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

Agenda

Item	Description	Owner	Action	Format
1.	Welcome, Introductions and Apologies • System Development and legislative change	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 7 July 2021, Matters Arising and Actions	Chair	Approve	Attached
4.	Key Messages	Andrew Bennett	Note	Verbal
Managing 2021/2022				
5.	Operational Recovery and Performance - Status reports on sector by sector recovery and performance	Andrew Bennett	Discuss / Endorse	Attached
6.	System Financial Recovery Update	Sam Proffitt	Discuss / Note	Attached
7.	ICS Finance Report	Elaine Collier	Discuss / Note	Attached
8.	Financial Context for 2021/22 H2 Operational Plans	Elaine Collier	Discuss / Endorse	Attached
9.	2021-22 Capital Update	Paul Havey	Discuss / Note	Attached
Building the system for 2021/22 and beyond				
10.	System Reform Update (a) General update (b) Integrated Care Partnerships (Place Based Partnerships) Development Programme and Delivery Update	Andrew Bennett Geoff Jolliffe	Discuss Discuss	Attached Attached
11.	The role of the VCFSE sector in the Health and Care Partnership	Peter Armer	Discuss / Endorse	Attached
12.	New Hospitals Programme Quarter 1 Report	Jerry Hawker	Note	Attached
13.	Items to Forward for the next ICS Board meeting	All	Note/ Support	Verbal
14.	Any Other Business	All	Note	Verbal
Date and Time of next formal ICS Board meeting: Formal meeting - Wednesday, 3 November 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, 7 July 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
Talib Yaseen	Director of Transformation	Lancashire and South Cumbria ICS
Jane Scattergood	Director of Quality and Nursing	Lancashire and South Cumbria ICS
Caroline Donovan	Chief Executive	Lancashire and South Cumbria NHS Foundation Trust
Karen Partington	Chief Executive	Lancashire Teaching Hospitals NHS Foundation Trust
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
Jackie Moran (representing Claire Heneghan)	Director of Integration and Transformation	NHS West Lancashire CCG
Geoff Jolliffe	Chair	Morecambe Bay CCG
Denis Gizzi	Chief Officer	Central Lancashire CCGs
Julie Higgins	Chief Officer	Pennine Lancashire CCGs
Cllr Graham Gooch	Cabinet Member for Adult Services/County Councillor	Lancashire County Council
Neil Jack	Chief Executive	Blackpool 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
Eileen Fairhurst	Chair	East Lancashire Hospitals NHS Trust
Jackie Hanson	Director of Nursing and Care Professionals	NHS England and Improvement
In Attendance		
Sam Proffitt	Director of Provider Sustainability	Lancashire and South Cumbria ICS
Sarah Sheppard	Interim Executive Director of HR & OD	Lancashire and South Cumbria ICS
Jerry Hawker	Senior Responsible Officer, New Hospitals Programme	Lancashire and South Cumbria ICS
Claire Muir	Transformation and Change Lead	Morecambe Bay CCG
Phil Green	Director Growth, Environment and Planning	Lancashire County Council
Dr Andy Knox	Director of Population Health	Bay Health and Care Partners
Catherine Bentley	Equality and Inclusion Team Manager	Midlands and Lancashire Commissioning Support Unit
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
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		
16 public attendees		

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.

Apologies had been received from Kevin McGee, Claire Heneghan, Peter Gregory, Nicky Latham and Andy Curran.

Questions and answers raised by members of the public prior to this meeting would be published with the minutes of the meeting.

The Chair reported that the ICS Lead Officer, Dr Amanda Doyle, had been appointed by NHS England/Improvement as the North West Regional Director, standing down from her ICS and Accountable Officer roles of Blackpool, Fylde and Wyre and West Lancashire CCGs. The Health and Care Bill was introduced in Parliament on 6 July 2021 and, if approved, would establish integrated care systems as statutory bodies across England. It was evident that Lancashire and South Cumbria was already well established on this road. Amanda had the ambition and determination to put population health improvement at the forefront of the Lancashire and South Cumbria agenda and to tackle inequalities. Amanda's leadership established early ICS status in Lancashire and South Cumbria to ensure ways of working were in place to tackle issues seen in communities and neighbourhoods. Amanda had continued to provide immense personal leadership to ensure that the ICS was in a good position, having built teams and established relationships and ways of working which would stand the ICS in good stead as it moved forward. Amanda's personal legacy would be there for years to come. The Chair, on behalf of the ICS Board and colleagues, thanked Amanda for the work she had undertaken in Lancashire and South Cumbria and wished her the best in her new role.

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

RESOLVED: No new declarations of interest were declared.

3. Minutes of the previous formal ICS Board meeting held on 2 June 2021, matters arising and actions

The minutes of the previous meeting were approved as an accurate record, seconded by Roy Fisher.

RESOLVED: The minutes of the meeting held on 2 June 2021 were approved as a correct record.

4. Key Messages

Amanda Doyle (AD) provided the following update:-

Health and Care Bill had received its first reading on 6 July 2021and the second reading was expected mid-July.

Amanda Pritchard, NHS England Chief Operating Officer/NHS Improvement Chief Executive Officer visited the area last week, meeting with various leaders from around the system. Good feedback had been received around system development and system working. Examples of real life integration were shown in Fleetwood and the community.

Perfect Week – Positive feedback had been received following the 'Perfect Week' exercise which ran across all provider services in Lancashire and South Cumbria commencing 21 June 2021. Health and social care partners put a huge focus on working to improve emergency care response, A&E, hospital discharge, etc. During this exercise, A&E performance had been sustained and improved during a very busy period. Learning and evaluation from the exercise was taking place and Dr Doyle thanked everyone involved.

Jane Scattergood was introduced as the newly appointed Interim ICS Director of Quality and Nursing.

Interim arrangements – Dr Doyle was due to start her new role with NHS England on 1 August 2021. Due to being unable to move to a substantive employment process at this stage, on an interim basis, Andrew Bennett would act as the ICS lead. Governing Bodies of the three CCGs where Dr Doyle is the Accountable Officer (AO) had supported a proposal that Andrew Bennett take over responsibility as interim AO, which was awaiting sign off.

Building the System for 2022 and Beyond

5. System Reform Update

A previously circulated report provided an update as to the progress of system reform work. Andrew Bennett highlighted the following points:

- Legislation about system reform went before Parliament on 6 July 2021; some aspects of the work described within the report would be subject to this legislative process.
- The ICS had now submitted its latest System Development Plan to the regional team of NHS England and NHS Improvement, setting out a clear programme of work to prepare for when legislation was passed.
- A national ICS Design Framework was published on 16 June, offering 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. Further information around governance and finance was expected in the next few months.
- A peer review had recently been held facilitated by the regional team with colleagues from Cheshire/Merseyside and Greater Manchester which proved helpful in setting out areas to share learning and information on challenges already being faced.
- Informed discussion had recently been held with colleagues across the system around how to distinguish work of the Partnership Board and the ICS Board; the Oversight Group would continue to focus on this
- An update on the work of the Provider Collaborative Board was shared. One aspect was to develop a clearer narrative to staff and the public around what collaborative arrangements were designed to achieve
- Communication and engagement with staff continued and two face to face staff briefings had been arranged over the next week which would provide an opportunity for staff to ask questions. A national Employment Commitment for NHS staff affected by the proposed changes had been published.

Mr Cherry asked if there was any soft intelligence about the financial framework and the delegation of resource to place-based partnerships. Mr Raphael explained that a regional finance group had been set up comprising ICS finance leads and nominations from CCGs and Trusts to discuss how allocations will be used, however, no agreement or decision had been made at this stage. Mr Raphael added that decisions about spending would be determined by the system when the national overarching framework had been developed.

Councillor Burgess asked about the delegation of functions to place and the associated timescale and expectation that the finance would follow. Mr Bennett advised that preparatory work was taking place about how functions would work at system and place level and this would be articulated through the ICP narrative and ICP development plan. There were evident functions around service integration, quality improvement and improving population health and likely to be both formal and informal delegation through the place-based teams

Cllr Gooch expressed concern that the Health and Care Partnership work could overlap with the Health and Wellbeing Board in relation to determinants of health and health inequalities and sought assurance as to how the system would be held accountable. Mr Bennett responded that there was an obligation to set up the Health and Care Partnership and the four Health and Wellbeing Boards across Lancashire would retain their statutory purpose. The Health and Wellbeing Board workshop, planned to be held later this month, would provide an opportunity to talk through this matter further. Mr Bennett had also recently taken part in a workshop looking at a potential work programme for the Lancashire Scrutiny Committee. The system architecture would need to give public accountability and exposure of issues that were being referred to. Mr Fisher added that he was in regular contact with the Chair of the Blackpool Overview and Scrutiny Committee and provided updates on progress on system reform.

In response to a question about the ICS appointments process, it was confirmed that several senior appointments to the NHS statutory body would be undertaken through a national process, with involvement of key partners in the system; colleagues would be involved when the detail is published. Local appointments would be undertaken with fairness, openness, and equity and the majority of staff will receive an employment commitment to continuity of terms and conditions.

Members discussion included the following comments:

- That this should be an opportunity to improve outcomes for populations and for patients. Wider community involvement would need to be visible within the plan.
- There is a need to strengthen work around culture.
- Clinical leadership and more clinical leadership across programmes would be welcomed; a senate across the ICS was being looked at.

- A need for more emphasis on the critical role of primary care and prevention within the plan. Dr Doyle referred to the work in Fleetwood around health inequalities, involving primary care which had translated into reductions in A&E attendances and admissions. This work would need to be undertaken systematically across the patch.
- Discussions with regard to defining functions at system, place and neighbourhood levels were taking place at the CCG Transition Board
- Reference was also made to work previously undertaken on the delegation of functions to the three levels and the next step would be to look at how to approach transformation of these functions and how they would work in the future.

The Chair acknowledged inevitable tension in the setting up of the new system which would be worked through via the new health and care partnership. There would be an emphasis on strong place-based partnerships to drive the business with rule-based transparency around finance and openness in decision making.

RESOLVED: The ICS Board:-

- **Noted that a System Development Plan was submitted to NHSEI by 30 June 2021**
- **Discussed the progress made across the LSC System Development Programme.**

6. Greater Lancashire Plan

On behalf of the wider Lancashire team, Phil Green presented and introduced work on the robust evidence base being prepared to inform the development of the Greater Lancashire Plan and updated on progress.

Mr Green explained that Lancashire has a major and unique contribution to make to the UK, however, with no single, place-based strategy, risks falling behind other regions. Lancashire also has challenges, with Covid-19 hitting its people, businesses and communities hard. A partnership approach is being sought and Lancashire leaders have demonstrated commitment and ambition to speak with one voice through the development of the Greater Lancashire Plan that sets out the overarching vision and place and people-based strategy and action plan for Lancashire. A robust, granular evidence base 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 recovery from the global pandemic. The evidence base includes 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 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 shared assets to help create the conditions for a sustained and consistent approach to prioritisation and delivery.

The plan will be based on robust tested evidence, overseen by an Independent Panel of experts. Evidence was being gathered, with the plan hoped to be published in early August.

Dr Doyle asked if the NHS, as one of the largest employers in Lancashire, was inputting enough into this work to ensure it reaps the benefits. The NHS is a large contributor to carbon overuse and has a part to play in the carbon reduction agenda. The NHS has well paid, long lasting jobs available and continues to struggle to fill vacancies with local people.

Julie Higgins reported she was working closely with the Lancashire team regarding a deep dive on health and wealth. This was also linked closely with the Health Inequalities Commission work supported by Professor Michael Marmot. The work undertaken by the team would be built on in relation to the impact of social deprivation and poverty on health inequalities and work was also taking place on the contribution of the NHS to health inequalities in relation to care provision and employment., These key pieces of work are inter-related and will focus on making a difference in health inequalities.

Aaron Cummings referred to the recent, positive meeting held with Amanda Pritchard and discussion about measures of success which the ICS would be held to accountable for. Mr Cummins asked that the ICS Design Framework dashboard include long term measures of success relating to the plan.

Mr Cherry sought assurance about the Independent Panel encompassing the views of the whole of the Lancashire population.
Mr Green responded that the Panel comprised people whose bibliographies struck a balance between external independent expertise and people who understand Lancashire. The Panel is there to review the evidence; place leaders will make the decisions.

The Chair expressed his thanks for the informative presentation and commented that the Plan provides a big opportunity to do more with the evidence base, working across the whole system.

RESOLVED: The ICS Board noted the Greater Lancashire Plan.

7. Anchor Collaboratives

Dr Andy Knox explained that the purpose of this paper and slide set was to introduce and explore the role of the NHS as an Anchor Institution within the Lancashire and South Cumbria ICS, to improve the population's health and reduce health inequalities.

Anchor Institutions are large public sector organisations rooted in and connected to local communities, which could make a difference to the economy and climate agenda, making a difference to the inequalities agenda. Dr Knox commented on the synergy between the Lancashire Plan and opportunities as an Anchor Institution across Lancashire and South Cumbria.

The proposed approach would include the use of a charter which could 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 would 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 would include the roll out of the Anchor Charter within each ICP through local leads.

Claire Muir described the approach and work undertaken in Morecambe Bay, which had been recognised nationally by the Health Foundation and NHS England and provided examples of work that could be undertaken as an Anchor Institute.

The Chair commended Dr Knox and Claire Muir on this excellent work and invited comments and questions.

Geoff Jolliffe commented that the work in Morecambe Bay was about building a vision, relationships and delivering previous plans and would welcome this initiative being rolled out and embedded across the ICS. Aaron Cummins offered to share the work currently being undertaken by University Hospitals of Morecambe Bay and the Bay.

Eileen Fairhurst reflected that this item and the Greater Lancashire Plan was a reminder of how the NHS was part of a much bigger picture and that it related to the establishment of the NHS which was about social justice and making life better, which is what population health is about. The Greater Lancashire Plan presentation provided a wide horizon of the potential of population health and the presentation on Anchor Institutions provided examples of how and what could be done to make a difference to people's lives. This was an opportunity to make these kinds of notions real to people who serve in Lancashire and South Cumbria.

Members expressed their support and enthusiasm for the initiative and were keen to see this rolled out across the ICS as a good foundation for what a health and care partnership could achieve. Work undertaken would need to convert quickly into action moving forward. Isla Wilson offered support on any aspects of the agenda.

It was suggested that there may be common messages from the 'Preston Model' project undertaken in 2015 which the team may wish to adopt. Reference was made to the ambition to reduce health inequalities and to work being undertaken by Dr Knox with population health leads in ICPs.

Gary Raphael asked members to be aware that the NHS was being asked to provide sustainability plans through the estates function and infrastructure work and it was important that these plans were linked into and reinforced the wider partnership work taking place in Lancashire and South Cumbria.

Cllr Gooch commented that Lancashire County were undertaking similar work and there was a danger of duplication. The plan involves lower tier district councils who would not have the budget to fund this. Dr Doyle responded that work would need to include both upper tier and local councils to be delivered at place, but the principles signed-up to as a system. Investment in this will result in improved health of the population, turning into more effective use of healthcare services.

Reference was made to the importance of delivery and the need to break down barriers.

Denis Gizzi referred to a major turnaround programme in Oldham when risks and challenges had been overcome. Jackie Moran commented on the need to work with local councils and local groups and to learn from the community as to what works for them.

The energy and enthusiasm from members was acknowledged alongside the opportunity this presented for complimentary action by multiple organisations. The challenge to all organisations within the system was the need to work differently.

The Chair asked that the practicalities should be looked at with the intention of developing a model that could work and address the barriers and issues described and looked forward to receiving detail on the next steps at the next ICS Board meeting. **ACTION: Andrew Bennett**

RESOLVED: The ICS Board:
- Noted the contents of this paper and presentation slides
- Committed to and mobile the NHS Anchor Charter/ approach across the ICS/ HCP.

8. New Hospitals Programme

Jerry Hawker updated members on the New Hospitals Programme being part of the government mandate to build 40 new hospitals in England and an opportunity to see substantial investment in hospital facilities in Lancashire and South Cumbria. The 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.

Mr Hawker provided an update on current progress of the programme and explored areas where the Health and Care Partnership (ICS) Board could help drive imagination and innovation to create opportunities for much greater additional benefits for the region.

As part of the assurance process, a successful meeting had been held with NHS England. Following feedback from NHSE/I and system leaders, the Case for Change would be presented for final approval to the L&SC Strategic Commissioning Committee on 15 July and then publicly launched with an intensive period of engagement with the public building on work through the 'Big Chat'.

It was noted that no decisions had yet been made and all options were on the table. System wide work was underway to develop proposals which delivered against the challenges detailed in the Case for Change. Agreement of the assumptions for the demand and capacity modelling was a critical milestone.

Mr Hawker referred to the previous two agenda items and commented that the New Hospitals Programme was working closely with the Enterprise Partnership around how to ensure that local enterprises had a genuine opportunity to build on and be involved.

RESOLVED: The ICS Board noted the progress of the New Hospitals Programme and considered the opportunities the programme presented to be used as a catalyst for wider partnership working.

9. Equality, Health Inequality Impact Assessments and Quality Impact Assessments

Talib Yaseen presented the report and informed the 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. The approach proposed begins with the necessary application and use of Equality and Health Inequality Impact Risk Assessments (EHIIRA) which arose from the Equality Act of 2010, in order that the ICS could measurably address equality and health inequality deficits that affected individuals and communities across Lancashire and South Cumbria, whilst recognising the need to go beyond these in order to achieve aims around unequal outcomes and health inequality.

The NHS Long Term Plan outlines a strong and comprehensive commitment to redressing equality and health inequality issues both within the NHS workforce and services and this is further reinforced within the ICS Design Framework.

Reference was made to the need to avoid duplication with the work taking place at the Lancashire Resilience Form on the impact of COVID on minority groups. This was noted by Dr Doyle as a member of that group.

Isla Wilson highlighted that there were a number of layers to this work. Impact assessments were a baseline measure; the next piece of work was how to use the information and then how to build on that using the provisions of the Equalities Act in terms of things that have got worse over recent years.

RESOLVED: The ICS Board:

- **Agreed to adopt and develop the existing EHIIRA service and process in place for the Lancashire and South Cumbria CCGs**
- **Supported 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 Lancashire and South Cumbria NHS Body, in order that we can measurably address equality and health inequality deficits that affect individuals and communities across Lancashire and South Cumbria**
- **Confirmed their intention to create an Equality, Diversity and Inclusion policy and process to make an impact on reducing health inequality.**

Managing 2021/2022

10. Elective Care Recovery

Sam Proffitt provided an update on elective care recovery. Trusts were required to achieve nationally set thresholds based on 2019/20 activity levels for elective care recovery, initially set at 85% Organisations in L&SC took a collective approach and signed up to become an accelerator site to achieve as close as possible to 120%. For April and May the gateway had been approved with funding to support the programme. A number of initiatives had been created, including a joint waiting list, to support the programme however challenges included staff tiredness, the ongoing pandemic with a number of COVID+ patients in hospital and pressure in A&E. The Trusts were performing well against 85%, however, this now needed to be driven up to 120% by the end of July 2021. Programmes were being measured were undertaking more work on a month by month basis.

The Chair added that the Accelerator Programme was being measured by doing more work on a month by month basis in each of the categories than in the equivalent months in 2019/20. Good progress was being made however this extra work would need to be managed in the context of increasing pressures in the medical service in hospitals and the rise of COVID+ admissions. The Board looked forward to receiving further update reports on this.

RESOLVED: That members of the ICS Board note the update of Elective Care Recovery.

11. System Financial Recovery Programme and Terms of Reference

Gary Raphael presented the report and explained 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. The Board was also invited to approve the draft terms of reference for the System Financial Recovery Board.

Councillor Gooch suggested input to the Board from someone not employed within the NHS to provide check and balance. The offer was acknowledged. It was noted that Ian Cherry was a representative on the System Financial Recovery Board, as a Lay Member with extensive experience as a finance professional and was able to provide external views, not being an NHS employee.

Talib Yaseen reassured members that work was taking place with regard to Continuing Health Care, with partners, to fully understand the position. Gary Raphael added that evidence of benchmarking of services in other parts of the NHS was being looked to identify potential areas to deliver savings and project initiation documents were being developed to scope requirements.

RESOLVED: The ICS Board:-

- **Noted the contents of the cover paper, to expect future reports on progress in all the areas highlighted in it**
- **Approved the attached terms of reference for the System Financial Recovery Board.**

12. Financial Report

A report had been provided with the meeting papers on the month 2 financial performance for the Lancashire and South Cumbria system, covering the revenue and capital positions of all Lancashire and South Cumbria NHS partners and the position on ICS central functions. Gary Raphael explained that the ICS was on track with its financial plan.

Assumptions had been made on the share of elective recovery funds to be received retrospectively from the national team. Cost improvement was a little behind plan; this being an area where there was specific monitoring by the system and regional team. Julian Kelly had invited the ICS to a meeting on 3 August when progress on the cost improvement programme would be discussed. More certainty on savings was currently being seen in Trusts than CCGs, due to CCGs having less discretion on spending decisions.

RESOLVED: That the ICS Board note the current financial position.

Financial investment – Year 1 – Community Diagnostic Hubs

Gary Raphael drew attention to a further report which had been circulated prior to the meeting, requesting retrospective approval of financial investment for year 1 of the Community Diagnostics programme. The ICS Board had approved the capital budget and application of funds at its June meeting. The budget was fully committed. In addition to the schemes agreed for funding, there were a number of other priorities that could not be afforded within the total capital available. Early last week the ICS team was asked to confirm whether it supported applying a small amount of capital (£419k) to ensure implementation of the year 1 (=2021/22) Community Diagnostic Hubs (CDH) programme. The indication for this support was required by Monday 4th July, to enable approval of the year 1 Lancashire and South Cumbria programme by the Regional team.

Mr Raphael explained that in response to the requirements of the CDH Programme Director it had been agreed that given the system wide CDH strategy, linked to elective care recovery; the strong likelihood of slippage this year; and the relatively small level of capital required, it was appropriate to support this request.

The report explained this money could come from slippage this year. Pre-committed priorities were yet to be fully determined. Comments were made about discussions taking place in provider organisations about the use of slippage to address priorities and the need to ensure these discussions were joined up. Jackie Moran commented that West Lancashire had an out of hospital focus, and there was a need to ensure they did not lose out due to not being represented in the provider collaborative. In response it was confirmed that there were separate pots of resource for primary care services. Amounts shown in this year's capital programme were mainly in Trusts and everything would be encompassed within the developing 5-year Capital Strategy.

Mr Raphael recognised that the Board was being asked to support something that had been undertaken on an expeditious basis rather than in line with criteria used for slippage, however criteria for decision-making had now been developed and would be presented to the ICS Board.

