fleur Carney	Programme Plan awaiting approval at Transition Board w/c 31 May 2021		Not Started
D04	**Due diligence: Ensure clarity and consistency in commissioning approach, through further development of a governance framework**	Steve Christian Fleur Carney	Programme Plan awaiting approval at Transition Board w/c 31 May 2021		Not Started
D05	**Planning & service development: Development of collaborative commissioning intentions underpinned by aligned strategies, e.g. MH, LD & A, carers and community health and social care**	Steve Christian Fleur Carney	Programme Plan awaiting approval at Transition Board w/c 31 May 2021		Not Started

	community health and social care services				
D06	**Strategy and communication: Lead, develop and finalise a system wide all age strategy for MH LD& A and communication and engagement plans**	Steve Christian Fleur Carney	Programme Plan awaiting approval at Transition Board w/c 31 May 2021		Not Started
D07	**Governance and Integration: Develop and implement governance structures that support joint decision making, manage conflicts of interest, prevent further fragmentation of service delivery.**	Steve Christian Fleur Carney	Programme Plan awaiting approval at Transition Board w/c 31 May 2021		Not Started
D08	**NHS E LPC Oversight: Transition of NHSE/I specialist commissioning functions into the Provider Collaborative model by 1 st October 2022**	Steve Christian Fleur Carney	Programme Plan awaiting approval at Transition Board w/c 31 May 2021		Not Started

Workforce - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
E01	**Develop critical path and key deliverables**	Cath Owen	Key objectives for the programme have been developed with consideration to workstream leads, deadlines and EIRAs This will then be validated against national guidance when received	14/05/21	Complete
E02	**Development of overarching principles and guidance (local)**	Cath Owen	CCG Transition Board has approved people transition principles, system resource and recruitment protocol, and a set of people transition FAQs. These principles and protocol will be in use during the current transition period whilst we await national guidance	14/05/21	Complete
E03	**CCG closedown/disestablishment (inc. transfer of workforce and relevant HR systems)**	Cath Owen	Awaiting national HR technical guidance in respect of formal transfer of staff. Membership of CCG closedown group (managed by Helen Curtis) and have developed key actions that will be required, pending guidance (linked to critical path above)	31/03/22	Not Started
E04	**Recruitment into NHS LSC senior leadership team and associated governance arrangements**	Cath Owen	Awaiting National Guidance on appointments process. Not expected until after passing of legislation and no appointments expected to be made until such time as legislation passed.	31/03/22	Not Started
E05	**Organisational development**	Cath Owen	OD support programme offer made available by NHSEI for AOs and Senior Directors within CCG. OD support programme for all staff to be developed and made available from Q2	31/03/22	In Progress no issues/delays
E06	**Staff engagement and consultation**	Cath Owen	First staff bulletin issued on 21 May 2021 in conjunction with C&E colleagues. Monthly bulletin will be issued. Staff Side engaged and being regulalry updated via establshed formal mechanisms.	31/03/22	In Progress no issues/delays

Finance - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
F01	**Influence and understand the design of the system level financial framework and the implications for the financial regime**		Awaiting release of the National Framework	30/06/21	Not Started
F02	**Develop the system level Financial Planning Framework in response to national guidance**			30/09/21	Not Started
F03	**Implement the system level Financial Planning Framework in response to national guidance**			31/03/22	Not Started

Communications & Engagement - Objectives

ID No	Scope, Objectives, Milestones, Tasks	Workstream Leads	Current Activity	Finish	Current Status
G01	**Strategic narrative documents and toolkits for use by senior leaders to set out language and messaging and to shape communica tio ns, engagement, involvement with all stakeholders**	Neil Greaves Hannah Brooks	Senior leadership toolkit completed and shared. Delivering Integrated Care Summary Document complete and shared. Terminology in ICP common narrative currently being updated ready to be shared in June.	31/03/22	In Progress no issues/delays
G02	**Co ordinating communications and engagement plans for all stakeholders at system and place levels, including those staff who are affected by the transition of activities associated with the closedown of CCGs**	Neil Greaves Hannah Brooks	Meeting scheduled on 15 June with ICP engagement leads and ICP programme directors to discuss communication and engagement plans to ensure consistent messaging and timing.	31/03/22	In Progress no issues/delays
G03	**Oversight, planning and direction to support communications and engagement of system reform across LSC and consistent key messages for staff, providers, partners and public**	Neil Greaves Hannah Brooks	Monthly staff briefings established (first one sent 14.05.21) for staff affected by transition of activities from closedown of CCGs and monthly wider stakeholder briefings established (first one sent 28.05.21). Regular communications and engagement network meetings to ensure all partners up to date with key messages and language to be used to describe Lancashire and South Cumbria system.	31/03/22	In Progress no issues/delays

Programme Risks and Issues

Risk Oversight	Risk No	Risk or Issue	Date Added	Risk Owner	Risk/Issue Description	Mitigating actions	Residual Risk Score
ICS Dev Oversight Gp	R0004	Issue	11/05/21	Andrew Bennett	Delay in Bill having second reading in	Attendance at NW ICS coordination	

					Parliament results in a further delay in the publication of national policy / guidance which RISKS the LSC System Development Plan being out of alignment with national direction of travel	group. Maintaining close working relationship with NHSEI as part of system development planning and implementation. Activities associated with significant national guidance assigned to Q3/Q4 of 2021/22	20
ICS Dev Oversight Gp	R0043	Risk	24/05/21	Sarah Sheppard	Risk that national guidance, frameworks and/or policy documents are shared too late in the transition year.	Development of local guidance, principles and framework/approaches that align to the requirements of the transition whilst meeting local employment policies.	20