RESOLVED: The ICS Board confirmed approval for £419k capital for the year 1 CDH programme as a first call on 2021/22 spending slippage. The amount would need to be treated as a pre-commitment against the 2022-23 ICS capital allocation.

13. System Performance

The item was for information only. Andrew Bennett (AB) confirmed that under the Strategic Commissioning Committee, performance reporting information was being brought together providing the opportunity to consider system performance report. Significant performance challenges would be reported to the ICS Board from autumn onwards. Work was ongoing.

14. Items to forward for the next ICS Board meeting

There were no items.

15. Any Other Business

System Reform Programme – Monthly Highlight Report – The report provided showed the way progress was reported for each workstream. For information.

Date and time of the next formal ICS Board meeting:
Wednesday, 1 September 2021, 10 am – 12.30 pm, MS Teams Videoconference

ICS Board – Action/Decision Log (Updated 23 August 2021)

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
ICSB210707- 07	**Anchor Collaboratives** To receive detail on the next steps at the next ICS Board meeting.	Andrew Bennett	Open	1 September 2021	Ongoing
ICSB210206-04	**People and Workforce Update** To take the discussion around key workforce risks to the next People's Board, reporting to the SCC.	Isla Wilson/Paula Roles / Karen Partington	Closed	August 2021	Paula Roles confirmed that this discussion was reported back to the People's Board and work is taking place on a number of areas in relation to the issues raised.
ICSB210206-06	**Revenue Financial Plans** **Health Inequalities –** Isla Wilson asked for urgent assurance as to the plan for health inequalities	ICS Execs	Open	July 2021	Ongoing
ICSB210206-05	**Elective Recovery Accelerator Programme** Key data on numbers, focussing on P1 and P2, number of cancellations, etc. to be provided at a future meeting.	Kevin McGee	Open	August 2021	Ongoing
ICSB210505-07	**Development of Remote Health Monitoring in L&SC and Docobo Contract** Concerns made re longevity of the contract and pilot; assumptions had been made about mental health patients. GR and CD to discuss outside of this meeting.	Caroline Donovan Gary Raphael	Closed	July 2021	Confirmation received that a meeting is being arranged to resolve this issue and action can be closed.

Questions with responses from ICS Board Meeting on 7 July 2021

Question 1:
The Health Systems Support Framework is an NHS England scheme to accredit companies to support the development of Integrated Care Systems. The HSSF already involves 200 companies including 30 US firms involved in the health market, providing health insurance or supplying services to insurers. It has been reported that the Government is proposing legislation which is expected to allow these companies onto ICS Boards and Committees. A Virgin Care representative currently sits on the ICS covering Bristol and North East Somerset, Swindon and Wiltshire. Has the Lancashire and South Cumbria ICS Board considered the damaging consequences of allowing private companies to participate in NHS decision-making and what would its attitude be to an application from a private company to join the Lancashire and South Cumbria ICS Board or one of its Committees?

Question 2:
Everywhere we have looked, from health systems even to football teams, we see the distorting effect of commercial interests on the workings and even principles of systems designed to work for communities.
Is the Lancashire and South Cumbria ICS Board aware of the damaging consequences of accepting an application from a private company to join the Lancashire and South Cumbria ICS Board or one of its Committees?

Response to questions 1 and 2:
Changes to national legislation are being discussed by Government as part of the Department of Health and Social Care white paper Integration and innovation: working together to improve health and social care for all. This is likely to result in changes to our current Governance meetings which will be led by those national legislative changes.

It is important that in Lancashire and South Cumbria there is a clear commitment from all health and care organisations towards a common vision that communities will be healthy and local people will have the best start in life, so they can live longer, healthier lives and this drives our collective decision making at the ICS Board. This vision will not change as a result of national legislation changes and is something which partners will remain committed to. More information about our shared vision is here: https://www.healthierlsc.co.uk/our-work/our-purpose. The ICS Board has clear Terms of Reference which are available on our website here: https://www.healthierlsc.co.uk/icsboard and is currently not accepting applications to join the Board.

An important publication of note is a King's Fund report about integrated care in February 2018 which stated:

"It would also be wrong to see ICSs and ICPs as a means of privatising services. They have emerged through the leadership of NHS organisations rather than via market testing and they are an example of partnership working in the public sector. Private providers may be brought in by NHS organisations where they have distinctive expertise to offer, for example in providing analytical support, but this has occurred throughout the history of the NHS and is not the result of the developments discussed in this paper."

Read more about integrated care systems in this Kings Fund report (opens in new window).

Question:
In light of the significant waste of public funds on expensive, failed contracts awarded without proper scrutiny during the pandemic, has the Board considered the damaging effects of the Government's proposal to allow ICS Boards to operate outside Competition Regulations and award contracts directly to a provider without going through a formal procurement process?

Response:
NHS commissioners in L&SC spend nearly £4bn a year on health services – it is not required, nor would it be practicable, to put out to tender all services; for example, there are only NHS providers of A&E and other urgent care services that are able to provide comprehensive treatment and care for whole populations covered by the normal catchment of NHS run hospitals.

Some smaller, discrete services with few interdependencies with other services have in the past been tendered, as have some more complex ones, like community services in West Lancashire and urgent treatment services in central Lancashire.

The advent of integrated care systems looks to collaboration across providers to join up health and social care across operational teams in order to deliver better quality, performance and health outcomes. Benchmarking and monitoring of anonymised data on service quality and patient outcomes will in future be the main driver of performance improvement, with accountability for those system-wide outcomes being held at the ICS Board - the effectiveness of the system will be clear for all to see.

Within NHS providers procurement discipline is strong in the acquisition of the goods and services necessary for running efficient and effective services. A joint procurement hub has been in operation for a number of years to make the most of the NHS' purchasing power across our providers, bringing more items under a common approach over time.

None of the above rules out the possibility of NHS commissioners tendering for certain services and choice of hospital will remain a key part of the offer to patients for elective services.

Boards across the NHS will remain accountable for securing best value for public money subject to external audit opinions and the CQC will also inspect service quality, with a wider remit to ensure the benefits of integrated care are delivered.

Question:
Regarding the make-up of the ICS board, how are members elected ? How are they accountable to those they supposedly represent ?Do any of the members have automatic places, if so how are they accountable to the users of the NHS rather than facilitators of the ever-growing privatisation of the service ?

Response:
Thank you for your question I can comment as follows:

The current ICS Board is a formal partnership of health and care organisations across Lancashire and South Cumbria – we have representatives of our local place based health and care partnerships such as the Bay (which includes South Cumbria and North Lancashire) as well as partner organisations such as Lancashire County Council.

The Integrated Care System executive team and accountable officer were appointed through a formal appointment process in 2018 overseen by NHS England. The independent chair of the ICS Board was appointed in the autumn of 2020 through a national appointment

process, again overseen by NHS England. Our Non-executive directors were recruited through a formal process in 2017/18 and are drawn from existing non-executive directors from our NHS Trusts and Clinical Commissioning Groups.

The remaining members of the ICS Board are nominated by partner organisations such as Local Authorities

The membership is detailed in the approved terms of reference for the ICS Board, which also sets out the governance underpinning the meetings. The Board meets in public and provides access to papers via the website and social media. This is one way in which we try to communicate with the people we serve. In addition the four Health and Wellbeing Boards that are operated by the County and Unitary Local Authorities also play a role in scrutinising local NHS services and how they are delivered.

The Accountable officer of the ICS is responsible both to the Independent Chair and to NHS England for the overall management of the system in Lancashire and South Cumbria. The ICS Body is not a statutory body but a partnership, however this is subject to legislation this year – once this proceeds through the House of Commons, the ICS will transition to become the Lancashire and South Cumbria NHS body in April 2022. The appointment of executives and the membership of this new body is subject to the new legislation and formal guidance. The interim guidance that has been published by the Department of Health and Social Care is attached for your information and deals with appointments from page 20 onwards.

Question:
Given the overwhelming enthusiasm on the board for Andy Knox's and Claire Muir's presentation on anchor institutions, please can we have a commitment to this from the board? Otherwise, Lancashire and South Cumbria's ICS could be extremely vulnerable to the market and the health and wellbeing of our population suffers under the disastrous awarding of contracts outside of Competition Regulations.

Response:
The Board endorsed the presentation and report presented during the committee which will be represented in the formal minutes of the meeting.

ICS Board

Date of meeting	**1st September 2021**
Title of paper	**Operational Recovery and Performance**
Presented by	**Andrew Bennett**
Authors	**Carl Ashworth, Andrew Bennett, Paula Roles**
Agenda item	**5**
Confidential	**No**

Purpose of the paper

Executive summary

Operational plans for the first half (H1) of this financial year have been approved and are now being implemented. These plans reflect national expectations for system-wide restoration and recovery of services which have been impacted by the Covid pandemic and have a specific national funding allocation.

This paper provides a sector by sector "situation report" offering an insight on current system performance, the challenges being faced and what we are doing about them. The reports were received by the System Leaders Executive on the 18th August alongside a presentation setting out the financial context for the imminent operational planning round for the second half (H2) of this financial year.

System leaders noted the situation reports; endorsed proposed actions for H2; confirmed common themes and risks that require collective actions in advance of H2; and supported the presentation of the reports to the ICS Board.

This paper is intended to provide the ICS Board with a summary of the key themes and risks identified within the situation reports; a mapping of risks against the ICS strategic objectives; and a summary of actions proposed to mitigate those risks.

Recommendations

The ICS Board is asked to receive and review the situation reports and to endorse SLE's proposed actions in advance of the H2 operational planning process.

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

Meeting	**Date**	**Outcomes**
SLE received SITREP presentations only	18th August 2021	Supported for report to ICS Board with covering paper describing proposed actions

Conflicts of interest identified

None

Lancashire and South Cumbria Health and Care Partnership

OPERATIONAL RECOVERY AND PERFORMANCE 2021/22

SITUATION REPORT for H1 & PROPOSED ACTIONS FOR H2

1. Background

Operational plans for the first half (H1) of this financial year have been approved and are now being implemented. These plans reflect national expectations for system-wide restoration and recovery of services which have been impacted by the Covid pandemic and have a specific national funding allocation. As we shift our focus towards the development of plans for the second half of the year, the ICS Executive is keen to provide the ICS Board with an insight on current system performance, giving a strong sense of the challenges being faced and what we are doing about them.

The Appendix to this paper contains a sector by sector "situation report" on our position as we go into the Autumn/Winter. These are tactical updates in the main but are intended to provide an all-round view of our performance and pressures.

These reports were received by the SLE on the 18th August and were considered alongside a presentation setting out the financial context for the imminent H2 operational planning round.

System leaders noted the situation reports; endorsed proposed actions for H2; confirmed common themes and risks that require collective actions in advance of H2; and supported the presentation of the reports to the ICS Board.

This paper is intended to provide the ICS Board with a summary of the key themes and risks identified within the situation reports; a mapping of risks against the ICS strategic objectives; and a summary of actions proposed to mitigate those risks.

2. Links between this paper and other agenda items

Board members are asked to note the connection between this paper and:

- Item 8 on the context for the H2 planning process, which highlights the challenges faced in developing H2 operational plans within a constrained financial envelope

3. Summary of key themes from sector situation reports

The Appendix to this paper contains a sector by sector "situation report" on

- our performance position as we go into the second half of the year;
- key actions for H2; and
- associated risks.

Overall these reflect the phenomenal success of our staff across the system in restoring services to meet the needs of the L&SC population.

Sectors covered include:

Sector
Local Resilience Forum - Covid Restoration and Recovery
Primary Care (General Practice)
Mental Health, Learning Disability and Autism
Ambulance Services
Urgent and Emergency Care
Care Sector
Elective care recovery
Cancer care

The key themes in common through these reports are as follows:

Capacity

- Generally, services are near to full restoration at pre pandemic levels BUT workforce availability and embedding of C19 processes into business as usual constrains available capacity
- Staff have had limited time for recovery from the effects of the pandemic– there are higher than usual levels of sickness combined with self-isolation are being managed day to day through use of agency staff
- Some lower paid staff (eg domiciliary care sector) are moving to jobs in hospitality or retail leaving gaps in service delivery, with further potential drift when vaccination becomes compulsory
- Service transformation and redesign programmes intended to improve the effectiveness of pathways were suspended pre-pandemic – some require investment, some require additional staff in a constrained market, therefore transformation will take some time to impact on service delivery

Demand

- Levels of demand being made upon services are significantly higher than pre pandemic – in some sectors 20-30% higher – with the balance shifted away from C19-related care.
- The imbalance between capacity and demand is leading to continued backlogs of people waiting to access services. The evidence of this includes poor flow through the system, with lower hospital discharges into constrained out of hospital support, high numbers of patients medically fit for discharge staying in beds, lower bed availability for admissions leading to crowded EDs with long waits.
- Whilst the C19 vaccination programme rollout continues, the possible impact of new variants together with usual or increased winter pressures can only mean that the above imbalance may grow.

Other factors

- Delivering services within the system financial envelope for H1 has required significant cost improvements to be made across services.

- The system reform programme focused on delivering the new ICS from April may distract from delivery, e.g. through development of PCNs, place-based partnerships and provider collaboratives.

4. Summary of common risks

The situation reports highlight a number of common risks to delivery of our plans:

- Resurgence of C19 virus and variants
- Continued impact of Infection, Prevention and Control measures
- Capacity-demand imbalances
- Reduction in funding in H2/non recurrent nature of funds
- Increased demand and patient complexity
- Workforce retention/recruitment/wellbeing
- Failing to match public expectations of care delivery
- Impact of winter pressures

5. Risk to delivery of system strategic objectives

As requested by SLE, we will assess the impact of our plans for H2 – and any gaps within them – against the system strategic objectives agreed by the Board in December 2020. Future performance reports will describe the risk to delivery of these objectives once plans are finalised.

ICS strategic objective
To improve population health and well-being and reduce in-inequalities
Delivery of safe, effective services
Managing capacity to meet demand for preventive, planned and urgent services and achievement of NHS Constitution standards as a minimum
A common approach to learning and innovation – to drive the transformation of service delivery and outcomes for patients
To achieve a high level of cost effectiveness, ensuring delivery of best value for the public purse and financial balance
A sustainable workforce model for public services across L&SC that enables a high level of staff health and well-being
To meet the requirements of the climate emergency, ensuring that the system makes substantial, progressive steps towards environmental/green targets

6. Summary of mitigating actions proposed

SLE considered the situation reports, and proposed priorities for H2 within them, in the context of constrained funding for H2 and constraints on workforce availability. It was felt that not all priority actions could be afforded or delivered and therefore that there needed to be trade-offs in delivery against national expectations during the second part of the year. SLE therefore proposed that we:

a) Focus on development of a true cross-sector workforce plan

b) Be clearer on priorities for delivery from within our constrained money and workforce in H2
c) Be clear on what we COULD do further if more resources were available

Cross-sector workforce planning

As part of the ongoing development of workforce planning at ICS level, an ICS workforce baseline has been produced. This includes the workforce picture from across the NHS, Social Care, Primary Care and Ambulance service. In addition to this, specific reports for ICP workforce boards to inform their priority setting are being developed. Specifically this has included an out of hospital focussed report for Bay HCP and Establishment vs Gap picture for Central Lancashire ICP. Each ICP has identified its key workforce priorities in conjunction with its local health and care partners.

The ICP People Board Chair will be meeting with providers, primary care and social care to continue development of the workforce plans and to identify the strategic priorities which we can use as the basis for agreeing some workforce redesign/transformation programmes.

Work is taking place to forecast future demand and supply pipelines for medics and nursing to inform the education commissioning process and we are working closely with HEE and education colleagues about the impact of the current and future increase on placement capacity. Targeted work is taking place to increase placement opportunities and therefore the scope to increase nursing within the regulated care sector. NHSEI are currently undertaking an inventory of medical workforce gaps in key specialties linked to elective recovery which will provide some additional insight to support development of workforce plans.

The H1 planning submission indicated fairly modest workforce growth over the first half of the year and we can continue to refine this as part of the H2 process. Given the constraints in workforce supply, the main issue will be how we seek to deploy the existing workforce most effectively to meet current and projected service demand.

Prioritisation of actions

To deliver actions (b) and (c), it was agreed to establish a task and finish group to review and confirm the most impactful changes across sectors that are affordable within the constrained H2 envelope. This will allow us to set out against the full range of national expectations:

- what we can do within available resources in H2 and
- what we could do additionally if more funding was available
- what we will not be able to achieve due to other constraints (eg workforce)

It is intended that the outputs from all actions will be available to feed into the H2 planning process – it is understood that this will commence with the publication of planning guidance on the 16th September.

7. Recommendations

The ICS Board is asked to receive and review the situation reports and to endorse SLE's proposed actions in advance of the H2 operational planning process.

Lancashire and South Cumbria
Health and Care Partnership

L&SC ICS Board
1st September 2021

SYSTEM PERFORMANCE H1 2021/22

APPENDIX -Sector Situation Reports

Situation reports follow on the following sectors:

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Lancashire Resilience Forum – Covid19 Recovery Co-ordinating Group

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. Lancashire partners continuing to work collaboratively through Lancashire Resilience Forum (LRF) 2. Specific working group themes supporting recovery of Lancashire 3. Moving towards embedding Covid19 practices into BAU 4. Debrief conducted with lessons identified and suggested recommendations received 5. Full mental health pressures/impacts yet to be fully realised	1. Initial Vaccinations for new groups 2. Secondary and booster vaccinations across existing groups 3. Additional health impacts on workforce (winter viruses etc) 4. Recruitment pressures 5. Winter pressures planning and business continuity	1. Resurgence of virus and variants 2. End of furlough Economic instability Recruitment challenges 3. Areas of stubborn transmission 4. Areas of low vaccine penetration 5. Reduction in funding Loss of services Critical services reduced

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Primary Care (General Practice)

Performance – current headlines (all data L&SC)	**Priorities going into second half of 2021/22**	**Risks**
1. GP appointments @ June 2021 • 764,068 appointments in June 2021 • 47% of appointments on same day • 55% face to face, 43% phone, 1.2% health visitor, 0.2% video/online 2. Vaccination uptake @ August 2021 • First Dose only – 10.55% • Second Dose – 71.58% • Remaining – 17.86% 3. GP patient survey 2021 • 72% of patients describe their experience of making an appointment as good and 13% describe it as poor 4. Quality and Outcomes Framework • Average % achievement was 97.5% (note that all the QI points were awarded in full and the majority of the other points were income protected based on performance in previous years due to Covid) 5. Workforce (ARRS) • In 2020/21 PCNs recruited an additional 261 WTE against a target of 282 • Target of an additional 200 WTE in 2021/22	a) Improving patient access to the right services at the right time b) Phase 3 vaccinations (flu and covid) and making every contact count c) Supporting workforce resilience and wellbeing d) Planning for and managing 'delayed demand' and 'winter pressures' e) Recruiting additional roles, including mental health f) Ensuring the full utilisation of the covid capacity expansion fund to deliver the seven national priorities g) Managing impact of and supporting elective recovery, especially cancer h) Integrating primary and community care working arrangements i) Implementing future operating model, including associated governance and leadership arrangements j) Supporting PCN development, including delivery of population health management plans	• Increased demand from patients and impact of activities in other sectors • Increased patient complexity • Clarity of national expectations/priorities for service delivery • Workforce retention, recruitment and wellbeing • Public expectations, experience and perceptions of access *Note that further details (including specific projects and deliverables) are contained in the collaborative work programme*

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Adult Mental Health

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
In the last four months (April – July 2021) community Mental Health demand in Lancashire & South Cumbria has been **16%** higher than in the four months prior to the first Covid-related Lockdown March 2021 saw a surge in demand that was **29%** higher than the average demand levels in the four months prior to the first Covid Lockdown All community Mental Health services have seen an increase in demand compared to pre-Covid levels, but increases have been particularly notable in key areas: CAMHS - **22%** increase Eating Disorders - **38%** increase Adult acute pathways: Home Treatment - **21%** increase Mental Health Liaison Teams (incl. A&E) - **24%** increase Crisis Line demand was **187%** higher in July 2021 than in July 2020 Older Adult community mental health teams – **22%** Home Treatment Teams have absorbed a proportion of the increased demand on the service, with adult and older adult inpatient admissions increasing by **10%**	Implement phased approach to IRS and street triage model Continue with current inpatient bed expansion Confirm system capital slippage to bring forward timeframe of inpatient bed expansion plan Continue to deliver against the investments schemes approved for 21/22 Continue with Trust wide improvement programme Building on LoS reductions to see a stepped reduction in stranded patients Continue to implement efficiency improvement schemes and develop schemes for 22/23	Recruitment of workforce continues to be a high risk. The Trust has engaged with a workforce attraction agency to support the Trusts new and ongoing recruitment campaigns Demand continuing at current unprecedented levels in both number and acuity In patient bed demand continues to rely on OAP provision about forecast levels Capital delays to bed expansion due to supplies / workforce

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Adult Mental Health cont'd

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
The use of Inappropriate OAPs is broadly commensurate with the number of Trust beds that have been closed to enable socially-distanced wards and estates works S136 detentions since April 2021 have averaged 152 per month, compared to 117.5 per month pre-Covid, an increase of **29%** The demand on bed capacity has been mitigated through improved flow, with median LOS in the Adult Acute inpatient system (including OAPs) reducing from **19 days** prior to Covid to **14 days** in Q1 2021/22 (a **26%** improvement) The Trust is expected to deliver a breakeven position for H1	See previous page	See previous page

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	CYP Mental Health

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. Eating Disorder waiting time targets (1 week CYP urgent and 4 week CYP routine) urgent achieved, routine waits recovering 2. National Access Rates - The 12-month rolling position (April 2020 – March 2021) demonstrates LSC is achieving a 46% target overall which continues to exceed the National target of 35% by 11%, bringing LSC only 6% below the local planned 2020/21 target of 52%. 3. Increasing number of VCFSE data flowing into the MHSDS	• Implementation of the approved THRIVE Clinical Model • Expansion of Mental Health Support Teams across the ICS footprint • Increase in Access to CYP services through an All age Front Door (IRS) • Development of a Crisis, Risk Support and Home Treatment Offer at Place • Increase the CYP workforce to deliver the transformed new model of care – 42 WTE 21/22 across the ICS (133 WTE by 23/24) • VCFSE offer to be enhanced through investment and partnership working • Develop Transformation Governance Structure • System Transformation – ICS,CCGs, Provider Collaborative	• Capacity to mobilise Thrive model at pace • Recruitment of practitioners with required skill set across the ICS area • Increase in Eating Disorder service referrals and acuity with challenges to access specialist EDS beds in a timely manner. • Consistent increase in CYP MH demand and complexity across all ICPs

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Learning Disability and Autism

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. People in a Secure bed – Q2 trajectory is 40. Current position is 38 Green. 2. People in a CCG bed – Q2 trajectory is 50. Current position is 54 Red 3. CYP in a Tier 4 bed – Q2 trajectory is 6. Current position is 2 Green 4. Annual Health Checks – 20-21 trajectory of 67%. End of year position of 68% Green	• Continue mobilisation and strengthening of commissioned Community Services, CLDT, IST, Community Forensic and Discharge CoOrd Team to reduce admission and LOS • Implement a programme of care and accommodation development for individuals to improve discharge • Reset of the LDA Improvement Board priorities and operational group – system ownership • System Transformation – ICS,CCGs, Provider Collaborative	• LSC remain the worst performing ICS for LDA inpatient bed performance • No LSC LDA bed base remains the LDA sectors greatest risk – extends length of stay, overreliance on OOA placements and impact on MH beds • Lack of learning disability hospital beds across the UK to meet the need to complex individuals • Cost of care and accommodation for complex individuals will be higher than the current hospital cost base • Lack of suitable providers and housing to meet the need of the most complex individuals

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	NWAS Ambulance - PES

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. Increasing demand and high acuity creating challenges across all but one of the response standards – Category 1 90th response target currently being achieved. 2. Year on year variation (19/20 to 21/22) shows 999 calls up 21%, incidents down 6%, conveyance to hospital also down by 11.4% 3. Activity increase in Category 1 (12%) and Category 2 (56%) – this has been as high as 75% during Q2. 4. Long waits on lower acuity calls due to the increase in numbers of high acuity incidents – resulting in some delays in inter-facility /healthcare professional transfers/admissions. 5. See & treat (29.5%) hear & treat (9.4%) See & convey to non-ED (7.6%) 6. Hospital handover times increasing with an average time of 31.27 minutes.	1. Workforce health and wellbeing and support. 2. Implementing a range of measures to meet pressures of growth in category 1 and category 2 calls. 3. Reduce long waits 4. Increase 999 call handling and additional clinical support in the control rooms to mitigate patient safety risks associated with challenges with response performance. 5. Increase voluntary service and private ambulance provision. 6. Increase clinicians by upskilling existing workforce where possible. 7. Transformation programme re-prioritising/expediting resources to those areas most likely to have an impact this winter.	1. Winter - increasing activity and system demand, Covid-19, Flu, nosocomial infections, etc. 2. Increased hospital handover delays reducing resource availability. 3. Availability of VAS/PAS to cover additional duties. 4. Wider NHS workforce abstractions or reduced capacity - impacting on S&T and CAS availability. 5. Capacity or availability of blue light driver training. 6. Decline in IFT/HCP performance due to the increasing acuity in C1 and C2. 7. Unable to plan on normal seasonal variation in relation to key dates due to the pandemic. 8. Requirement to support the ambulance sector with call taking capacity. 9. Lack of clarity on H2 funding

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	NWAS Ambulance - PTS

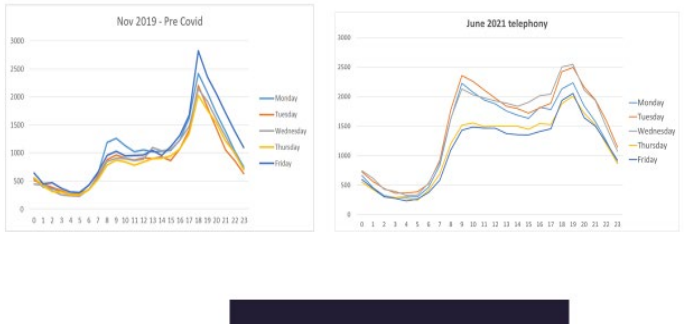
Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. Enhanced Priority Service (EPS) patients – Arrival standards good across all contracts but more challenged in GM. Collection after treatment for EPS patients is strong across all four contracts 2. Arrival standards for patients travelling for outpatient appointments is reasonable (over 80% on average arriving for appointments up to an hour before to on time) but more challenged in GM and Merseyside Collection after treatment for outpatients more challenged in GM 3. Response to on the day discharges is high across Cumbria and Merseyside with greater challenges in GM and Lancashire.	1. Patient Safety, Staff safety, regulatory compliance and transformation are our main recovery priorities. 2. Continue to support 999, prioritise discharge requests to support patient flow through the system and support elective recovery priorities. 3. Ensure enhanced priority service (EPS) patients i.e. patients travelling for haemodialysis and cancer treatment continue to receive high standard of service 4. Work collaboratively with systems to effectively manage on the day discharge requests 5. Health & Wellbeing and staff support. 6. Ensure robust contractual arrangements are in place for the effective procurement of private ambulance provision.	1. PTS supported PES by providing over a hundred staff to work on frontline 999 ambulances at the onset of the pandemic, this has continued. PTS is relaying on external providers to fill the gap and is also in the process of recruiting to replace them to ensure continuity of service. 2. Social distancing measures prevent PTS from loading more than 2 patients on an ambulance (1 person in a car) which creates pressure on available ambulance capacity meaning that its costing more to transport fewer patients overall 3. Further release of PTS staff to support 999 will have an impact on PTS ambulance capacity

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	NWAS - NHS 111

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
• Year on Year variation – July 19/20 vs July 21/22 – 111 calls up 50.5% • Calls answered in < 60 secs July '21 = 25.6% • Calls abandoned July '21 = 29.4% • Average time to answer July '21 = 9:04 • Significant change in demand profile not aligned to rota patterns	• Agree new activity baseline to inform H2 funding discussions • Against agreed activity baseline profile new rostering requirements • Fully implement staff H&WB plan • Optimise call handling time (AHT) • Recruit against additional Aug/Sept funding and H2 funding settlement • Pilot new escalation procedure for call answering in times of high call demand • Work with ICSs to ensure system working and promotion of 111 on-line • Develop digital systems to optimise clinical capacity support from specialisms e.g. Paediatrics and mental health	• Winter - Increasing activity and system demand – RSV, flu, D&V, etc. • Continuing in hours growth in calls from primary care • Availability of agency clinicians to supplement 111 team • Staff absence and attrition due to impact of continuous demands on service and availability of previous/alternative employment • Lead in time of NHS Pathways training aligned to H2 settlement • Reliance on system capacity to reduce/ prevent further growth in demand • Lack of available workforce especially clinicians

New Demand Profile
Mon – Fri In Hours



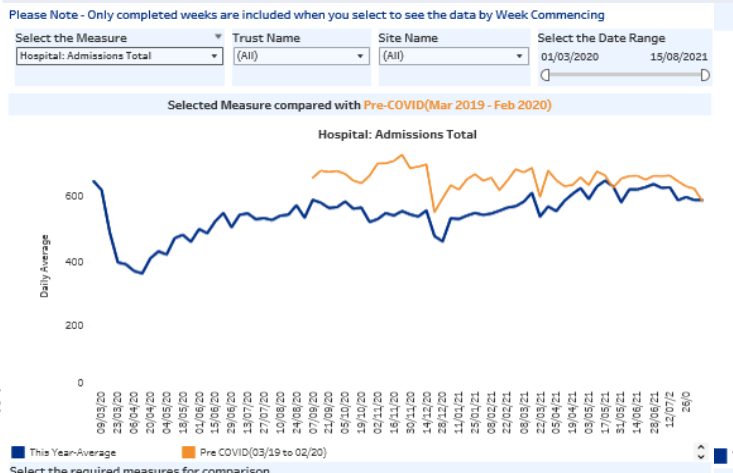
Lancashire & South Cumbria ICS – Situation Report

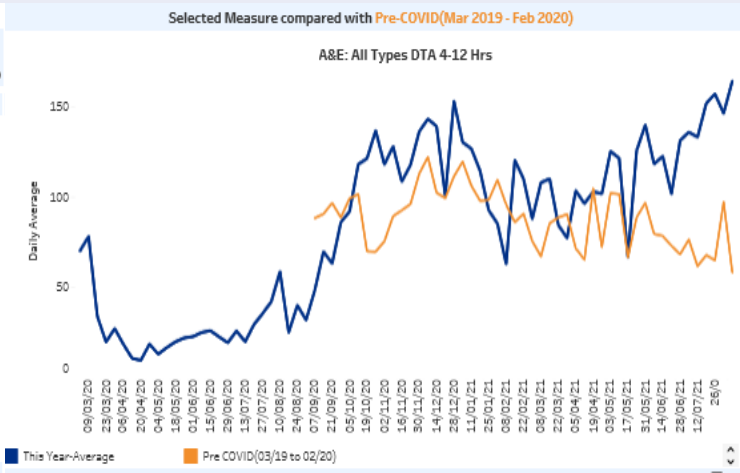
Name of Sector	Urgent & Emergency Care

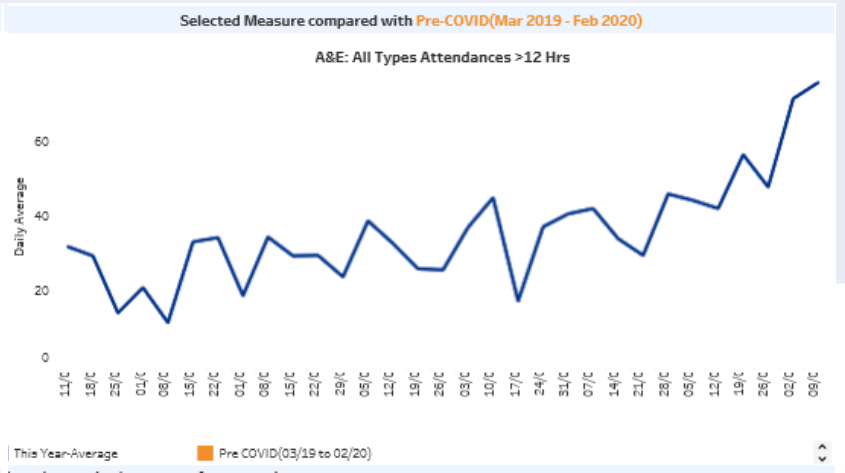
Performance – current headlines

Whilst LSC Ed performance is higher than both the NW and national position (4hr performance) the following challenges continue

1) Delays for Mental Health assessment and admission,, the latter being often in excess of 24 hours
2) Delays in ED for admission measured as 4-12 hour waits and 12 hour plus delays from decision to admit to admission at levels broadly twice the NW average
3) In consequence crowded EDs where the time to first clinical assessment (seen in 60 minutes time) has deteriorated to 25% (compared with 50% pre COVID)
4) Significant shortfalls in discharges at weekends driven by very high levels of NMC2R rates (not meeting criteria to reside) and low weekend uncomplicated discharge rates (pathway 0)
5) Misconception that performance is driven by activity rather than pathway delays







Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Urgent & Emergency Care

Priorities going into second half of 2021/22

1. Transforming access to UEC services
   - NHS 111 primary route to all UEC services
   - Maximise booked slots into EDs (at least 70%)
   - Maximise direct referral from NHS 111 to other hospital services (SDEC, hot clinics etc) and other urgent community services (UTCs, 2-hour UCR, mental health services etc)
   - Ensure local Clinical assessment Services are resilient
   - Review Directory of Services to ensure patients can be diverted to most appropriate service

2. Ambulance Services (mainly covered in separate section by Daren)
   - Define future PTS requirements for LSC including:
     - Support for elective restoration
     - Respond to national review of PTS
     - Support urgent care delivery and discharge arrangements
     - Review additional transport commissioned through local arrangements

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Urgent & Emergency Care

Priorities going into second half of 2021/22

2. Ambulance Services (continued)
    - Work with NWAS on integrated urgent care delivery model (111, 999 & PTS) including call handling and front-line responses
    - Review governance arrangements with NWAS at LSC as 'lead commissioning' ICS
    - Review further opportunities to further reduce conveyances (additional community pathways, access for paramedics to clinical advice and support etc)

3. Developing Capacity in Community & Mental Health Settings
    - Develop consistent urgent community 2-hour crisis response services 8am-8pm, 7 days per week
    - Ensure Lancashire Falls Response & Lifting Service is integrated with other UEC services (E.g 2-hour crisis response)
    - Review existing Urgent Treatment Centres (capacity & specifications)
    - Review and develop additional mental health capacity

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Urgent & Emergency Care

Priorities going into second half of 2021/22

4. Improving Flow through Hospitals
    - Review Same Day Emergency Care provision against recently released national strategy
    - Review arrangements across Trusts in providing rapid clinical assessment against the proposed new standard

5. Managing Hospital Occupancy
    - Discharge to Assess / NMC2R – maintaining & developing capacity to underpin local arrangements in H2
    - Development of Discharge to assess case management model and review of workforce across CHC, Local Authorities, NHS
    - Development of Transfer of Care model to manage discharge and case management consistently
    - Urgent Community 2-hour Response Services

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Urgent & Emergency Care

Priorities going into second half of 2021/22

6. Measuring performance against the proposed new standards
    - Review data available against the proposed new standards and develop reporting
    - Identify performance issues to be prioritised to support improvement

7. Winter Planning & Assurance
    - Review and co-ordinate mobilisation of winter plans across ICS
    - Develop and implement winter communications plan at system and place

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Urgent & Emergency Care

Risks

- Funding
  - Winter
  - Non-recurrent
  - Uncertainty for planning
  - NHS111 and Clinical Assessment Services
- Fragility of care sector, especially crisis and reablement
- Workforce shortages
- Demand
- Maintaining elective delivery

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Care sector

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. Increased demand, especially upon domiciliary care – around 20% up on last year's levels 2. Immediate & growing risk arising from lack of staff capacity to meet demand, leading to delayed packages of care at highest known levels across all L&SC Councils 3. This risk likely to be exacerbated over coming months as care sector staff leave due to mandatory vaccination requirements – between 3 and 5% 4. Longer term approach is to attract more staff through higher pay and revised immigration controls 5. In the meantime, crisis management is underway to meet priority demand within constrained capacity	1. We will continue with the development of an ICS strategy for all care sector services, including intermediate care, to ensure we understand modelled demand, required capacity and market availability 2. We will create a system wider set of criteria to manage consistent immediate allocation of services and support across ICPs 3. We will establish a set of principles to how we will apply these criteria i.e. NHS not separately commission, apply mutual aid where this is available etc. 4. We will be clear on what are the key priorities against national expectations across all service sectors and be clear on resource commitments 5. We will identify what other immediate options we might be able to activate to augment the volume/capacity issues	• Further loss of care sector staff due to mandatory vaccination regulations • Potential care sector provider failure due to staff shortages • Blocking of flow of discharges from the acute sector • CQC expectations of providers re staff vaccination mandate • Many sectors 'fishing in same pond' for workforce

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Elective Care Recovery

Performance – current headlines

Restoration %
Rolling 4 week average w/e 1st August:

IP	97%	MRI	105%	Colonosc	136%
DC	89%	CT	116%	Gastrosc	110%
OPF	94%	US	101%	Flex Sig	62%*
OPFU	92%				

All POD system restoration %: 94%**

52 week waiters
Acute - 10,171 versus trajectory 12,943
ISP CCG - 1,171 June***

104 weeks 346

P2s waiting >1 month for treatment
483 versus trajectory 614

* Low levels compared to 19/20 due to change in practice, a proportion now being undertaken as Colonoscopy instead

** WAR data excludes non-consultant led & ISP direct contract activity

*** ISP have been asked to produce a 52 week wait reduction trajectory

Priorities going into second half of 2021/22

Restoration: Continue to improve restoration rates and work towards Accelerator target of 120% by end November

Reduce Long Waits: Continue to reduce the number of patients waiting over 52 weeks with a focus on working across the ICS to eliminate any over 104 weeks

P2s > 1 month: Continue to reduce the number of P2 patients waiting longer than 1 month in line with LSC trajectory

Outpatient Priorities: Increase A&G, PIFU and Virtual Consultation usage, working towards national targets

HVLC: Continue speciality dashboard development and agree priority areas and improvement plan for each HVLC area.

Elective Recovery Gateways: Maintain and improve performance against the 5 Gateways:

1. Clinical Validation, Waiting Lists and Long Waits
2. Health Inequalities
3. Transforming Outpatients
4. System Led Recovery
5. People Led Recovery

Risks

COVID: Future waves will impact on our ability to achieve restoration targets due to:
- Staff and patient availability (infection and isolation)
- Elective bed capacity reduced due to increased COVID admissions
- Discharge to community becomes difficult when capacity is affected due to the same issues outlined above

Workforce: Delivery of extra activity very reliant on resilience and willingness of staff to undertake extra shifts. Lack of availability of agency staff

Insourcing: Slow mobilisation issues and anecdotal feedback that prices are increasing

Finance: Delivery of activity beyond core funded activity potentially restricted due to the recent ERF threshold which reduces access to funds to deliver premium cost activity

Monitoring: Systems are not yet in place to robustly capture PIFU activity. ISP CCG direct contract activity data is delayed because it is currently only available via SUS*

* A weekly ISP WAR data became available at the start of Aug but contains Acute subcontracted and CCG direct contract activity combined. There is currently no way to make a distinction between the two and the national team have confirmed that this will not be rectified

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Cancer care

Performance – current headlines

1. Restoration of Referrals

- **Top of the national list May and in 20-21**

Latest weekly referrals are 105% against the same week in 2019. The monthly position is 114% (May)

- **Lancashire and South Cumbria are the most restored alliance nationally**

Breast (122%), Head and Neck (132%), Lower GI(139%) and skin (111%) most restored . Urology (82%) and Lung (79%) least restored.

2. Restoration of Treatments

Treatments in May at 89% of the 2019 baseline
Surgery accounts for majority of gap

Have delivered 80% of the 21-22 plan (April and May YTD) – with 400 fewer treatments**.** Upper GI, Breast and Lung least restored for treatments

- **Gap in treatments from other referral routes (screening and routine) impacting**

3. Backlog

>62 day backlog is highest position at 1,509 (against 285 target)
>104 days is 241
~ 56% of backlog are non-cancer patients where we cannot evidence communication of diagnosis to patient (change of recording from 1/4/21)
Urology and Lower GI are the largest proportion of the backlog

Priorities going into second half of 2021/22

Restoration of referrals

Whilst we have restored urgent referrals and are receiving significantly higher volumes than the baseline we have a number of areas of focus:

- Supporting trusts manage the increase in referrals through pathway redesign
- Work to address inequality and inequity of access and referrals
- Supporting work on utilising double FIT to risk stratify Lower GI pathways into endoscopy
- Rolling out targeted lung health checks
- Implementing RDCs in upper and lower GI and prostate

Treatments

- Improvement work in endoscopy and pathology to turn around diagnostics faster to enable more treatments
- Programme of work to implement to optimal timed pathway for lung and the new Q2 Gynaecology and Head and Neck Pathways
- Supporting restoration of screening programmes (most specifically bowel)

Backlog

- 6 week backlog reduction plan to remove 10% of >104 backlog per week
- 6 week plan to reverse the growing trend of >62 Day FDS patients
- Improvements in recording of patient communications

Risks

Referrals

- Restoration of lung and urology
- High volume of referrals places pressure on trusts and services
- Staff sickness and self-isolation impacting on capacity

Treatments

- Bowel screening capacity is not in line with demand
- System-first and mutual aid difficult to enact in practice
- Staff sickness and self isolation impacting ability to meet demand
- Critical care capacity causing cancellations of cancer cases that are difficult to reschedule
- Theatre capacity constraints
- Significant pressures within oncology

Backlog

- High volume of referrals impacting service capacity to reduce backlog
- Diagnostic constraints in endoscopy, pathology and urology impacting on ability to reduce backlog in some specialties
- Uploading of FDS patients makes system an outlier nationally

ICS Board

Date of meeting	**1st September 2021**
Title of paper	**System Financial Recovery Update**
Presented by	**Sam Proffitt, Director of Provider Sustainability**
Author	**Sam Proffitt, Director of Provider Sustainability**
Agenda item	**6**
Confidential	**No**

Purpose of the paper
The paper seeks to provide members of the ICS Board with an update following the System Financial Recovery Board meeting 23rd August 2021.
Executive summary
The system remains on track to meet its H1 (half year to 30th September 2021) position. Pace and focus is required to ensure we begin to reduce our recurrent costs and support continued delivery as we move into the second part of the year. It is anticipated that the cost savings within the programmes are likely to start to impact during H2. The System Financial Recovery Board received a number of papers and presentations including updates on; • The current system position and H1 forecast • System Financial Diagnostic • Corporate Service Strategic Transformation • Update on Efficiency Programmes This paper summarises the key messages from the System Financial Recovery Board and progress on reducing the costs across the system.
Recommendations
ICS Board members are asked to note this update
Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
System Financial Recovery Board	**23rd August 2021**	

Conflicts of interest identified

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:	Aaron Cummings , Chief Executive UHMB (Chair of the System Financial Recovery Board)

Lancashire and South Cumbria
Health and Care Partnership

System Financial Recovery Update

Introduction

1. This report is intended as a comprehensive update from System Financial Recovery Board (SFRB).

   The paper seeks to provide update on:

   - The current system position and H1 forecast
   - System Financial Diagnostic
   - Corporate Service Strategic Transformation
   - Efficiency Programmes

Current System Position and H1 Forecast

2. The current position remains on track at Month 4 to meet the H1 position as shown in **Table 1**. More detail of the current financial position will be presented in a separate paper to the Board.

Table 1 – System summary financial position as at the end of month 4 (July) 2021

Financial Position Overview - M04						
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)	(2.0)	(2.0)	(0.0)	0.1	0.1
NHS Providers	(1.8)	5.1	7.0	(2.0)	(0.1)	1.9
System Financial Performance	**(1.8)**	**3.1**	**5.0**	**(2.0)**	**(0.0)**	**2.0**

3. A paper was presented to the System Financial Recovery Board introducing the work to capture monthly run rate information for each of the organisations. The System Financial Recovery Board will monitor expenditure run rates to assess the impact of the savings plans. This requirement has been discussed with the Chief Finance Officers and Directors Finance at their Financial Advisory Meeting and they fully support it.

4. The delivery of organisational savings have included some non-recurrent action along with growing pressures within the system to support recovery and restoration. At month 4, actual savings of £29.8m have been achieved which is £5.1m behind plan. The forecast outturn is indicating recovery to deliver the full plan at the end of the 6 month period.

System Financial Diagnostic

5. The system financial diagnostic support has been procured and launched and we are now four weeks into a 13 week programme of work.

6. There has been a successful start to the diagnostic with a full data submission, a successful launch day with key stakeholders, a weekly oversight group and regular feedback on the emerging themes.

7. A number of hypothesis are being tested through the process that will highlight the drivers of cost and indicate where solutions can be identified.

8. The system Financial Recovery Board received a presentation to provide an update. A good discussion was held with members of the Board to support the development of the work. This included ensuring the connection with the clinical vision and ensuring clinical leadership as the solutions are developed.

Corporate Services

9. NHSE/I are working with us to review the corporate benchmarking work and support some additional in-year opportunities.

10. The work will take 6 weeks and is aligned with the wider system diagnostic. It is anticipated that the this work will be able to identify further savings opportunities in year.

11. NHSE/I are supporting resources in terms of senior team members, tools and data along with learning from other areas across the country.

12. The Corporate Collaboration Board at its meeting on 17th August committed to supporting the work, with access to Trust CIPs, Model Hospital data, and other required information.

Efficiency Programmes

13. The Corporate Collaboration Board received updates from HR, Procurement and Finance work streams. Each is supporting the H1 position with schemes such as agency rates, contract reviews, asset reviews all supporting the position.

14. Further opportunities were described in a paper from HR colleagues that include;

- Developing an agreed rate card for Lancashire and South Cumbria Nursing and AHP Banks.
- Creating an attractive employment offer that encourages people to become permanent members of staff, joining up local recruitment efforts, international and other workforce growth plans.
- Review Rostering solutions
- Use of Robotic Process Automation to remove repetitive, manual transactional tasks to free up colleagues to operate at the top of their license on value-add work while removing unnecessary burden of delivering current operating procedures.
- A review of Occupational Health Services to enable reduction in unwarranted variation in the offer to our staff, helping to make Lancashire and South Cumbria a great place to work, reduce burden of absenteeism and presentism and maximise the wellbeing of our workforce

15. Further opportunities were described in an update from Procurement colleagues. Opportunities described include:

- Contract management – a full review of contracts across the whole system to gain the benefits of scale.
- Digital/IT and Estates procurement - ongoing support to deliver savings plans and map out current contracts and opportunities.
- Procurement services across the ICS to further develop collaborative working and move away from department level purchasing.
- Develop a programme of standardisation of products consumed across the trusts and specialities, comply, or explain basis, leverage GIRFT data/knowledge.

16. Finance continues to work on the asset review and a report on the progress is due to come to PCB in September.

17. Other programmes include medicines management and CHC schemes

Recommendations

18. The ICS Board is requested to note the contents of the report

Sam Proffitt
Director of Provider Sustainability
18th August 2021

Lancashire and South Cumbria
Health and Care Partnership

ICS Board

Date of meeting	1 September 2021
Title of paper	ICS Financial Report
Presented by	Elaine Collier, ICS Head of Finance
Author	Elaine Collier, ICS Head of Finance
Agenda item	**7**
Confidential	No

Purpose of the paper
For noting.
Executive summary
This paper reports on the month 4 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 4 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 has now been resolved.

2.2 Table 1 below shows a summary of the original 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 4, we are reporting that we are on track to deliver our H1 plan. The ERF income earned so far this year has enabled us to honour the plan commitment to cover provider plan deficits of £20.4m. We have also now resolved the £2m NWAS 111First funding issue which means that we are now forecasting to breakeven.

2.4 Table 2 below shows a summary of the month 4 position. The year to date position is showing a favourable variance against plan but this is due to the initial profiling of ERF income in plans being different to actuals and we expect this to smooth out over the next two months. For H1 outturn, we are now forecasting breakeven.

Table 2 – L&SC summary financial position as at the end of month 4, Julu 2021:

Financial Position Overview - M04						
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)	(2.0)	(2.0)	(0.0)	0.1	0.1
NHS Providers	(1.8)	5.1	7.0	(2.0)	(0.1)	1.9
System Financial Performance	**(1.8)**	**3.1**	**5.0**	**(2.0)**	**(0.0)**	**2.0**

2.4 Appendix 1 shows a more detailed overview of the financial performance by CCG and provider sector, showing income and expenditure by 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 4, July 2021:

System performance Surplus / (Deficit) - M04						
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	0.0	2.0	2.0	(0.0)	(0.0)	(0.0)
Fylde Coast ICP	0.0	2.7	2.7	0.0	0.0	0.0
Pennine Lancashire ICP	0.1	0.1	0.0	0.0	(0.0)	(0.0)
Morecambe Bay ICP	(1.2)	(1.6)	(0.4)	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	(0.7)	0.2	0.8	(2.0)	(0.1)	2.0
Lancashire and South Cumbria NHS FT	(0.1)	(0.2)	(0.1)	0.0	(0.0)	(0.0)
ICP Financial Performance	**(1.8)**	**3.1**	**5.0**	**(2.0)**	**(0.0)**	**2.0**

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 £56.6m for the system.

3.2 At month 4, we are reporting actual savings of £29.8m which is £5.1m behind plan. Although most organisations are forecasting that they can recover this position in H1, many of the solutions are non-recurrent. This is likely to impact on H2 where the ask is even more ambitious. We are monitoring this position closely and are working with these respective organisations to help understand their plans to mitigate any risks to delivery. Work is also ongoing to identify system-wide schemes to supplement the organisational schemes. 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 4, July 2021:

Efficiencies : CIPS / QIPPS - M04						
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	7.5	6.2	(1.3)	13.0	12.9	(0.1)
Fylde Coast ICP	7.5	7.5	0.0	12.6	12.6	0.0
Pennine Lancashire ICP	9.5	8.2	(1.3)	13.1	13.1	0.0
Morecambe Bay ICP	6.0	5.0	(1.0)	10.2	10.1	(0.1)
West Lancashire MCP	0.6	0.6	0.0	2.1	2.1	0.0
North West Ambulance Service NHS Trust	2.4	1.7	(0.7)	3.6	3.6	(0.0)
Lancashire and South Cumbria NHS FT	1.4	0.6	(0.8)	2.1	2.1	0.0
ICP Performance	**34.9**	**29.8**	**(5.1)**	**56.6**	**56.5**	**(0.1)**

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 4, we are reporting that we are broadly in line with the plan. 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 in summary but a separate capital report will cover this in more detail.

Table 5 – L&SC summary capital position as at the end of month 4, July 2021:

Capital Overview - M04						
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	**32.8**	**25.1**	**7.7**	**112.0**	**112.9**	**(0.9)**
National allocations plus other items charged to CDEL	16.1	9.2	6.9	44.9	44.9	0.0
Capital DEL	**48.9**	**34.3**	**14.6**	**156.9**	**157.8**	**(0.9)**

5. ICS Central Functions

5.1 Table 6 below provides an update on the financial position for ICS central functions. Nationally funded budgets are currently showing a year to date underspend but we anticipate that these funds will be spent as they relate to key deliverables set by region and national teams. We are working to identify if there is likely to be any slippage on these areas.

Table 6 – ICS central functions summary financial position for month 4, July 2021:

ICS Central Functions - M04						
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	104	97	7	313	313	0
Enabling Functions	598	616	(18)	6,420	6,420	0
Executive Functions	831	620	211	2,460	2,460	0
Other Support Functions	123	131	(8)	369	369	0
	1,656	1,464	192	9,562	9,562	0
Nationally Funded Budgets	3,655	2,256	1,399	10,890	10,890	0
System Funded Budgets	274	95	179	823	823	0
TOTAL	**5,586**	**3,815**	**1,771**	**21,275**	**21,275**	**0**

6. Recommendation

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

Elaine Collier
ICS Head of Finance
19 August 2021

Lancashire and South Cumbria
Health and Care Partnership

Appendix 1

Detailed overview of financial performance by CCG and provider sector.

Financial Position Overview - M04						
Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan £m	Actual £m	Variance to Plan £m	Plan £m	FOT £m	Variance to Plan £m
Acute Services	724.1	722.3	(1.8)	1,021.1	1,021.6	0.5
Mental Health Services	126.2	126.5	0.3	196.6	197.0	0.4
Community Health Services	97.6	98.6	1.0	148.4	149.7	1.3
Continuing Care Services	59.9	63.8	3.9	89.0	93.8	4.8
Primary Care Services	131.3	130.0	(1.3)	198.3	196.5	(1.8)
Primary Care Co-Commissioning	90.9	90.8	(0.1)	136.0	136.3	0.2
Other Programme Services	24.9	27.3	2.3	67.9	67.2	(0.7)
Running Costs	10.5	10.4	(0.1)	16.0	16.0	0.0
Hosted Services	0.0	0.0	0.0	0.0	0.0	0.0
COVID Outside Env & ERF Unvalidated	2.1		(2.1)	4.9		(4.9)
Total CCG Net Expenditure	1,267.7	1,269.7	2.0	1,878.2	1,878.1	(0.1)
In-Year Allocation	1,267.7	1,267.7	0.0	1,878.2	1,878.2	0.0
CCG Total	**(0.0)**	**(2.0)**	**(2.0)**	**(0.0)**	**0.1**	**0.1**
Income Excl Reimbursements	1,082.0	1,085.9	3.8	1,634.1	1,619.9	(14.2)
COVID-19 Reimbursements	3.9	14.1	10.1	5.1	20.7	15.6
Total Income	1,085.9	1,099.9	14.0	1,639.2	1,640.6	1.4
Pay	(725.7)	(727.2)	(1.5)	(1,091.2)	(1,092.9)	(1.8)
Non Pay	(348.1)	(353.7)	(5.6)	(529.1)	(526.8)	2.3
Non Operating Items (exc gains on disposal)	(14.0)	(13.8)	0.1	(21.0)	(20.9)	0.0
Total Expenditure	(1,087.8)	(1,094.8)	(7.0)	(1,641.2)	(1,640.7)	0.5
NHS Provider Total	**(1.8)**	**5.1**	**7.0**	**(2.0)**	**(0.1)**	**1.9**
System Financial Performance	**(1.8)**	**3.1**	**5.0**	**(2.0)**	**(0.0)**	**2.0**

ICS Board

Date of meeting	**1st September 2021**
Title of paper	**Financial Context for 2021/22 H2 Operational Plans**
Presented by	**Elaine Collier**
Authors	**Gary Raphael, Carl Ashworth**
Agenda item	**8**
Confidential	**No**

Purpose of the paper

Executive summary

Operational plans for the first half (H1) of this financial year – reflecting national expectations for system-wide restoration and recovery of services within constrained funding – have been, or are being, mobilised. It is anticipated that planning guidance for the development of plans for H2 will be published on 16th September.

This paper provides the ICS Board with an update on the sign off of H1 financial plans; sets out the challenges that the system will face in preparing plans for H2; and proposes an approach intended to meet these challenges.

Recommendations

The ICS Board is asked to endorse the approach described at section 7 to ensure that the overall shape of our plans for H2 is agreed to consider alongside national guidance.

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

Meeting	**Date**	**Outcomes**
SLE	18th August 2021	Endorsement of proposed approach

Conflicts of interest identified

None

Lancashire and South Cumbria
Health and Care Partnership

Financial context for 2021/22 H2 Operational Plans

1. Introduction

Operational plans for the first half (H1) of this financial year – reflecting national expectations for system-wide restoration and recovery of services within constrained funding – have been, or are being, mobilised. It is anticipated that planning guidance for the development of plans for H2 will be published on 16th September.

This paper provides the ICS Board with an update on the sign off of H1 financial plans; sets out the challenges that the system will face in preparing plans for H2; and proposes an approach intended to meet these challenges.

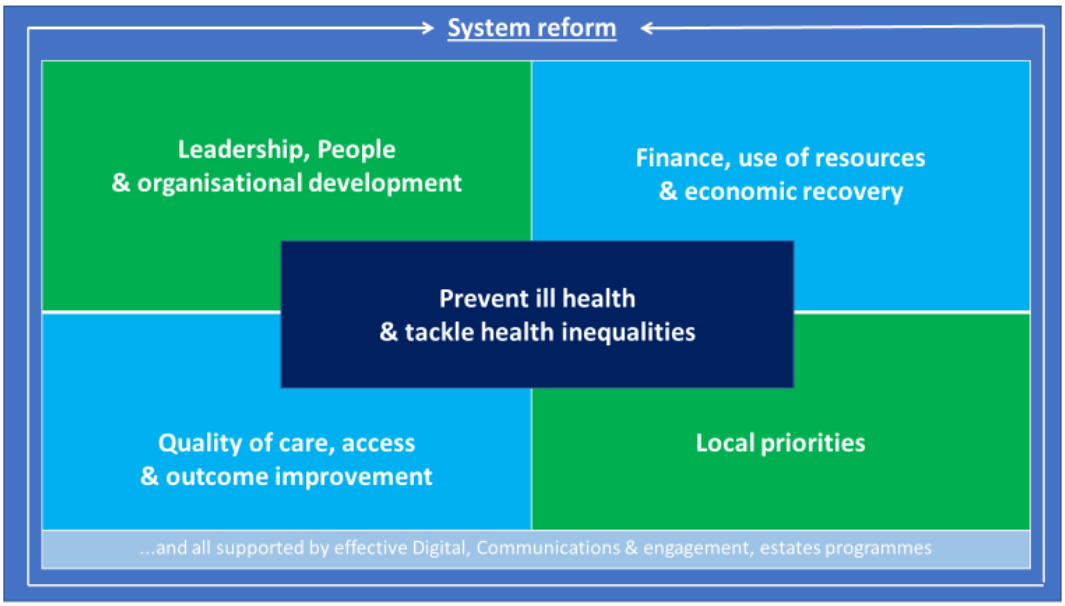
2. Links between this paper and other agenda items

Board members are asked to note the connection between this paper and:

- Item 5 on the H1 performance situation reports and proposed actions for H2

3. 2021/22 Key themes from System Oversight Framework/Planning Guidance

The recently published System Oversight Framework sets out priorities for delivery by Integrated Care Systems during 2021/22 – an MOU is under development that will set out how the ICS will be held to account for delivery of those priorities. The priority themes contained within the SOF align fully to H1 operational planning guidance – it is anticipated therefore that planning guidance and expectations for H2 will be built upon the same themes.



4. H1 financial plans – finalisation and mobilisation

There has been robust regional and national scrutiny of the system financial plan that we submitted for H1. A meeting was held with Julian Kelly on 3rd August 2021 where the following points around finalisation and mobilisation of the plans were agreed:

- L&SC approach to H1 and H2 - we will be given the room to be able to implement our plans, but we must ensure we hit our financial envelopes and deliver the additional system savings we have identified for H2
- Jonathan Stephens to arrange meeting with Julian Kelly, Gary Raphael, Sam Proffitt and Trust DoFs to better understand how IPC requirements are driving costs, even though C19 activity is low
- Julian asked us to ensure we have a clear line of sight on cumulative/monthly expenditure run rates from organisations to the ICS team, region and then the national team. Any signs of increasing expenditure run rates must be identified and mitigating action taken quickly. We need to build this monitoring system rapidly
- In response to a question from Julian Kelly, the major issues we identified as potential strategic strands during and post H2 were:
    - The need for a change in how we organise elective services, making better use of theatres and other assets, agreeing new rotas with clinicians to improve efficiency
    - The work being undertaken by the providers on their corporate collaborative
    - NHP, which has the potential to help us deliver structural changes, if a different approach were to be taken nationally to capital constraints
    - Our wave 4 pathology scheme
- A further meeting will be held at the end of September, corresponding with completion of phase 1 of our system diagnostic and national guidance on H2. It will be to ensure we are still on plan, provide feedback on H2 issues, report on findings from the diagnostic and provide the information on run rates via the monitoring system agreed with regional and national teams.

5. The H2 challenge

There are a number of challenges to the development of plans for H2 that will meet all national priorities within the available financial envelope:

- In order to meet H1 service and operational priorities within a constrained financial envelope, L&SC took into account the natural impact of late decisions for priority developments i.e. slippage on implementation timescales
- The System financial plans also assumed a £20m contribution to the bottom line from the Elective Recovery Fund
- Across the NHS pressures are building because the impact of the present wave of Covid and RSV was not part of the H1 plan and the predictions for the winter period are of a simultaneous increase in seasonal flu. In L&SC our vaccination programme for Covid and Flu is designed to reduce the incidence of outbreaks
- Emerging national financial policy for H2 (not yet confirmed) is that systems like L&SC could be subject to a 3% reduction in their financial envelope compared to H1 – this would be £54m for LSC ICS
- It has also become apparent that the Treasury will ensure that access to ERF money, if it makes any available at all, will be much tighter than for H1, which could mean the System has to plan to reduce the costs of the elective care programme to below the H1 core scenario level from now onwards
- Taken together, these challenges will make H2 a much more difficult planning round than H1, but we still have the opportunity to avoid incurring additional costs

6. Current issues and constraints

The scale of the financial challenge in H2, related to the service and policy issues that are emerging this year, is likely to be significant. The biggest financial challenge would be a 3% reduction in the financial envelope (£54m) and the loss of ERF income (£20m), but there will also be a considerable impact from the priority developments that had a slow/delayed implementation during H1.

There is a lot of uncertainty on the costs and/or sources of funding for new and emerging pressures, but the messages coming out from the Centre are that no more money will be forthcoming. The pressures here could be substantial.

We anticipate therefore that H2 will be even more constrained financially than H1 - we will need to construct our plans on the basis that no new money will be forthcoming for new pressures, our FE could be cut by 3% and we will have severe staffing shortages.

7. Potential approach

As a consequence of the issues and constraints described above, we will need to work on the basis of planning for contingencies in developing our plans for H2 – for example:

- What needs to happen if our financial envelope is cut by 3%?
- What will we need to do if there is no Elective Recovery Fund or it is significantly curtailed?
- If we can't get the staff to deliver increased service capacity, how will we recognise that in our plans?
- What will be the impact upon system commitments outlined in the SOF that are sure to be reflected in H2 planning guidance?
- What trade-offs in delivery against national expectations are we prepared to make? Urgent for elective care? Covid CC for elective CC? Paediatrics for adult services?
- Can we take a different approach to elective productivity gains? In outpatients? Theatres? Use of IS?

This pragmatic approach was supported by SLE at their meeting on the 18th August when these same challenges, risks and proposed mitigations were considered. It also aligns with the actions proposed by SLE in respect of risks to system performance, ie:

a) Focus on development of a true cross-sector workforce plan
b) Be clearer on priorities for delivery from within our constrained money and workforce in H2
c) Be clear on what we can't afford to do but COULD do further if more resources were available

To deliver the work on system priorities, a task and finish group is being established to review and confirm the most impactful changes across sectors that are affordable within the constrained H2 envelope. This will allow us to set out against the full range of national expectations:

- what we can do within available resources in H2 and
- what we can't afford to do but could be done additionally if more funding was available
- what we will not be able to achieve due to other constraints (eg workforce)

8. Recommendations

The ICS Board is asked to endorse the approach described at section 7 to ensure that the overall shape of our plans for H2 is agreed to consider alongside national guidance.

Lancashire and South Cumbria
Health and Care Partnership

ICS Board

Date of Meeting	1st September 2021
Title of Paper	2021-22 Capital Update
Presented By	Paul Havey, Executive Financial Adviser
Author	Gareth Jones, ICS Finance
Agenda Item	9
Confidential	No

Purpose of the Paper
For noting and approval.
Executive summary
This paper reports on the 2020/21 provider capital position in the context of an envelope of £112m and identifies the priorities that would need to be considered for funding, should any slippage on capital schemes occur later this financial year.
Recommendations
The Board is asked to note the current position and the process going forward.

Governance and Reporting
(List other forums that have discussed the issues in this paper)

Meeting	Date	Outcome
None		

Conflicts of Interest Identified
Not applicable

Implications

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

2021/22 Capital Update

Introduction

1. At the meeting on 2nd June 2021 the ICS Board received a paper regarding the capital planning process and approved the plan for the deployment of the £112m capital envelope. The purpose of this paper is to update the Board on the position against this plan as at the end of Q1, describe further emerging pressures on the capital envelope and to describe work undertaken to prioritise these pressures and further schemes which could be progressed, should additional resources be identified later this year.

Update

2. The paper that the Board received in June described a plan that resulted in there being a small contingency of £885k. Since then a number of new pressures have emerged as shown in the table below which has effectively removed this contingency. There is now a £1.3m over commitment against the capital envelope which will need to be managed in-year.

	£000
Original contingency as per 2nd June Board Paper	885
Error in treatment of disposal of Ridge Lea	(2,500)
Internal funding to support purchase of CT scanner at LTHT as part of CDH bid	(419)
NWAS confirmed slippage as at Q1	690
Revised contingency / (over commitment	(1,344)

3. In compiling the original plan an error was made in netting off the sale of Ridge Lea, which now needs to be added back in. On the basis that this will be managed from in year slippage this represents a pre-commitment against next year's CDEL.

4. The actual costs of implementing the Community Diagnostic Hub scheme at LTHT was £419k more than the national PDC funding allocated and given the relatively small sum involved the Board agreed that this could be treated as a first call on slippage this year and a pre-commitment against next year's CDEL.

5. At the Q1 capital review meeting with Trust DoFs, NWAS was able to confirm a reduced requirement of £690k against their plan. None of the other Trusts were able to confirm any slippage at this stage. A further review meeting with DoFs is scheduled to take place on 27th September 2021 at which point the expectation is that Trusts will have an accurate year end forecast position with a confirmed and final level of slippage. Furthermore Trusts have been asked to confirm a realistic forecast spend for each of the schemes underspent at Q1. The Q1 capital envelope position is shown in the table below and is currently £6.56m underspent (31%).

Org Name	YTD Plan (£m)	YTD Actual (£m)	YTD Variance (£m)
Blackpool Teaching Hospitals NHS Foundation Trust	2.06	1.80	0.26
East Lancashire Hospitals NHS Trust	2.29	0.37	1.92
Lancashire and South Cumbria NHS Foundation Trust	1.06	1.24	(0.18)
Lancashire Teaching Hospitals NHS Foundation Trust	7.61	6.52	1.09
North West Ambulance Service NHS Trust	1.71	1.12	0.59
University Hospitals of Morecambe Bay NHS Foundation Trust	6.75	3.87	2.88
ICS Total	**21.48**	**14.92**	**6.56**

Additional/new priorities identified since the capital budget was approved

6. A number of further priorities and developments have been identified which include the year 1 capital costs of implementing the approved Stroke business case (£0.75m) and the potential for the 4 acute Trusts having to fund the costs of developing the Pathology Collaboration FBC (£1m). The pathology FBC issue has arisen due the approval of the OBC currently being on hold pending the Spending Review in the Autumn and DHSC therefore not being able to commit, at this stage, to early draw down of the funding for the business case development costs. Confirmation on the availability of this funding should be known towards the end of Q3. Further capital costs in relation to additional mental health schemes of £8m have also been identified in-year. The costs described above are in addition to the £22.6m additional backlog maintenance costs that Trusts flagged as essential but were unaffordable within the current envelope when the plan was agreed. A summary of these additional costs is shown in the table below.

	£000
Essential backlog maintenance costs flagged when capital plan originally set	22,600
Additional Mental Health schemes not in plan	8,000
Year 1 capital element of Stroke Business Case	750
Pathology FBC development costs	1,000
Sub-Total - new commitments	32,350
Existing pressure on capital envelope as at Q1	1,344
Total - potential new commitments plus existing pressure	33,694

7. At this stage the costs presented above are unafforable within the £112m envelope as currently there is a £1.3m over commitment on the existing plan which excludes the items in the table above. However as and when slippage on the existing plan is confirmed the schemes above will need to be prioritised and be ready to proceed in order that the resource can be spent in year. Furthermore, additional funding may be available should there be slippage in the other two ICS's within the region and so it would be good practice to have a set of schemes ready should this be the case. As previously highlighted any slippage in year will need to be replaced by known schemes from 2021/22 as the expenditure will need to be a first call on next year's CDEL.

Prioritisation of unfunded schemes

8. To faciliate this a set of prioritisation criteria was agreed and shared with the system. The criteria are intended to be hierarchical with the first requirement being seen as the most important criteria that the scheme must address in order to be approved. This will ensure that only schemes that address the most pressing needs are given approval to proceed should there be funding available through slippage.

   The criteria are as follows:

   1. Regulatory Intervention / Requirements e.g. Fire, Health and Safety, Water, CQC recommendations;
   2. Patient and staff safety;
   3. Patient and staff environment;
   4. Ability to deliver revenue savings;
   5. Capacity to deliver strategy;
   6. Ability to improve performance.

Backlog maintenance issues

9. Analysis of the £22.6m backlog maintenance figure utilising the definitions of High and Significant risk backlog as taken from the DoH guidance document "A risk-based methodology for establishing and managing backlog" as set out below has been undertaken:

   Significant risk elements - require expenditure in the short term but should be effectively managed as a priority so as not to cause undue concern to statutory enforcement bodies or risk to healthcare delivery or safety.

   High risk elements - must be addressed as an urgent priority in order to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution.

   This has identified that approximately £9m of schemes from the Trusts' returns meet the definition of high risk. Consequently, these schemes would meet the requirements of criteria 1 to 3 above and it is therefore recommended that these are taken forward for consideration against any in-year slippage as they would inevitably fall within next year's priorities.

10. Given the relatively small value, it is proposed that the 4 acute trusts identify £250k slippage within their existing plans to cover the potential costs of developing the pathology FBC. It will not be confirmed until Q3 if these costs will be covered by national PDC.

11. It is proposed that following the review of expenditure on 27th September that the SLE (or other ICS Board preference) meet to prioritise the use of any slippage identified in excess of what is required to balance the programme.

Gareth Jones

ICS Finance

13th August 2021

ICS Board

Date of meeting	**1st September 2021**
Title of paper	**System Reform Programme – (a) General Update**
Presented by	**Andrew Bennett, Interim Chief Officer, LSC ICS**
Author	**Dawn Haworth, Senior Programme Manager, Peter Tinson, Director of Collaborative Commissioning, Sam Proffitt, Director of Provider Sustainability, Steve Christian, Chief Integration Officer, Andrew Bennett, Interim Chief Officer**
Agenda item	**10a**
Confidential	**No**

Purpose of the paper

The purpose of this report is to provide the ICS Board with an update on the work of the Lancashire and South Cumbria Integrated Care System Development Programme.

Executive summary

The System Development Programme is progressing at pace, overseen by the ICS development Oversight Group, with significant work being undertaken across all workstreams. This report provides a high-level update for the ICS Board at the end of quarter 1 and focusses specifically on the following key areas of work:

- National guidance
- System Development Plan
- NHS England & Improvement's Direct Commissioning Functions
- CCG Functions
- Workforce & OD
- Provider Collaboration
- Clinical & Professional Leadership

A separate report is also being provided for the Board in relation to the development of place-based partnerships.

Recommendations

The ICS Board is asked to

- Discuss the report which updates on the current system development programme.

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

Meeting	Date	Outcomes

Conflicts of interest identified

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			N/A	
Equality impact assessment completed			N/A	An Equality Impact and Risk Assessment is in development
Privacy impact assessment completed			N/A	
Financial impact assessment completed			N/A	
Associated risks			N/A	
Are associated risks detailed on the ICS Risk Register?			N/A	A Risk and Issues Log for the System Development Programme has been established

Lancashire and South Cumbria
Health and Care Partnership

Quarter 1 Update Report: System Development Programme

1. Introduction

The purpose of this report is to provide the ICS Board with an update on the work of the Lancashire and South Cumbria Integrated Care System Development Programme.

2. National Guidance

The White Paper, *Integration and Innovation: working together to improve health and social care for all* which was published in February 2021, outlined how the NHS in England needs to change to enable health and care to work more closely together. This was followed in June 2021 by the *Integrated Care Systems: Design Framework* which set out how NHS organisations are expected to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022.

The Health and Care Bill (2021), is currently proceeding through the parliamentary process, having received its first and second readings in the House of Commons. A range of guidance has recently been published with clear expectations that further guidance is to follow. Guidance remains subject to the continued progression of the Bill.

Board members should note that there are some changes in nomenclature which are being used as the legislation progresses – this includes the name "Integrated Care Board" (ICB) to refer to the statutory NHS body which is expected to take effect across Lancashire and South Cumbria from 1st April 2022.

Published 10th August:

- Working together at scale: guidance on provider collaboratives

Published 19th August:

- Interim guidance on ICB functions and governance including
  - Draft Model Constitution
  - List of statutory CCG functions to be conferred on Integrated Care Boards (ICBs)
- ICS People Function
- HR Framework
- ICS Establishment guidance (Due Diligence)
- CCG Closedown and ICB Establishment Due Diligence Checklist
- ICS Readiness to Operate Statement (ROS) and checklist
- Direct Commissioning Functions: Pre-Delegation Assessment Framework

Expected 3rd September:

- ICS "What good looks like" framework (digital and data)
- Thriving Places (place-based partnerships)
- Professional and clinical leadership within ICSs
- Integrated Care Systems and the Voluntary, Community and Social Enterprise Sector
- ICS Implementation Guidance on working with people and communities

Expected 10th September:

- Draft guidance on establishment and operation of the Integrated Care Partnership
- ICB Financial Governance and reporting guides
- Model profiles for Director of Finance, Director of Nursing and Medical Director roles
- "How to" guide on developing population based blended payment models

The slide set attached at appendix A sets out a timeline for publication of anticipated national guidance, provides links to published guidance documents and to summaries of key documents.

Work on the Lancashire and South Cumbria System Development Programme is continuing to progress as far as possible without waiting for guidance. Wherever possible proposals are developed and cross-checked against any guidance that is subsequently issued where necessary.

3. System Development Plan

The LSC System Development Plan (SDP), which was submitted to NHSEI at the end of June 2021, sets out the key objectives and deliverables for the development of the LSC Integrated Care System and encompasses a number of key workstreams (including ICS development; ICP development; commissioning reform; and provider collaboration) alongside a number of cross-cutting workstreams (including quality, performance and assurance; financial frameworks; HR frameworks and OD; communications and engagement).

A review of quarter one deliverables has now been undertaken with a number of these having been completed. Due to delays in national guidance, progression of some deliverables has not been possible and these, together with any others that are subject to minor delays will now be carried forward into quarter two.

The delays to those quarter one deliverables which have been carried forward into quarter two have not, as this stage, created any significant impact to the overall programme. However, the Programme Risk and Issue log identifies two issues (having originated as risks but been re-graded as issues). Both relate to the impact of delays in the progression of the Health & Care Bill resulting in delays to the

publication of guidance and the impact that this has on the ability to undertake significant change during the second half of 2021/22.

The ICS development Oversight Group continues to meet monthly and oversees delivery of the system development programme through receipt of a comprehensive monthly highlight report. This incorporates reporting from each workstream against its objectives and deliverables, together with any risks or issues for escalation.

4. NHS England and NHS Improvement's direct commissioning functions

The NHS Operational Planning Guidance for 2021/22 set out the intention to delegate some of NHS England and NHS Improvement's direct commissioning functions to Integrated Care Boards as soon as operationally feasible from April 2022. This is a key enabler for integrating care and improving population health and will provide the ICS with the flexibility to join up key pathways of care, leading to better outcomes and experiences for patients, and less bureaucracy and duplication for clinicians and other staff.

It is expected that from April 2022 the Integrated Care Board will:

- assume delegated responsibility for primary medical services (currently delegated to all clinical commissioning groups [CCGs], and continuing to exclude Section 7A Public Health functions)
- be able to take on delegated responsibility for dental (primary, secondary and community), general ophthalmic services and pharmaceutical services (including dispensing doctors and dispensing appliance contractors)
- establish mechanisms to strengthen joint working with NHS England and NHS Improvement, including through joint committees, across all areas of direct commissioning (where they are not already delegated)

And by April 2023, all Integrated Care Boards will have:

- taken on delegated responsibility for dental (primary, secondary and community), general ophthalmic services and pharmaceutical services
- taken on delegated commissioning responsibility for a proportion of specialised services (subject to system and service readiness) with national standards and access policies remaining at a national level
- worked collaboratively with NHS England and NHS Improvement to determine whether some Section 7A Public Health services will be delegated, with decisions on the appropriate model and timescale
- worked collaboratively with NHS England and NHS Improvement to determine whether some health and justice, sexual assault and abuse service commissioning functions will be delegated, with decisions on the appropriate model and timescale.

Further details are expected over the coming months, including:-

- A pre-delegation assessment process
- Full detailed scope of what will be delegated and what will be retained
- The specific enablers, including staff deployment
- Financial framework

An ICS project team has been formed which is progressing work with colleagues in the Regional team of NHS England and NHS Improvement. A detailed paper is being received by the CCG Transition Board at its September 2021 meeting.

5. CCG Functions

Significant pieces of work are underway to review the wider range of commissioning functions and consider the model for future provision at system-level and across the five place-based partnerships:

1. Strategic commissioning functions
   A timeline and approach has been agreed drawing on learning from the accelerator groups. Proposals are to be concluded by the end of September 2021.
2. Corporate functions
   Functions have been mapped against those set out in the ICS Design Framework and work is underway to identify senior SME leads who will determine arrangements for their transition and/or transformation.
3. 'Accelerator' areas
   Proposals are in the final stages of development.

A paper was approved at CCG Transition Board in August 2021 which proposes transition to the new operating model to take place from September 2021 for accelerators and during Q3 for other functions. This proposal is supported by the Transitional Ways of Working Principles created by the HR team and will support staff by providing greater clarity on the sense of direction during the transitional year of 2021/22 and from April 2022 onwards. It will also meet key deliverables as set out by NHSEI in the ICS Design Framework.

6. Workforce and Organisational Development

Recruitment of the new Chief Executive Officer for the Integrated Care Board (ICB) is expected to commence 1 September 2021 with a formal appointment expected to be made late-October. This appointment marks a vital step in the development of the ICB as it continues its journey towards statutory establishment next April. Following this appointment new executive structures that reflect the ICS Design Framework will be developed and subsequently recruited to, firming up the future senior leadership arrangements of the ICB. Non-Executive Director

recruitment is expected to start early October enabling the new Board to operate in shadow form from January 2022.

The much awaited HR framework for developing Integrated Care Boards has now been published, outlining the national policy ambition and practical support for dealing with the change processes required to affect the transfer and the transition. This guidance builds upon the four core HR transition principles (people centred approach, compassionate and inclusive, minimum disruption, and subsidiarity) agreed with national trade unions to support an effective and safe transfer. A comprehensive transition plan has been developed by the People team which will now be reviewed to ensure it is reflective of this new guidance. Communications and engagement sessions will take place with those affected during staff-briefs in September explaining this new guidance in more detail and what this means for colleagues.

In addition to the HR Framework, NHS England and Improvement have shared guidance in respect of developing the ICS People function which outlines the functions, accountabilities and responsibilities of the ICB. This guidance will inform the design of the future operating model, governance arrangements and priorities of the ICB's People function. The guidance intends to help NHS system leaders and partners support a 'one workforce' approach, enabling systems to have more staff, working together better in a compassionate and inclusive culture – helping make the local area a better place to live and work. The guidance is instrumental in informing the foundations and design of the future operating model for the ICB's people function and wider system responsibilities.

7. Provider Collaboration

Acute and Mental Health

Good progress is being made in the development of a provider collaborative comprising the four acute hospital Trusts and the Mental Health and Learning Disability Provider. A purpose and vision are being developed which will aim to ensure that by working together the providers can improve population health outcomes, reduce inequalities, ensure good quality services, build a strong resilient workforce and deliver financial sustainability.

All five provider Trusts are working together to develop the provider collaborative with support from NHSE/I. Members of the Provider Collaborative Board comprising all Trust Chairs and Chief Executives have been developing the purpose and direction for the Provider Collaborative and a further development session is planned in September which will include wider Board members to develop this further.

Governance Structures have been put in place, establishing two Collaborative Boards – one Corporate and one Clinical, each chaired by a Trust Chair. The collaborative Boards include membership from all provider Trusts.

The Corporate Collaboration Board is developing a number of efficiency programmes including agency rates cards, asset valuations, procurement initiatives etc. This group are also working closely with the National productivity team to develop a more strategic approach to developing corporate service supported by the national benchmarking data.

The Clinical Collaboration Board has a focus on recovery and restoration and urgent and emergency care and is also working to develop a clear clinical vision aligned to the ICS Clinical Strategy supported by clinical benchmarking data.

Mental Health, Learning Disabilities and Autism

As part of the ICS System Development Plan architecture the System Transition Board for Mental Health, Learning Disabilities and Autism (May 2021) has been established comprising of a broad range of stakeholders including NHS providers, LA, ICS, and VCFSE. This Board will act as the Provider Collaborative for Mental Health and Learning Disabilities & Autism services. The provider collaborative will adopt a Lead Provider (LP) model which will be hosted by LSCFT.

The providers, that form part of the System Transition Board for Mental Health, Learning Disabilities and Autism, are working collaboratively to plan and deliver system reform and transformation for mental health, learning disability and autism services and to manage system performance. The Board has a shared purpose, to:

- reduce unwarranted variation and inequality in health outcomes, access to services and citizen/patient experience
- improve provider resilience, reduce duplication, reduce contracting burdens, and build on best practice examples
- ensure that specialisation and consolidation occur where this will provide better outcomes and value and support patients to remain closer to their communities, social networks and families

The expectation is that the System Transition Board will:

- Oversee the delivery of the Lead Provider collaborative model for Mental Health, Learning Disabilities and Autism services to deliver an agreed scope of commissioning arrangements. The Roadmap plans to:
    - Transfer into the LP model all current in-scope NHS England specialist commissioning responsibilities (whole budget) for Children and Young people (CYP) Tier 4 services and Adult secure low/medium services on 1st October 2021.
    - Make recommendations about the delegation of NHS commissioning responsibilities for all-age Mental Health services and Learning Disability and Autism services into the Lead Provider collaborative with timelines for implementation. It is expected that a phased approach will be taken

to implementation to allow an effective period of due diligence and further development.

- Support system-wide transformation using Population Health Management approaches and collaborative opportunities through the introduction of 3 all age transformation groups jointly led by Director level SROs from Local Authority and NHS.
- Lead the development of 3 all age system-wide strategies for Mental Health, Learning Disabilities and Autism
- Have close relationships with the Places they serve, ensuring the needs and voices of local communities are a key driver for transformation at scale
- Work with existing clinical networks and other networks to avoid disrupting existing beneficial collaboration
- Work with the established North West Provider Collaborative for region wide complex care commissioning arrangements to support benefits at scale and mutual aid

The System Transition Board meets bi-monthly to oversee and authorise decisions within its programme of work, as well as making key recommendations for the ICS board to consider.

The System Transition Board governance arrangements will be regularly reviewed to ensure the programme aims are delivered within the required timeline. The System Transition Board includes a broad range of stakeholders who are invited to influence and shape future models of care. The members include:

- ICS Board Non Executive Director (Chair)
- ICS Interim Chief Officer
- Senior Responsible Officer, LSCFT Chief Executive
- Programme Director, LSCFT Chief Integration Officer
- LSCFT, Chief Operating Officer
- Executive Director of Adult Services and Health & Wellbeing (Lancashire County Council)
- Strategic Director (BwD Borough Council)
- District Local Authority CEO (Chorley and South Ribble Council)
- Deputy Chief Executive (Cumbria County Council)
- Blackpool Local Authority Director of Adult Services
- VCFSE Representative (Chief Executive Lancashire MIND)
- Primary Care Provider Representative (GP Executive NHS Morecambe Bay CCG)
- NHS Providers Medical Director Representative
- Service User/ Carer Representative, Chair of Service User and Carer Council

The System Transition Board has adopted Task & Finish Groups that will support system wide transformation and NHS transition. The key priorities for these Task & Finish Groups are informed by the Moorhouse review. All Task & Finish Groups will have commenced and mobilised by September 2021.

8. Clinical and Professional Leadership

As set out in the ICS Design Framework, each ICS needs to develop a clinical and professional leadership model that will ensure that clinicians/professionals are fully involved in key decision-making across the various different levels of system, places, provider collaboratives and neighbourhoods. Whilst the national expectations around clinical leadership within the ICS NHS body at board level are defined in the ICS Design Framework, the wider model is for ICSs to determine locally.

A paper was approved at the ICS development Oversight Group in July 2021 which sets out the mandate for a task and finish group:

- To review the content of the White Paper, the ICS Design Framework, and any other relevant national guidance related to system development and identify the key requirements of a Clinical and Professional Leadership Model based on national expectations.
- To review national best practice publications in relation to the ICS Design Framework to identify how these key requirements can best be addressed, and possible options for consideration.
- To incorporate work already developed and continuing to be developed by the Primary Care Sub Cell and the Provider Collaborative
- To develop a proposed Clinical and Professional Leadership model for Lancashire and South Cumbria that:
    - Meets national expectations
    - Takes into account best practice from elsewhere, whilst meeting the specific needs of Lancashire and South Cumbria
    - Will support delivery of the Lancashire and South Cumbria ICS clinical strategy
    - Is representative of the different professions and sectors within the Lancashire and South Cumbria Health and Care Partnership
    - Provides appropriate connectivity between PCNs, places, provider collaboratives and the system
    - Provides appropriate connectivity across organisations, alliances and networks
- To identify the key requirements of an organisational development programme that will support clinical and professional leaders to work across traditional organisational and/or professional boundaries and make a successful transition to collaborative leadership.

The Task Group will deliver the following outputs
By the end of October 2021:

- A proposed Clinical and Professional Leadership model for Lancashire and South Cumbria will be created

- The key requirements of an organisational development programme for clinical and professional leaders will be described

By the end of November 2021:

- A local framework and plan for clinical and care professional leadership that demonstrates how the involvement of clinical and care professionals will be achieved will be presented to the current ICS Board.

Recommendation

1. The ICS Board is asked to discuss the report which updates on the current system development programme.

Lancashire and South Cumbria
Health and Care Partnership

National guidance for developing Integrated Care

v1.3
August 2021

System reform timeline

*Estimated timescales

February 2021
Government White Paper published

July 2021
1st & 2nd reading of the Bill in the Commons

***September-October 2021**
Committee stage of the Bill

***November 2021**
Report/Third reading; Introduction in Lords

***November 2021 – March 2022**
Lords stages

***Mid-March 2022**
Final stages and Royal Assent

June 2021
- ICS design framework
- Employment commitment guidance
- NHS system oversight framework
- NHS oversight metrics 2021/22

10 Aug 2021:
- Working together at scale: guidance on provider collaboratives

18 Aug 2021:
- Interim guidance on the functions and governance of the Integrated Care Board
- Draft model & list of statutory CCG functions to be conferred on ICBs
- Building strong integrated care systems everywhere: guidance on the ICS people function
- ICS implementation guidance: ICB readiness to operate statement (ROS) and checklist

ICS Implementation Guidance: Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG Close Down

***Due 3 Sep 2021:**
- Thriving Places
- Clinical and Care Professional Leadership within ICSs
- ICSs and the VCFSE sector
- Guidance on working with People and Communities

***Due 10 Sep 2021:**
- Guidance on deployment of ICB resources
- ICB Financial Governance and Reporting guides
- Model profiles for Dir of Finance, Dir. Of Nursing and Medical Director roles
- How to guide on developing pop-based blended payment models
- Draft guidance on ICP

1 April 2022
Establishment of ICS statutory NHS Body

Core documents

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

  26 November 2020

  Details how systems and their constituent organisations will accelerate collaborative ways of working in future, considering the key components of an effective ICS and reflecting a range of local leaders' experiences.

- Integration and Innovation: Working together to improve health and social care for all

  11 February 2021

  The Government white paper 'Working together to improve health and social care for all' sets out legislative proposals for a Health and Care Bill; including establishing ICSs in law.

- ICS Design Framework

  16 June 2021

  Provides the next level of detail to ICSs about how they will operate from April 2022 and the core expectations as part of ICS establishment. It describes the 'core' arrangements expected for each system and the ways in which NHS organisations will be able to flex their approach to collaboration.

Health and Care Bill Journey

Health and Care Bill >>

Bill passage

Published Guidance

- ICS design framework
  16 June 2021
- Guidance on the employment commitment
  16 June 2021
- NHS system oversight framework
  24 June 2021
- NHS oversight metrics 2021/22
  24 June 2021
- System development progression tool (Excel doc issued to ICS leads)
  1 July 2021
- Working Together at Scale: Guidance on Provider Collaboratives
  10 August 2021
- Interim guidance on the functions and governance of the Integrated Care Board
  18 August 2021
- Draft model constitution
  18 August 2021
- List of statutory CCG functions to be conferred on ICBs
  18 August 2021

Published Guidance

- HR Framework for developing Integrated Care Boards
  18 August 2021
- Building strong integrated care systems everywhere: guidance on the ICS people function
  18 August 2021
- ICS implementation guidance: ICB readiness to operate statement (ROS) and checklist
  18 August 2021
- ICS Implementation Guidance: Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG Close Down
  18 August 2021

Guidance in development

Governance and accountability

- Thriving Places (place-based partnerships)
- ICS Implementation Guidance on working with people and communities
- Integrated Care Systems and the Voluntary, Community and Social Enterprise Sector
- Code of Governance for NHS Provider Trusts
- Good practice guide to working in collaboration with local government
- Professional and clinical leadership within ICSs
- Quality governance and oversight function in ICSs
- Statutory guidance on establishment and operation of the Integrated Care Partnership
- Guidance on quality assurance and risk management
- Updated NHS Foundation Trust Accounting Officer and NHS Trust Accounting Officer memorandums

Guidance in development

Change and transition

- Recruitment guidance and principles

People and culture

- Future of NHS HR & OD programme
- ICS People function and operating model
- Supplementary guidance and implementation support for ICSs to help deliver the people operating model

Guidance in development

Financial framework

- Developing population-based blended payment models
- Final ICB allocations and guidance
- Financial governance and reporting guidance
- Guidance on deployment of resource at place
- NHS Operational Planning and Contracting Guidance – ICB financial framework
- Who Pays? Guidance

Guidance in development

Digital and data

- Flatpack guide to population health management
- Guidance on cross-system ICS intelligence functions
- Target architecture guidance
- ‘What Good Looks Like’ Digital and data maturity framework for ICS

Delegated commissioning guidance

- Guidance to support joint commissioning arrangements
- Oversight and assurance mechanisms for functions to be delegated in 2022/2023
  Pre-delegation assessment framework
- Standard direct commissioning delegation agreement

Further detail on published guidance

Published Guidance

ICS Design Framework Summary

- Sets out how NHS organisations are expected to respond in the next phase of system development, including the anticipated establishment of statutory ICS NHS bodies from April 2022
- Describes the ‘core’ arrangements expected in each system and those to be determined by local partners in their local context
- Aims to provide some ‘guide rails’ for NHS organisations as they develop their plans
- Subject to legislation

Access summary PowerPoint: ICS Design Framework Summary

Published Guidance

Guidance on the employment commitment

- The employment commitment outlines that *"it is envisaged that all functions of a CCG will transfer to the statutory ICS and therefore colleagues below board level should **lift and shift** from one organisation to the other, resulting in minimal change."*
- The commitment provides assurance that a large scale organisational change programme (similar to that undertaken in 2012/13 when implementing the Health and Social Care Act) is not required ahead of the ICS being created.
- The employment commitment has a strong emphasis on the importance of open and transparent communication and engagement with colleagues as we go through the process. This reflects our ambitions locally to ensure that our colleagues are kept informed and involved throughout the process.

Published Guidance

Working Together at Scale: Guidance on Provider Collaboratives

- Sets out the **minimum expectations** for how providers should work together in provider collaboratives and provides some guiding principles to support local decision-making
- Describes **what provider collaboratives** are and why they are needed
- Sets out **expectations for NHS providers** in relation to provider collaboratives
- Describes the **role of provider collaboratives** in health & care systems
- Explains how the **Health and Care Bill** would create further opportunities for providers and their system partners to work together effectively by providing new options for trusts to make joint decisions
- Describes the **range of mechanisms** that are available now and will be available after the enactment of the legislation to ensure that provider collaboratives are **accountable** to deliver their agreed shared objectives
- Sets out **next steps**

Access summary PowerPoint: Working Together at Scale: Guidance on Provider Collaboratives

Published Guidance

Interim guidance on the functions and governance of the integrated care board

Draft model constitution & list of statutory CCG functions to be conferred on ICBs

- This interim guide covers the expected governance requirements for Integrated Care Boards as outlined in the Health and Care Bill and the ICS Design Framework. The guidance is designed for all ICS partners involved in the establishment of Integrated Care Boards, particularly ICS leads, CCG AOs and their teams as well as NHSEI regional teams.

Published Guidance

HR Framework for developing Integrated Care Boards

- The HR Framework provides national policy ambition and practical support for NHS organisations affected by the proposed legislative changes as they develop and transition towards the new statutory ICBs. The guidance is designed for all ICS partners and ICS leads, CCG AOs and in particular those leading on people/workforce/HR&OD.

Published Guidance

Building strong integrated care systems everywhere: guidance on the ICS people function

- The ICS People Function guidance builds on the priorities set out in the People Plan. It is intended to help NHS system leaders and their partners support their 'one workforce' by delivering key outcome-based people functions from April 2022. The guidance is designed for all ICS partners and ICS leads and in particular those leading on people/workforce/HR&OD.

Published Guidance

ICS implementation guidance: ICB readiness to operate statement (ROS) and checklist

- This document provides a template ICB Readiness to Operate Statement (ROS) and accompanying ROS checklist. It describes how the checklist will be used to enable system leaders to assess progress and transition towards the establishment of ICBs. The guidance is designed for ICS leads, ICS Implementation Programme Directors, CCG AOs and their teams across all functions as well as NHSEI regional teams. An Excel version of the ROS checklist is available to download as a working document ROS Checklist.

Published Guidance

ICS Implementation Guidance: Due Diligence, Transfer of People and Property from CCGs to ICBs and CCG Close Down

- This guidance outlines the due diligence process which underpins the legal transfer of people (staff), property and liabilities to ICBs, the legal establishment of ICBs and abolition of CCGs, and close-down activity for CCGs. The guidance is designed for CCG AOs and their teams across all functions, ICS leads and NHSEI regional teams. An Excel version of the due diligence checklist is available to download as a working document.

Lancashire and South Cumbria

Health and Care Partnership

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ICS Board

Date of meeting	**1st September 2021**
Title of paper	**System Reform Update (b) Integrated Care Partnerships (Place Based Partnerships) Development Programme and Delivery Update**
Presented by	**Dr Geoff Joliffe Chair, ICP Development Advisory Group**
Authors	• **Karen Kyle, System Programme Director, Bay Health and Care Partners** • **Sarah James, Integrated Care Partnership Director, Central Lancashire** • **Philippa Cross, Head of Integrated Care Partnership Development (Interim) – Pennine Lancashire** • **Victoria Ellarby, Programme Director – System Reform, LSC ICS** • **Pauline Wigglesworth, ICP Programme Director, Fylde Coast** • **Karen Tordoff, ICP Programme Director, West Lancashire**
Agenda item	**10b**
Confidential	**No**

Purpose of the paper
For information/discussion.
Executive summary
In September 2020, the ICS Board agreed a two-step process for ICP development as part of the wider system reform agenda. Step 1 was the creation of a common ICP strategic narrative to set out what working in partnership means for us, what we want to do together as partners and how we will enable that change. Step 2 was the prioritisation and scoping of a number of work programmes to describe in greater detail, and subsequently deliver, the content of the strategic narrative. Following the scoping of the work programme, the ICS Board agreed an ICP Development programme on 6th May 2021 to be undertaken across the five places focussing on the following areas: • Overarching themes and success measures for places • How we will organise ourselves to work together as partners • Place Based Leadership & Implementation This report will outline progress to date on the ICP Development Programme during quarter 1. The ICP Development Advisory Group (DAG) also noted that whilst the ICP Development programme is a significant undertaking across the 5 place based partnerships, and joint working across all partners within Health, Local Government & Voluntary, Community and Faith Sector and Enterprise (VCFSE)

that innovation and delivery of integration at place, community and neighbourhood level continues to progress and delivery tangible benefits for our communities. The paper therefore showcases some of the great work being undertaken today within our ICPs demonstrating integration at place within our communities across Lancashire and South Cumbria

This report outlines and provides an overview on the following:

- ICP Development progress to date in Quarter 1 2021- 22,
- Expected ICP Development deliverables for Quarter 2 – 2021- 22
- Overview of progress against the broader ICP Development programmes
- Update on delivery of integrated working within the five place based partnerships.

Recommendations

The ICP Board is asked to:

- Note the progress made against the ICP Development programme for Quarter 1 2021- 22
- Note the deliverables for Quarter 2 2021-22
- Note the achievements in the place based partnerships on delivery of integration at place level in 2021/22, presented as case studies.

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

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Implications

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

Report authorised by:	Dr Geoff Joliffe Chair, ICP Development Advisory Group

Integrated Care Partnerships (Place Based Partnerships) Development Programme and Delivery Update

ICS Board – Wednesday 1 September 2021

1. Introduction and Context

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

1.2. Following engagement with system leaders across ICPs and the ICS, the common strategic narrative for ICPs in Lancashire and South Cumbria was approved by the ICS Board in December 2020

1.3. The Board also gave approval to proceed with Step 2 including:

- The creation and deployment of an ICP Maturity Matrix to support self and peer-assessments on the different levels of maturity in each ICP
- A number of 1:1 / small group conversations with system leaders from various sectors within the ICS
- Larger-scale sessions with primary care colleagues in response to specific feedback received via the LMC
- Four externally facilitated workshops – three linked to specific topics that were identified by the ICP Development Advisory Group as a result of feedback received during the development of the common ICP strategic narrative, and a final workshop to test the outputs of Step 2 before presentation to the ICS Board.

1.4 Building on the outputs of step 2, an ICP Development plan for 202/22 was developed focussing on 3 key areas:

- Overarching themes and success measures for places
- How we will organise ourselves to work together as partners
- Place Based Leadership & Implementation

1.5 The ICP Development Programme was approved by the ICS Board on 6th May, with oversight of delivery through the ICP Development Advisory Group (DAG).

2. An overview of the ICP Development Programme 2021/ 22

2.1. The ICS Board agreed to a two part approach for ICP Development from May 2021 to March 2022, outlined below:

- 1. Immediate actions to accelerate the development of place-based partnerships in the next 3 – 6 months - These actions were deemed unlikely to require external facilitation / support, but instead could be undertaken locally through sharing of good practice across the ICPs as identified through the ICP Maturity Matrix self-assessments and peer-to-peer reviews.

- 2. Proposals for the content of a broader development programme across the whole of 2021/22, linked to the more challenging aspects within the common ICP strategic narrative and informed as appropriate by national guidance. These are the areas where it was believed would require external facilitation / support and would be beneficial; and, where national guidance is expected and/or where there are significant interdependencies with the creation of the statutory ICS NHS body.

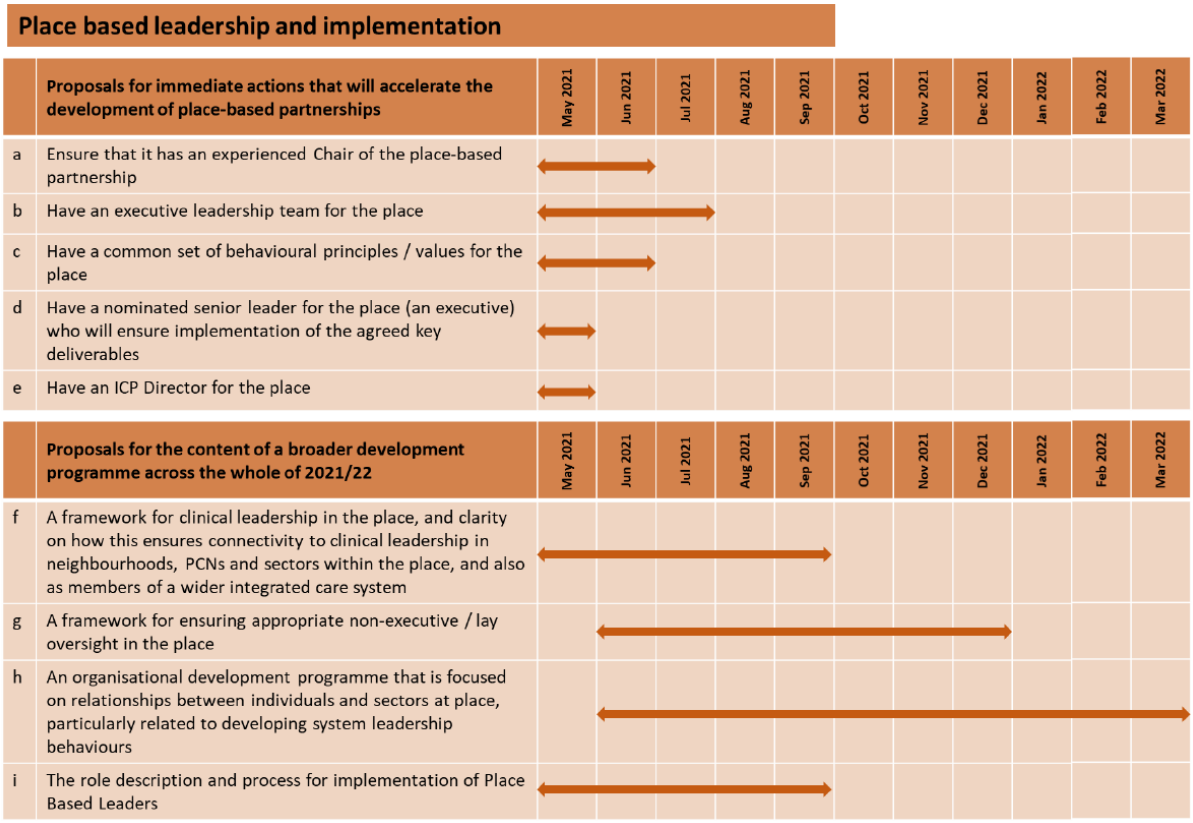
2.2. These two work programmes are working in parallel, and commenced in May 2021. A reminder of the content is contained below:

Overarching themes and success measures

	Proposals for immediate actions that will accelerate the development of place-based partnerships	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
a	Review and refresh the vision and aims for the place	←	—	→								
b	Create a local development programme	←	—	→								
c	Create and implement a local communications and engagement plan	Create	—	→	Implement	—	—	→				
d	Develop a balanced scorecard		Create	—	→	Refine & implement	—	—	→			
e	Develop a plan and mechanism for engaging local residents		Create	→	Implement	—	—	—	→			
	Proposals for the content of a broader development programme across the whole of 2021/22	**May 2021**	**Jun 2021**	**Jul 2021**	**Aug 2021**	**Sep 2021**	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
f	Developing an integrated approach to planning services across all sectors/partners in the place-based partnership	←	—	—	—	—	—	—	—	→		
g	Ensuring the implementation of the NHS System Oversight Framework connects with the balanced scorecard in each place, and also connects with all partners across the system and in places (i.e. beyond NHS organisations)		←	—	—	→						

How we will organise ourselves to work together as partners

	Proposals for immediate actions that will accelerate the development of place-based partnerships	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
a	Ensure that the place-based partnership has meaningful involvement of all partners	←	—	→								
b	Implement a partnership agreement between all partners	←	—	→								
c	Have a place-based partnership board	←	—	→								
d	Have formal place-based groups that have accountability for planning and delivering		←	—	→							
e	Adopt an open-door policy across organisational committees / groups	←	—	→								
f	Have a cross-organisational, multi-professional clinical and professional leadership body	←	—	—	→							
	Proposals for the content of a broader development programme across the whole of 2021/22	**May 2021**	**Jun 2021**	**Jul 2021**	**Aug 2021**	**Sep 2021**	**Oct 2021**	**Nov 2021**	**Dec 2021**	**Jan 2022**	**Feb 2022**	**Mar 2022**
g	An accountability framework, setting out what place-based partnerships will be accountable for delivering as members of a wider integrated care system		←	—	—	—	—	—	→			
h	A decision-making framework, considering a scheme of delegation from organisations to place-based partnerships to support integrated working		←	—	—	—	—	—	→			
i	A financial framework, including how place-based allocations will be made within the future integrated care system		←	—	—	—	—	—	—	—	—	→
j	A clear understanding of how place-based partnerships will generate a tangible sense of accountability to residents		←	—	—	—	—	—	→			
k	A clear understanding of how place-based partnerships fit within the governance of the integrated care system		←	—	—	—	—	—	→			



3. Progress made against the ICP Development Programme within place based partnerships in Quarter 1 and a look to Quarter 2

3.1. A significant amount of progress has been delivered against this ICP development programme since May individually within the five place based partnerships, in terms of the immediate actions, and the full progress update is outlined within the quarter 1 highlight report in appendix 1. This report shows the last monthly activity report by place based partnerships, noting within it the actions that are completed, or the RAG rating against those yet to be completed. It also shows the end quarter one updates for the specific actions. It is worth noting that across the five place based partnerships, they have collectively delivered 52 actions since delivery began in May 2021, with a further 27 actions in progress. The report provides more detail as to the progress of individual actions.

3.2. The second part of the report at appendix 1 contains the overview of actions set for delivery in quarter 2.

4. Progress made against the broader ICP Development Programme

4.1. The ICP Directors are supporting and leading on wider aspects of the broader development programme across the five place based partnerships. Outlined below is progress to date on some of the cross cutting programmes including Organisational Development (OD) and Place Based Partnership Governance Options Appraisal.

4.2. Organisational Development (OD) - The ICP organisational development programme will be focused on relationships between individuals and sectors at place, particularly related to developing system leadership behaviours. Working with the ICP Directors, the ICS System Talent, Organisational Development and Leadership Lead, is leading this programme under three defined phases over the coming months:

Scoping: June 2021

- To gain an understanding of work already ongoing in this space and who is doing it
- To agree goals, behaviours, aims, opportunities and quick wins
- To identify what is in and what is out of scope
- Agree a common set of behaviours principles and values of the place
- To provide OD support to the partnership agreement implementation (as required)

Diagnosing, Proposing and Socialising: July 2021 – August 2021

- To gain a full understanding of the current culture and the actions and development needed to achieve the things set out in the strategic narrative
- To map and align the people and cultural elements of the maturity matrix scores to proposed local development programme
- Support development of metrics for the balanced score card around leadership and capability (aligned to NHS E/I leadership compact and competencies)
- To engage as many relevant partners as possible in developing a clear picture of the "as is" and the "to be".
- To inform areas of focus for subsequent development plans
- To test thinking back out into place
- To engage and cite the DAG and the L&SC people board
- Interdependency mapping
- OD and leadership development plan proposal

Delivery Phase: September 2021 to March 2022

- To provide an OD programme that is focused on relationships between individuals and sectors at place
- To provide system leadership development and behaviours support
- To provide a place based leadership, action learning and coaching and mentoring offer
- To facilitate culture change in the ICPs in order to deliver the objectives set out in the strategic narrative

4.3. Place Based Partnership Governance Options - The *Integrated Care Systems: Design Framework* was published by NHS England in June 2021, with further guidance specifically related to the development of place based partnerships published in July 2021. The guidance sets out five place-based governance arrangements that could be established by the NHS ICS body in partnership with local authorities and other partners to jointly drive and oversee local integration. This is set out within appendix 2.

4.4. Through the ICP Development Advisory Group, an options appraisal on these five place based governance arrangements is being undertaken with wider engagement across the five place based partnerships to collate views. These options will be considered against a number of underpinning principles in line with the ICP Strategic narrative. This work will progress throughout quarter 2.

4.5. There are additional aspects within the broader development programme to be delivered across the whole of 2021/22, which are linked to the more challenging aspects within the common ICP strategic narrative including the development of: Financial Frameworks; Delegated Decision making; Workforce Frameworks; Governance. These work programmes will be informed as appropriate by national guidance throughout 2021/22 as it is published.

5. Place Based Integration – what we are delivering today at place

5.1. Alongside the ICP development programme across the five place based partnerships, each place continues to drive integration in the neighbourhoods and localities, driving the delivery of transformational change across the partners to make real, tangible benefits for our communities, neighbourhoods, citizens, patients and staff.

5.2. Outlined in appendix 3 are case studies across the five place based partnerships showcasing what has been delivered across Lancashire and South Cumbria in 2021, demonstrating that despite the challenges a national pandemic can bring and working within a significant amount of national and organisational change within the NHS and Local Government, the place based partnerships continue to drive integration for the benefits of our communities.

6. Recommendations for the ICS Board

6.1. The ICS Board is asked to:

6.1.1. Note the progress against the ICP Development programme for Q1 in 2021/ 22 outlined in section 3

6.1.2. Note the deliverables for Q2 outlined in section 3 and 4

6.1.3. Note the achievements in the place based partnerships on delivery of integration at place level in 2021/22, presented as case studies in appendix 3

Appendix 1

Highlight report containing;

- Progress update on Q1
- Overview of key deliverables in Q2

Appendix 2 Place Based Partnerships

Integrated Care Systems: design framework, published by NHS England, June 2021
Extract from section on Governance and management arrangements:

Appendix 3

Delivery of ICP Integration Case Studies

LSC ICS

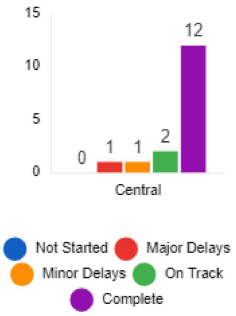
ICP Development Advisory Group Quarterly Update Report

Lancashire and South Cumbria Health and Care Partnership

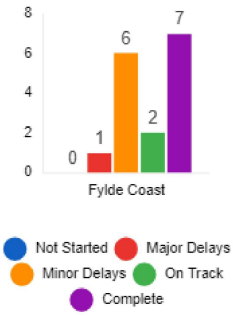
ICP Development - Summary

ID No	Scope, Objectives, Deliverables	Workstream Leads	Programme Status	Current Status
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 Minor Delays	
B01	**Develop and agree the ICP Strategic Narrative**	Vicki Ellarby		Complete
B02	**Develop and agree the ICP Maturity Matrix**	Sarah James		Complete
B03	**Develop and agree the scope the ICP Development Programme**	ICP Programme Directors		Complete
B04	**Overarching Themes and Success Measures for places**	ICP Programme Directors		In Progress but with minor issues/delays
B05	**How we will organise ourselves to work together as partners**	ICP Programme Directors		In Progress but with minor issues/delays
B06	**Place-based leadership and implementation**	ICP Programme Directors		In Progress but with minor issues/delays

ICP_Monthly Activity Report



ICP_Monthly Activity Report



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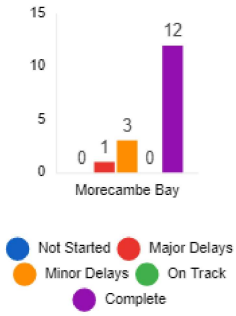

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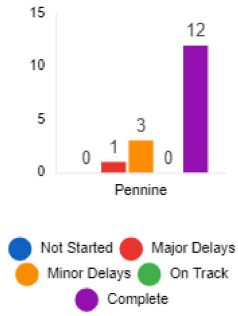
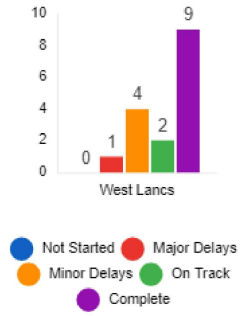


ICP_Monthly Activity Report



Quarter 1 Overview

ID No	Scope, Objectives, Deliverables	Quarters _ delivered within	Quarter End Updates	Deliverables by Quarter - RAG	Revised Quarter - delivered within
B04-1	Refreshed vision and aims for each place, with common elements across all	Q1 2021/22	Delays experienced in getting the Vision and Aims signed off at local Boards	In Progress - no significant impact to overall programme	Q2 2021/22
B04-2	Local development programme for each place	Q1 2021/22		Complete	
B04-3	Create local communications and engagement plan re development of place-based partnerships	Q1 2021/22	ICP PDs are working closely with the ICS Comms & Engagement Team to support the development of a collective Comms & Engagement framework whilst still supporting localised engagement.	In Progress - no significant impact to overall programme	Q2 2021/22
B04-4	Create plan for engaging residents in determining success measures of place-based partnerships	Q1 2021/22	Aligned with development of success measures for system and place; and with wider engagement activities across the system. Deadline to implement in June and complete end of October (same as Community Engagement Plan). Agreed a plan has been created, so on track.	In Progress - no significant impact to overall programme	Q3 2021/22
B05-1	Partnership agreement in each place (with core common content across all five places)	Q1 2021/22	Minor delays associated with obtaining sign off in places (due to scheduling of relevant meetings) and some places actually getting hard signatures. LSCFT/LCC will be one pack with 5 partnership agreements within it. Deadline of 30th September.	In Progress - no significant impact to overall programme	Q2 2021/22
B05-2	Place Based Partnership Board established in all five places	Q1 2021/22		Complete	
B05-3	Open-door policy deployed across organisational committees / groups	Q1 2021/22	Minor delays due to capacity issues within some ICPs. PW got in TOR to be signed off this time and others have included statement in partnership agreement.	In Progress - no significant impact to overall programme	Q2 2021/22
B06-1	Interim Chair in post for all five places	Q1 2021/22		Complete	
B06-2	Interim nominated senior leader in post for all five places	Q1 2021/22		Complete	
B06-3	ICP Director in post for all five places	Q1 2021/22		Complete	
B06-4	Common set of behavioural principles/values adopted across all five places	Q1 2021/22	Minor delays associated with obtaining sign off in places (due to scheduling of relevant meetings)	In Progress - no significant impact to overall programme	Q2 2021/22
B06-5	Scope requirements of organisational development programme	Q1 2021/22	Scoping work underway.	In Progress - no significant impact to overall programme	Q2 2021/22

Quarter 2 Overview

ID No	Scope, Objectives, Deliverables	Quarters _ delivered within	Quarter End Updates	Deliverables by Quarter - RAG	Revised Quarter - delivered within
B04-6	Implementation of local communications and engagement plan re development of place-based partnerships	Q2 2021/22			
B04-7	Create place-based balanced scorecard that aligns with system-level success measures and takes into account views of residents	Q2 2021/22			
B05-4	Develop draft MoUs between LSC Health and Care Partnership and place-based partnerships	Q2 2021/22			
B05-5	Formal place-based groups established with responsibility for planning and delivering using an integrated approach	Q2 2021/22			
B05-6	Clinical and Professional Leadership body established in all five places	Q2 2021/22			
B06-6	Role description and model for Chair of the Place-Based Partnership from April 2022 onwards	Q2 2021/22			
B06-7	Interim executive leadership team for the place, with members who hold lead director role responsibilities across the place for specific portfolios	Q2 2021/22			
B06-8	Define place-based leader role and process for appointment	Q2 2021/22			
B06-9	Model for clinical/professional leadership at place	Q2 2021/22			
B06-10	Create model for organisational development programme	Q2 2021/22			
B06-11	Organisational development programme commences	Q2 2021/22			

Appendix 2

Integrated Care Systems: design framework, published by NHS England, June 2021

Extract from section on Governance and management arrangements:

Place-based partnerships

"Partnerships between organisations to collectively plan, deliver and monitor services within a locally defined 'place' have a long history. These place-based partnerships have typically been established by local agreement according to their context and this bottom-up approach has been an important enabler to meaningful collaboration. However, as part of the development of ICSs, we now expect that place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health.

We have asked each system to define its place-based partnership arrangements, covering all parts of its geography, agreed collaboratively between the NHS, local government and other system partners working together in a particular locality or community.

There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. In the smallest ICSs, the whole system may operate as a single place-based partnership. The arrangements for joint working at place should enable joined-up decision-making and delivery across the range of services meeting immediate care and support needs in those local places but should be designed flexibly to reflect what works in that area.

The ICS NHS body will want to agree with local partners the membership and form of governance that place-based partnerships adopt, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support

The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership. Each ICS NHS body should clearly set out the role of place-based leaders within the governance arrangements for the body.

An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration:

- *consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners*
- *committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources**
- *joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation*

*** Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity.*

- *Individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies*
- *Lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place.*

Effective leadership at place level is critical to effective system working, but the specific approach is to be determined locally. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority."

Healthier Lancashire & South Cumbria

Delivering Integrated Care

Case studies and examples of partnership within the 5 place based partnerships in Lancashire and South Cumbria 2021

Mobilisation and delivery of pop up, pop in vaccination provision

ICP: - West Lancashire Partnership

Who: West Lancashire primary care, NHS West Lancashire CCG, West Lancashire College, Lancashire County Council, Lancashire Care NHS Foundation Trust, third sector.

What: Mobilisation and delivery of pop up, pop in vaccination provision in centres of community to address low vaccine uptake including those with underlying health conditions overdue their second dose.

How: Rapid mobilisation of a core group from the CCG and WLBC to plan and mobilise. Use of data to identify targeted populations and corresponding centres within the community (non clinical) for vaccine provision. Data sharing of targeted groups with underlying health conditions overdue their 2nd dose for conversations with staff trained in health coaching and MECC to encourage uptake. Co-ordination of the LCC vaccine bus and the LSCFT HARRI bus as part of the approach

Benefit to patients/community/ staff: In a 3 week period, 21 vaccine sessions were delivered totalling around 114 hours of vaccine session time. Over 1943 doses were given across West Lancashire.

Success in reaching underserved groups including asylum seekers and refugees and migrant workers.

WEST LANCASHIRE PARTNERSHIP

Science Summer School

ICP: - West Lancashire Partnership

Who: West Lancashire College & local schools, NHS West Lancashire CCG, Virgin Care

What: Delivery of the Brian Cox Science Summer School in Skelmersdale with over 400 young people in attendance, as the catalyst for a longer term programme on raising aspiration as part of tackling inequalities – linked to the ICP's aspiration as a teaching and learning Partnership

How: Collaboration with Well North Enterprises with Well Skelmersdale match funding investment secured from the 1851 Foundation to host, at West Lancashire College, the Brian Cos Science Summer School

Benefit to patients/community/ staff: Raising aspiration and giving young people exposure to future career pathways in STEM related areas, including health and care roles of the future.

For more information see https://wellnorthenterprises.co.uk/huge-success-for-science-summer-school-debut-in-skelmersdale/

Healthier Pennine Lancashire ICP, Together an Active Future (TaAF)

Who: Partners including: Sport England; Blackburn with Darwen Council; Burnley, Pendle, Rossendale, Hyndburn, Ribble Valley and Rossendale District Councils; District Leisure Trusts; Department for Work and Pensions; VCFSE groups.

What: Following a bid from the ICP, Pennine Lancashire was selected as 1 of 12 national Sport England Delivery Pilots to seek to address the issue that for the 1 in 4 people doing less than 30 mins physical activity a week, a different approach was needed. Following a successful pilot a further £7million investment has successfully been secured to support grass roots physical activity.

How:

- Creative engagement and involvement TaAF have learnt a lot and been successful in engaging and involving members of the public who haven't traditionally engaged with formal services
- Taken a "life course approach" to understanding how people's relationship with physical activity changes during the course of their lives and what impacts this
- Networks and connections established/strengthened in Districts that feel much more focussed on the wellbeing of people and communities
- Examples of successful programmes included:
    - Played a lead role in shaping the ICS Winter Campaign for Pennine Lancashire. Changed to be more personal, more positive and aspirational, connect better with the audience and ultimately encourage more people to be active as a way to help their wellbeing.
    - Active Lifestyles Hub - This hub is a shared way of working across Pennine Lancashire's 6 leisure providers, bringing together the best elements of the BwD re:fresh model and the East Lancashire's Up and Active model.
    - Creative Football - A number of different initiatives using Football in a positive way to engage people informally, anchoring football at the heart of relationships to understand and help with wider needs. The project won the FA Grassroots Football Organisation of the Year award.

Benefit to patients/community/ staff: Engagement with people for whom the current offer wasn't working, to facilitate access and improve their health and physical and mental wellbeing and reduce pressure on services.

Healthier Pennine Lancashire

"It was the first time for years that some-one had actually spoken to me as a person and saw me as a human being". This person had been sleeping on the floor of the hotel accommodation as he 'didn't feel worthy' of a bed.

"Sara's health and wellbeing have improved and she is now registered with a GP and accessing health support as required. Sara has been supported by the Homeless project and has now successfully obtained a home for herself and her children. She is now beginning to use her life experiences to help others who may be experiencing the same issues."

"Partnership working has come into its own through this work. The majority of people have grasped this opportunity by the horns and they have thrived, making real inroads into a transformation that is seeing them reducing and even coming out of addiction, some have now got relationships with their families for the first time in many years.

Healthier Pennine Lancashire ICP, Enhanced Homeless Health Offer Project

Who: Blackburn with Darwen and East Lancashire CCGs; Blackburn with Darwen Council; Lancashire County Council; Burnley, Pendle, Rossendale, Hyndburn, Ribble Valley and Rossendale District Councils; Pennine Lancashire INTs; East Lancashire Hospital Trust; Lancashire and South Cumbria Foundation Trust; Mental Health Services and Drug & Alcohol Services.

What: In Pennine Lancashire, we committed to providing an enhanced, holistic, proactive health provision to homeless people residing in Covid Secure and Protect accommodation, Temporary accommodation and those living in Homeless Hostels in line with the best practice model across Blackpool and Central Lancashire.

How: Utilising the INT provision and existing support already provided by our system partners and recruitment of a Band 6 Holistic Health Practitioner. The offer included a review of everyone on the homeless list; undertaking a holistic Health Needs Assessment and signposting or initiating an intervention as per individual need.

Benefit to patients/community/ staff: Over the last 13 months, a total of 634 initial contacts have been made with Homeless People from across Pennine Lancashire resulting in 264 Holistic Health Assessments being undertaken

The enhanced holistic homeless health offer project has been a huge success and had a number of positive outcomes for one of the most vulnerable cohorts of people across Pennine Lancashire.

This project has also led to improved partnership working between housing and health colleagues and also wider system partners including mental health, drug and alcohol services, probation and the community and voluntary sector.

Under 18 Alcohol/Substance Misuse Project

- **Who:** Barrow Integrated Care Community, The Well Communities, Furness Youth Work Partnership, CADAS, Barrow CAP, Barrow Police

- **What:** Reduce the number of children and young people attending hospital for alcohol/drug misuse

- **How:** Support parents where there are issues with alcohol/drug misuse. Support children & young people where there are issues with alcohol/drug misuse. Ensure any safeguarding concerns are shared with partners.

- **Benefit to patient/community**: Improved information and communication between partners to ensure safeguarding . Improved safeguarding outcomes for children and young people. Reduction in hospital admissions for alcohol misuse for under 18's. Children and young people are safer from harm and have their needs met. Engage schoolchildren and create pathways to support.

Frailty Coordination Hub

Who: UHMB – Integrated Community Care Group linking to NWAS, Primary Care, Social Care (Lancashire and Cumbria County Councils), Age UK

What: The Frailty Coordination Hub is a service provided by the UHMB Integrated Community Care Group that provides referrers with clinical decision making support aiming to enable patient choice, provide appropriate types of healthcare, avoid unnecessary admissions and support people in their own home.

How: The Hub operates 7 days a week, 8am – 8pm and is staffed by clinical specialist assessors and referral coordinators. Clinicians can ring the hub where admission avoidance is clinically appropriate. The hub can also be used if the clinician would welcome a supportive conversation or help to reach a decision and/or access support available in the community.

Benefit to patients/community/staff:

Since the service launched in December 2020, the Frailty Coordination Hub has taken 579 referrals from NWAS, Primary Care & community services and has avoided 469 admissions.

Helps keep patients at home with the support they need, avoids admission or conveyance to hospital. Provides advice & guidance - the Hub have access to EMIS, Lorenzo, NWAS patient record & social care information and can inform clinicians on status of referrals

"It's brilliant. I have been so impressed by this service - how quick and easy it is to refer patients who are in the precarious zone between home and hospital. Long may this service continue. Would have admitted patient to hospital if the Frailty Coordination Hub was not available" – GP, North Lancs

"Very easy to talk to and very helpful service. Saved a lot of phoning around different services to get the care I needed in place. Thank you. Would have admitted patient to hospital if the Frailty Coordination Hub was not available" – ANP Primary Care, Furness

Fylde Coast
Integrated Care Partnership

Young People's Self Harm Project

Image: Young Person's Distraction Box

ICP: - Fylde Coast

Who: Young People (YP), Parents/Carers (P/C's), HeadStart Programme, Blackpool Teaching Hospitals (BTH), Blackpool Council, Blackpool, Fylde and Wyre CCG, VCSFE partners.

What: YP and P/C's partnered with HeadStart's team of Resilience Coaches and colleagues at CAMHS to coproduce and pilot a self harm project for YP presenting at BTH A+E dept. with self harming behaviours. Evidence of successful outcomes has now led to BFW CCG funding the project for a further 12 months.

How: During YP assessments CAMHS colleagues in A+E offer YP and their families a referral to a Resilience Coach following their presentation. A whole systems approach based on Resilient Therapy for 8-12 weeks offering short term, focused actions including self identified goals, distraction boxes, coping strategies as well as connecting YP to support in the wider system i.e. schools, VCSFE, positive activities and supporting to attend CAMHS appts. Following CCG funding, the referral pathway now includes schools.

Benefit to YP and families: 82% of YP (64 out of 89) did not re-present to A+E following the end of their support.

Fylde Coast
Integrated Care Partnership

Fleetwood Post Covid Economic Recovery Project

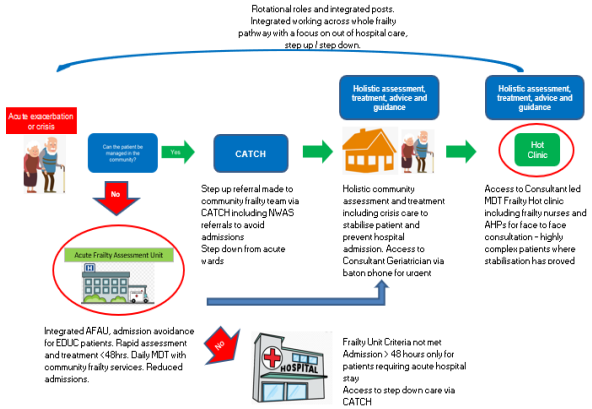
ICP: - Fylde Coast

Who: Fleetwood PCN, Wyre Council, Lancashire CC, VCSFE orgs, Primary and Secondary Schools, Regenda Housing Association, Lancaster University, Fleetwood Town Football Club Community Trust, Fleetwood Trust (owners of Fleetwood Community Hospital), Department of Work and Pensions.

What: A Resident led, multi-agency approach to reducing the economic impact, and hence the long term health impact, of Covid 19 across Fleetwood, with a focus on the 4 key domains of Data, Digital, YP employment and Adults recently made redundant.

How:Jointly funded by NHS England, PCN monies and Lancaster University research grant. A whole community approach to improving access to education, training and employment through further developing whole system working as well as the development of an adult education facility in the town, (Fleetwood Academy) based at Fleetwood Hospital, accredited by Lancaster University.

Benefits for people who live, work or volunteer on the FC:
Sustainable employment in a “good job” is one of the key factors in addressing health Inequalities and improving overall health and well being. In the first 6 months of the project , 24 YP have gained meaningful work experience with the aim of long term employment through the governments Kick Start programme in our local anchor institutions such as schools, community pharmacy, the urgent care sector, housing and the voluntary sector via Healthier Fleetwood.



Frailty Service

ICP: - *Central Lancashire*

Who: Close collaboration between LSCFT, NWAS,Age UK, Helping Hands, CCGs and LTHTR involving multiple professional groups.

What: Opened an acute frailty unit providing holistic care through multidisciplinary and integrated, cross organisational working to optimise patient independence, health and wellbeing, and quality of life.

How: Integration of the Acute and Community frailty teams, through the BIG room supported by QI

Benefit to patients/community/ staff:

- Excellent clinical care (time to consultant review 4.4 hours)
- Improved patient experience
- Improved identification of frailty
- Integrated working across community and hospital settings
- Reduction in length of stay (average LOS 86 hours)
- Direct admission for NWAS
- Improved awareness of frailty within all sectors.

North West Ambulance Service NHS Trust

Lancashire & South Cumbria NHS Foundation Trust

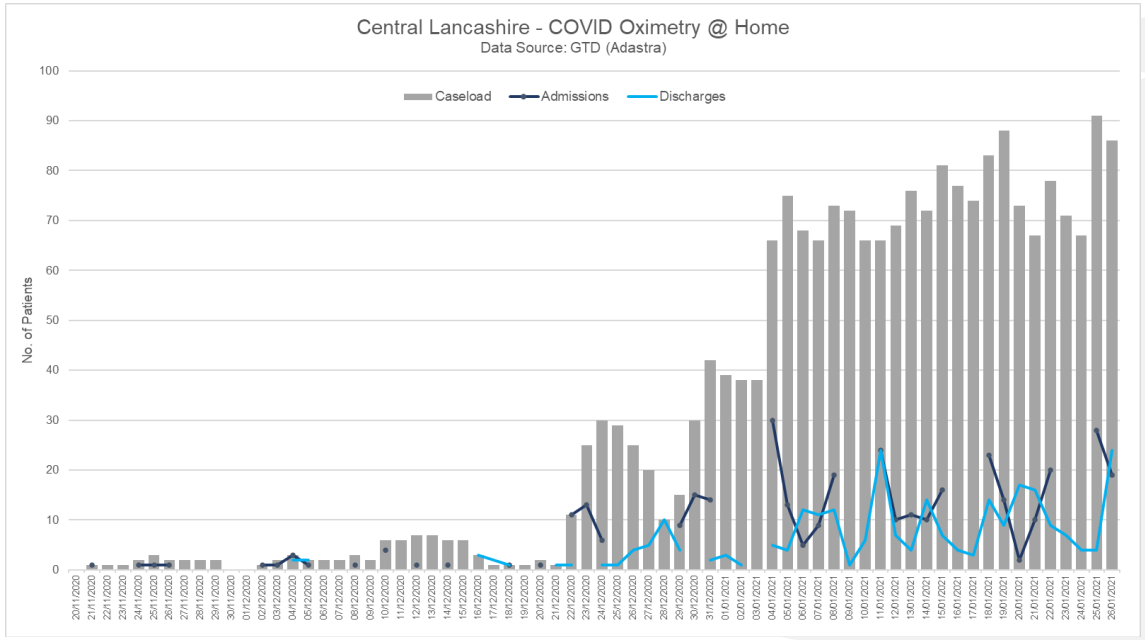
Lancashire Teaching Hospitals NHS Foundation Trust

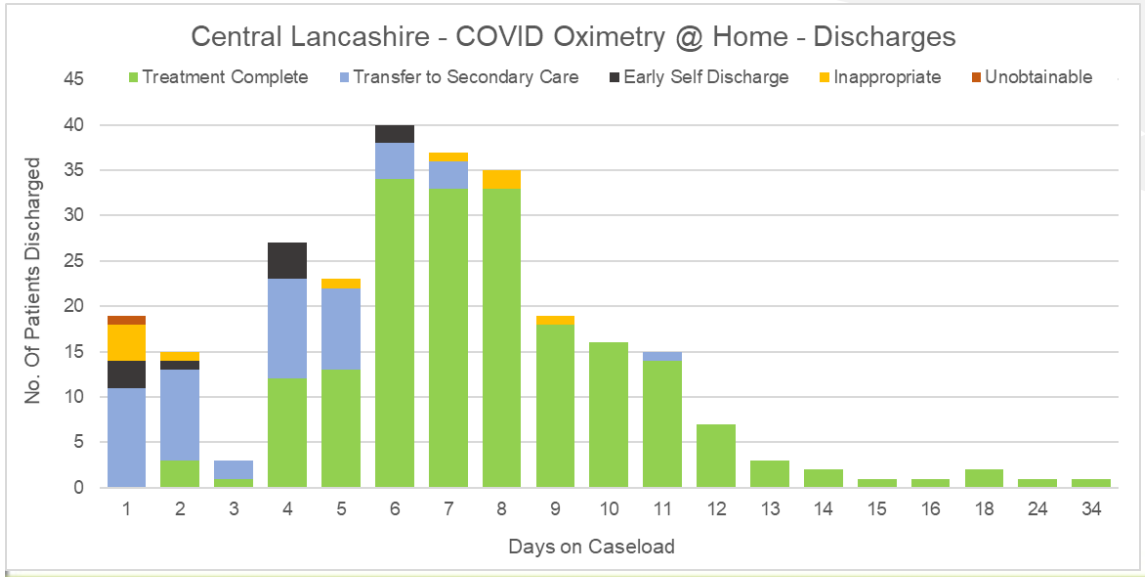
Helping Hands Caring since 1989

age UK

Chorley and South Ribble Clinical Commissioning Group
Greater Preston Clinical Commissioning Group

OUR Central Lancashire





COVID Pulse Oximetry @ home

ICP: - *Central Lancashire*

Who:

- Primary Care GPs
- Patients
- Hospital Consultants
- Hospital managers
- Community managers
- Go To Doc (GTD) out of hours provider
- NWAS

What:

Risk stratified pathways for monitoring and escalation

Patients considered ‘moderate risk’ in the community, are safely managed at home by regularly monitoring their oxygen levels, heart rate & symptoms

How: Developed by multiagency agreements

Benefit to patients/community/ staff:

Remote monitoring, patients are monitored daily (usually 3 times a day) by a team from GTD healthcare, who are available 24 hours per day, 7 days per week

Cases of deterioration can be identified at an earlier stage, thereby providing treatment promptly in the hospital setting if required

Lancashire and South Cumbria
Health and Care Partnership

ICS Board

Date of meeting	**1st September 2021**
Title of paper	**Place and strategy of VCFSE within the ICS and ICP structures of Lancashire and South Cumbria**
Presented by	**Peter Armer – Chair of Lancashire and South Cumbria VCFSE Alliance**
Author	**As above**
Agenda item	**11**
Confidential	**No**

Purpose of the paper
This paper is designed to brief the ICS Board on work completed to date in shaping the Lancashire and South Cumbria VCFSE sector, and the VCFSE strategy and "next level" planning
Executive summary
The L&SC VCFSE Alliance has been developing toward a position and structure that will allow VCFSE organisations to take part in, and make valuable contribution to, emerging health and social care structures. This has resulted in the VCFSE Alliance developing a "Four Pillars" model, with each pillar describing an area of responsibility to the sector and responsibility to the health and social care system. In addition to responsibility, each pillar represents opportunities for the VCFSE sector to make an enormous contribution, particularly with its knowledge of communities and the issues that affect our communities, especially those groups of citizens that are seldom heard or hard to reach. This will be an enormously important contribution as we address the wider determinants of health and health inequalities. The Four Pillars around which the VCFSE is developing its plans are: (1) Voice, (2) Influence, (3) Engagement, and (4) Representation. The paper goes on to describe the sector's "Next-Level" planning process, and how the sector will develop specific plans to meet the needs on the respective ICPs and how plans will adapt to the characteristics of places in which we operate.
Recommendations
The ICS is asked to endorse the VCFSE planning process and comment on work to date and the plans for future development
Governance and reporting (list other forums that have discussed this paper)

Meeting	**Date**	**Outcomes**
ICP DAG	**21st July 2021**	**Paper endorsed**

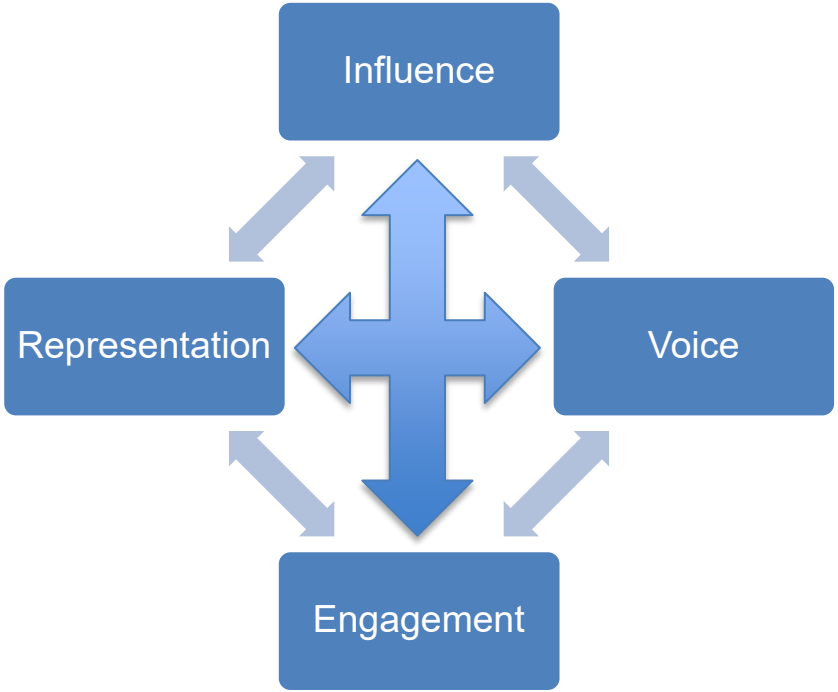
Conflicts of interest identified
None

Lancashire and South Cumbria
Health and Care Partnership

VCFSE – Position within emerging health and social care structures

The L&SC VCFSE Alliance

The VCFSE Alliance Four Pillars.

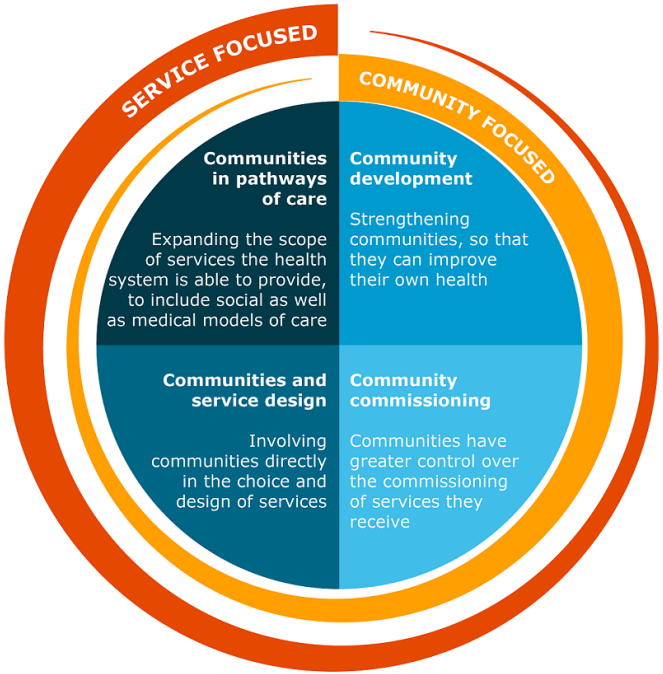


VOICE – speaking up, speaking out and speaking for.

- Community voice – to ensure the voice of our communities is heard across decision making powers and where services are planned and delivered.
- Articulate needs of communities – to tell the stories that help the issues come to life.
- Speak up for those who are “Seldom Heard”, ensuring their voices are listened to and respected equally.
- Create opportunities for VCFSE organisations voices to be heard, however large or small they are.
- Use our collective voice to influence the narrative around Health and Social Care.
- Articulate the activities, reach and impact of the VCFSE so the Health and Social Care sector understands and recognises our work and achievements.

INFLUENCE

- We will influence the priorities of the Lancashire & South Cumbria Health and Social Care Sector
- Through building connections with the VCFSE and communities we will influence strategy across the Health and Social Care system
- We will use our expertise to influence the delivery of health and social care and repair the fragmentation within the system.
- The allocation of resources will be influenced by us articulating the needs of communities
- The health and wellbeing outcomes of people and communities will be positively influenced by telling the stories of our people and communities and realigning resources based on needs.



ENGAGEMENT

- We will provide guidance and expertise on engaging with people and communities across the Lancashire and South Cumbria Health and Social Care System
- We will act as an enabler or catalyst to engage more effectively with residents at ‘place’
- We will provide mechanisms for engagement with VCFSE organisations, large and small within the Health and Social Care system
- We will enable collaboration and partnership across the VCFSE sector; leading by example and operating in an inclusive way
- We will demonstrate the value and strength of VCFSE partnerships through stories and examples from across the sector
- We will engage with colleagues across the Health and Social Care System in a transparent and consistent way, through and agreed set of values

REPRESENTATION

- We will ensure that all representatives of the VCFSE have a mandate to act as a representative and a clear understanding of their role
- We will ensure there are opportunities to identify representatives from across the VCFSE sector, who can bring with them the knowledge, skills and experience to represent the VCFSE
- We will represent VCFSE organisations in each ICP area, across Health and Social Care structures
- We will represent the needs of our communities in decision making forums with the aim of ensuring the VCFSE is an equal partner in decision making across the health and social care system

Next steps for the VCFSE Alliance

- To co-produce a “next level” plan based around the four pillars
- To further develop activity at place to fully integrate the VCFSE within each ICP
- To use ICS/ICP matched funding for VCFSE Alliance development, of £5k per ICP, to further plan and articulate VCFSE activity and contribution
- To lever in additional resources to deliver the next level plan over the next 3-5 years
- To produce a maturity matrix against the plan identifying key actions and development areas
- To continue to work closely with our communities to identify emerging health and care needs as we recover from the pandemic

Next steps for the VCFSE Alliance

The Lancashire and South Cumbria VCFSE Alliance Leaders' Group has presented a view of its current position within the emerging system reform planning process. We have articulated our responsibility and ambition for: -

1) Speaking up for our communities, for VCFSE organisations, for "seldom heard" elements of our communities, and ensuring these messages are heard and recognised as system reform takes place.

2) Influencing H&SC priorities and strategy, influencing delivery of care, influencing allocation of resources, and positively influencing outcomes.

3) Engaging with communities at place, engaging with all providers in the system, engaging with VCFSE organisations. Engaging to bring strength to the sector through collaboration.

4) Representing – VCFSE organisations and communities.

- ***We ask the ICS to: -***
- ***Endorse the four pillars and associated content, and recognise that this is the VCFSE Alliance "offer" to the place-based partnerships within Lancashire and South Cumbria***
- ***Recommend that these plans form part of key activities within the ICS development plan and ICP development plans, both in each ICP and collectively across the five ICPs.***

Next steps for the VCFSE Alliance

- The “Four Pillars” document has received wide approval from VCFSE Alliance Leaders. Each Alliance leader will now take the plan back into their ICP VCFSE regional groups to use as a basis for “next level” planning. Next level plans will be prepared on an ICP-by-ICP basis and will detail actions under each element of the Four Pillars. These plans will be explicit about how we will work with partners, including PCN’s and Acute Trusts, and will be strong on principles such as equality, diversity and inclusivity, community engagement, etc.

- Peter Armer will attend as many Alliance “Next Level” launch events as possible, to allow demonstration of unity and consistency across the ICS. The aim is to complete next-level plans by the end of September and bring the Alliance Leaders team back together during the first week in October, thereby allowing comparison and calibration of plans. It is intended that Next-Level plans from each of the five VCFSE Alliance teams will be presented to ICP DAG on 20th October 2021. At this meeting ICP DAG will be asked to review the plans for depth, detail, appropriateness, fit with System Reform strategy, and affordability.

- VCFSE Alliance Leaders felt that they should have the freedom to develop their own plans, rather than having a centrally mandated template, as they have the best and most detailed knowledge of characteristics of their ICP regions. However, to avoid individual plans omitting activities which are known to be important to system reform, Peter Armer has agreed to prepare a document of “Key Themes” which will be shared and discussed among Alliance Leaders and will act as a guide to the elements for inclusion in Next-Level plans.

Next steps for the VCFSE Alliance

Voice

- Community voice – in parallel with PCN's, local authorities, and other partners who connect with communities and citizens
- Articulate needs of communities – how?
- Channelling information gathered by VCFSE organisations in our "places"
- How will you provide opportunities for other VCFSE voices to be heard, however large or small the organisation?
- VCFSE voice to ICS and ICP's concerning issues in the health and social care system, and identifying areas for improvement or action
- Collectively influence ICP agendas and ensure consistent application across the five ICP's
- Collective agreement of priorities, rolling over time – this will be in conjunction with ICP colleagues, so you need to articulate your strategy for achieving this
- VCFSE voice when dealing with other organisations and bodies in the H&SC system, e.g. LEP, LLP, etc.
- Voice of the "Seldom Heard", as these are the groups suffering from the greatest inequalities – how will you identify and engage with these groups?

Next steps for the VCFSE Alliance

Voice

- Voice of the ICS and ICPs to the VCFSE sector – how will you ensure consistency and provide channels of communication?
- Clear articulation of activities of VCFSE sector to ensure the H&SC sector understands and recognises the work and achievements of the sector – make a clear statement on how you will do this via your seat on the ICP board

Next steps for the VCFSE Alliance

Representation

- The VCFSE Alliance provides an opportunity to identify representatives from across the VCFSE sector – what are the arrangements in your ICP region for election of Alliance leaders/officers?
- The Alliance represents VCFSE organisations in each ICP area, across H&SC structures – how do we ensure we are seen by all VCFSE organisations as the “door” to the emerging H&SC system?
- The Alliance provides an opportunity to bring together representatives of the VCFSE sector to form collective viewpoints and responses – how will you ensure we have a consistent and transparent forum in order to achieve this?
- VCFSE representatives need a mandate to act on behalf of VCFSE sectors in their ICP region – how will you achieve this mandate?
- We represent our communities – how do we ensure our communities know about us, what we do, and what we can do for them?
- How do we represent the “Seldom Heard”, and those who are subject to greatest inequalities of health, e.g. BAME, LGBQ+, etc.
- The VCFSE Alliance has the power to elect an independent chair to sit on the ICS Board to represent the interests of the VCFSE sector and provide ICS level leadership – how will this person be appointed and what are the terms of appointment?

Next steps for the VCFSE Alliance

Influence

- Influencing policies, strategies, and structures in line with community needs – how will you achieve this?
- Influencing priorities in H&SC sector for L&SC
- Influence direction of the H&SC sector as we collectively respond to emerging requirements
- Influencing the H&SC sector on behalf of the whole VCFSE sector
- Influencing allocation and realignment of resources to address the requirements of our communities
- Influence health and wellbeing outcomes
- Relate stories and examples of lived experiences to ICP's and ICS

Next steps for the VCFSE Alliance

Engagement

- Provides a forum for engagement with VCFSE organisations within the H&SC system – How?
- How will you enable collaboration and partnership across the VCFSE sector in your ICP region?
- How will you "sell" the Alliance to VCFSE organisations, thereby ensuring the ICP has all VCFSE capability at its disposal?
- Creating opportunity for engagement across the whole spectrum of VCFSE organisations
- Engaging with local infrastructure organisations to ensure consistency and reach of message
- Provide expert guidance on how best to engage with people and communities
- How will we champion change, thereby engaging more effectively in our places?
- There will be an increasing occurrence of projects that cut across the five ICP's, with current examples being PHM, First Response Service (mental health), Community Mental Health Transformation. You will need to articulate how you will engage with these cross-cutting projects, how you will secure the necessary resource, and clarify the benefits the VCFSE sector can bring to these projects

Lancashire and South Cumbria

Health and Care Partnership

Web healthierlsc.co.uk | **Facebook** @HealthierLSC | **Twitter** @HealthierLSC

ICS Board

Date of meeting	**1 September 2021**
Title of paper	**New Hospitals Programme Quarter 1 Board Report**
Presented by	**Jerry Hawker, Programme SRO**
Author	**Jerry Hawker, Programme SRO**
Agenda item	**12**
Confidential	**No**

Purpose of the paper

For information.

Executive summary

The purpose of this report is to provide an update on the New Hospitals Programme for the quarter 1 period, April – June 2021.

The report includes progress on the revised governance, progress against plan including the key products to support business case development along with the public, patient and workforce communications and engagement activities underway.

This quarterly report is presented to the following Boards;

- University Hospitals of Morecambe Bay FT
- Lancashire Teaching Hospitals FT
- East Lancashire Hospitals Trust
- Blackpool Teaching Hospitals FT
- Lancashire & South Cumbria FT
- Integrated Care System (ICS)
- Provider Collaborative
- And the Strategic Commissioning Committee.

Recommendations

It is recommended the Board;

- Note the progress undertaken in Q1.
- Note the development of the products to support business case development (section 5).

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	✓			A NHP risk register has been developed and discussed at the NHP Strategic Oversight Group
Are associated risks detailed on the ICS Risk Register?			✓	

Report authorised by:	Jerry Hawker

Lancashire and South Cumbria
Health and Care Partnership

NEW HOSPITALS PROGRAMME Q1 BOARD REPORT

1. Introduction

1.1 This report is the 2021/22 Quarter 1 update from the New Hospitals Programme (NHP).

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.

3 Programme governance and risk

3.1 During Q1 an internal review was undertaken of the current governance arrangements including feedback from a range of executive and non-executive directors. A set of recommendations were proposed to streamline decision making whilst strengthening

non-executive involvement. The recommendations were approved by boards leading to a revised governance structure being implemented in August 2021. To support this new way of working, a governance advisory group is now meeting monthly with attendance from the Trust Executive Director leads and nominated Non-Executive Directors from UHMB, LTHTR and the Strategic Commissioning Committee. In addition a monthly drop in for Non-Executive Directors to meet with the SRO and Programme Director is now established.

3.2 All working groups and oversight groups are now mobilised with representation from across the ICS including lay member representation on the Communications and Engagement Oversight Group.

3.3 During Q2, MIAA (Mersey Internal Audit Agency) will begin working with the NHP to undertake an independent review of the programme governance arrangements. This will include completion and agreement to a decision making matrices in line with programme and statutory body governance frameworks as well as that of the PCBC and SOC process.

3.4 The programme has a fully populated risk register and risk management processes in place with working groups taking ownership for allocated risks and associated mitigations. The full risk register is reported to the Programme Management Group on a monthly basis with risks scoring 15 and above reported to the SOG each month.

4 National New Hospital Programme – NHSEI, DHSC

4.1 In May 2021 the NHP presented the draft Case for Change and Communications and Engagement Plan to a NHSEI stage 1 assurance panel. This strategic sense check provided useful feedback and guidance for the NHP, particularly with regard to strengthening the Case for Change in the context of the ICS vision and strategy. The panel confirmed their support for the NHP to proceed to developing a PCBC.

4.2 In June 2021, the Programme received an update from the national team. The salient points are as follows:

a) Continued aim to create a national programme, consolidating learning and facilitate continual improvement in the support provided to schemes

b) Commitment to delivering the whole programme (40 new hospitals) by 2030 with the provisional assessment of timings for the L&SC scheme being construction starting in the period January 2025-September 2026 and completion between 2027-2030.

c) Specific timeline, including expected business case preparations and submission dates to be determined along with future funding aligned to the required pace of delivery.

5 Progress against plan (for the period April – June 2021)

5.1 Programme scope

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. Significant progress is being made to ensure close alignment between the Provider Collaborative Board and the New Hospitals Programme.

5.2 **Key products to support business case development –** During Q1 a number of key products were developed and reviewed by the SOG prior to being presented to statutory bodies for approve/information as required. These products represent key building blocks in the development of the PCBC and SOC, including the process and methodology that supports progressing from a long list of proposals to the final short list of options to be included in the PCBC and SOC. Statutory Bodies are not required to approve all these products, but the programme has ensured that all statutory boards and committee members have been engaged, sighted and supportive of them recognising the final business cases will be constructed using them. Each product has been subject to significant engagement, input and challenge from all the NHP working and oversight groups and was presented to SOG with their support. The products are:

5.3 **Case for change** – members will be well sighted on the progress made on the Case for change over this period. Following approval by the SOG (29th April 2021) and the SCC (13th May 2021), the case for change was presented to NHSEI stage 1 assurance. Our case for change was subsequently updated responding to feedback

from NHSEI stage 1 assurance and key stakeholders. The final document was approved by SCC at its meeting held in public on 15th July 2021. Agreed communications and engagement activities are now underway.

5.4 **Communications and engagement strategy and plan** – members will be familiar with the communications and engagement strategy having received a presentation on the approach at the Board to Board held earlier in the year. Feedback from a wide variety of stakeholders resulted in a strengthened strategy which was approved by the SOG (29th April 2021) and SCC (13th May 2021) ahead of presenting to the NHSEI stage 1 assurance panel. This was well received by the panel with minor amendments required. NHSEI and colleagues from the Department of Health and Social Care remain linked in via established relationships, working and oversight groups. The plan is now well underway.

5.5 **Framework model of care** – clinical leads have worked alongside external partners to develop a framework model of care. This is the clinical vision and outlines the aspirations for what future care should look like within our hospitals. The document will be iterative throughout the course of the programme. The latest version of the framework model of care will be presented to the Clinical Oversight Group (COG) and SOG in August 2021. Given this is interdependent with the work of the Provider Collaborative Board (PCB), work is underway ensure alignment. Finally, the North West Senate will undertake an informal review of the framework. This is in the role of critical friend to help support the NHP to further develop the document ahead of a formal Senate review as part of NHSE stage 2 assurance.

5.6 **Key assumptions –** A robust set of assumptions have been developed combining local intelligence and National guidance and will be used to develop the long list of proposals and associated sizing and costing of hospital facilities. The assumptions include the key outputs from the demand and capacity modelling. These phase 1 working assumptions were approved by SOG on 9th July 2021. It is worth noting that:

a) These assumptions do not include planned or future service reconfiguration in line with the agreed scope of the programme – SOG agreed to the principle that these are included once any formal consultation is complete.

b) Some assumptions require wider system commitment to delivery e.g. Investment in Integrated Community services / Intermediate Care services etc.

5.7 **Long list of proposals –** A long list of proposals have been developed exploring different scenario's around new builds (new site), rebuilds (existing sites) and refurbishment. These have been used to support our understanding of the feasibility of different approaches and continued discussions with the National team on aligning potential options with affordability and deliverability. The long list of proposals have been shared with the SCC and used to support Board discussions with LTHTR.

5.8 **Critical Success Factors (CSFs) –**The CSF's help to provide a framework for assessing all proposed options against the Case for Change, National ambitions/requirements and our local ambitions and objectives. CSFs will be used to underpin the process to appraise the long list of options to determine a shortlist to be carried forward to the PCBC.

5.9 It is important the Board notes the strong interdependency between the Programme assumptions and critical success factors and the requirement to demonstrate that all options included in the business cases are affordable, clinically viable and deliverable.

6 Programme timeline

6.1 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.

6.2 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.

7 Public, patient and workforce communications and engagement

7.1 A number of key communications, involvement and engagement activities got underway this period namely:

a) Colleague summit – attended by c1000 attendees over 2 events. Colleagues from across L&SC received and update on the NHP and dedicated time for questions and answers with a panel made up of senior leaders from across L&SC.

b) The Big Chat – as at 25th June 2021 this online workshop had received contributions equivalent to 80+ workshops. The first phase of the Big Chat closed

early July and has now launched with new themes for discussion focused around the case for change. Subsequent conversations will focus on proposals and appraisal criteria. The Big Chat is open to all NHS staff across L&SC along with the Trust membership and governors from UHMB and LTHTr.

c) Healthwatch workshops – to meet our ambition to involve a wider audience, Healthwatch has launched a series of small workshops and outreach focusing on those who are digitally excluded, marginalised, harder to reach groups and people representing protected characteristics groupings.

d) Finally, the launch of proactive promotions of the brand and social media channels went live this period:

- New Hospitals Programme website
- like the New Hospitals Programme on Facebook
- follow the New Hospitals Programme on Twitter

8 Board development

8.1 Following an initial joint Boards session (UHMB and LTHT) in Q4 2020/21, subsequent Board developing sessions (separate and joint) were held this quarter. Boards focused on the case for change and draft long list of proposals with a focus on the capital funding available and how best to maximise this in addressing the case for change. These were highly engaged sessions with broad alignment demonstrated.

9 Dependencies

9.1 Members will recognise that with any complex programme such as this there are many dependencies and interdependencies. This period, the NHP has focused on understanding these aligned to the demand and capacity assumptions and programme risks. As a reminder, at business case stage the NHP can only proceed with options that are affordable, clinically viable and deliverable. The NHP therefore has dependency relationships including but not limited to a-d below.

a) Successful and timely delivery of out of hospital services.

b) Successful and timely delivery of planned or future service reconfiguration and associated clinical models.

c) Agreement to the capital funding available.

d) Depending on c above and any resulting scenarios requiring new sites/land, there is a dependency on land availability.

9.2 A series of mitigation actions have been agreed to manage the dependencies and interdependencies including; alignment of the NHP work with the Provider Collaborative and discussions with the national programme team etc.

10 Stakeholder management

10.1 The Board will recognise there will be a breadth of stakeholders in such a programme. During Q1, there has been the launch of proactive internal and external communications including stakeholder updates with MPs and local authorities. A report was submitted and presented to the Cumbria Health Overview and Scrutiny Committees (HOSC) in July 2021 and an informal update with the Lancashire Scrutiny Officer was held. Formal engagement is underway with MPs across the region with a focus on the case for change and the process the NHP is following. In addition, the NHP has progressed discussions with the Lancashire Local Enterprise Partnership (LEP) Health Sector Board and the programme is looking forward to working with Board partners over the coming period.

11 Next period – Q2 2021/22

11.1 The next quarter will see significant progress in translating the key products developed in Q1 into the PCBC/SOC (subject to options). The next quarter will also be crucial in our negotiations with the National team regarding finalizing the capital envelop.

12 Conclusion

12.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 1 2021/22.

13 Recommendations

13.1 The Board is requested to:

- Note the progress undertaken in Q1.
- Note the development of the products to support business case development (section 5).

Rebecca Malin
Programme Director
July 2021

Jerry Hawker
Programme SRO