Lancashire and South Cumbria
Health and Care Partnership

Formal Integrated Care System (ICS) Board

2 March 2022, 10.00 am – 12.30 pm

Via MS Teams Videoconference

Agenda

Item	Description	Owner	Action	Format
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Declarations of Interest/Conflicts of Interest relating to the items on the agenda	Chair	Note	Verbal
3.	Minutes of previous formal ICS Board meeting held on 12 January 2022, Matters Arising and Actions	Chair	Approve	Attached
4.	Key Messages	Andrew Bennett	Note	Verbal
Managing 2021/2022				
5.	ICS Finance Report	Sam Proffitt	Discuss/ Note	Attached
Building the system for 2022/23 and beyond				
6.	System Operational Planning 2022/23 – System Planning and Financial Framework	Sam Proffitt	Endorse	Attached
7.	Lancashire and South Cumbria Infrastructure Strategy 2022	Gary Raphael	Endorse	Attached
8.	New Hospitals Programme – Quarter 3 Report	Jerry Hawker	Discuss / Note	Attached
9.	System Reform Programme Update	Andrew Bennett	Discuss / Note	Attached
10.	Mental Health, Learning Disability and Autism System Transition Board	Andrew Bennett / Steve Christian	Discuss / Note	Attached
Items for information only				
11.	Lancashire and South Cumbria System Development Programme – Highlight Report	-	Note	Attached
12.	Lancashire and South Cumbria Health and Care Partnership - Programme Summary Report	-	Note	Attached
Routine Items				
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: Wednesday, 4 May 2022, 10.00 am to 12.30 pm, MS Teams videoconference				

Development of the Integrated Care System
Key terminology visual attached

Lancashire and South Cumbria Integrated Care System (ICS)

NHS ENGLAND

NHS England will set strategic aims and priorities and will continue to commission some services at a regional level, providing support to the NHS bodies working with and through the ICS. NHS England will also agree ICBs' constitutions and hold them to account for delivery.

CARE QUALITY COMMISSION

Independently reviews and rates the ICS.

STATUTORY ICS

LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD (ICB)

The most recent national guidance states that this is the new NHS organisation that will be established on 1 April 2022, subject to the Health and Care Bill (2021) being passed. We expect this is likely to be known publicly as "NHS Lancashire and South Cumbria" and will be accountable for NHS spend and performance and responsible for the day-to-day running of the NHS in Lancashire and South Cumbria.

CROSS-BODY MEMBERSHIP, INFLUENCE AND ALIGNMENT

LANCASHIRE AND SOUTH CUMBRIA HEALTH AND CARE PARTNERSHIP

The broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. The partnership will enable partners to plan for the future and develop strategies using available resources creatively in order to address the longer term challenges which cannot be addressed by a single sector or organisation alone.

INFLUENCE

INFLUENCE

LANCASHIRE AND SOUTH CUMBRIA PARTNERSHIP STRUCTURES

System
Covers a population of 1.8m

Provider collaboratives

Service providers will be collaborating at the various different levels of system, place and neighbourhood according to need. National guidance has been published and a Provider Collaborative Board (PCB) has been established to enable partnership working of the acute, mental health and community providers across Lancashire and South Cumbria.

Place
Covers a population of 114,000 to 566,000

Place-based partnerships

Planners and providers working together across health, local authority and the wider community, to take collective responsibility for improving the health and wellbeing of residents within a place.
Our five place-based partnerships are Pennine Lancashire, West Lancashire, Fylde Coast, Morecambe Bay, Central Lancashire.

Neighbourhood
Covers a population of 30,000 to 50,000

Primary care networks

Most day-to-day care will be delivered here. Neighbourhoods will develop to bring together partners across health and social care to deliver integrated care and may align with Primary Care Networks.

Some of the information in this summary is subject to the Health and Care Bill (2021) being passed in Parliament.
A detailed glossary for Lancashire and South Cumbria is available on our website: **Lancashire and South Cumbria glossary of language**

Lancashire and South Cumbria
Health and Care Partnership

Subject to ratification at the next meeting

DRAFT Formal Meeting of the ICS Board

Minutes of Meeting	
Date	Wednesday, 11 January 2022
Venue	Microsoft Teams Videoconference
Chair	David Flory

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Andrew Bennett	Interim ICS Lead	Lancashire and South Cumbria ICS
Jane Cass	Director of Strategic Transformation / Locality Director	NHS England and NHS Improvement NW
Gary Raphael	Executive Director	Lancashire and South Cumbria ICS
Talib Yaseen	Director of Transformation	Lancashire and South Cumbria ICS
Sam Proffitt	Director of Provider Sustainability/ ICS Director of Finance	Lancashire and South Cumbria ICS
Roger Parr	Interim Director of Performance	Lancashire and South Cumbria ICS
Jane Scattergood	Interim Director of Nursing and Quality	Lancashire and South Cumbria ICS
Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Carl Ashworth	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Kevin McGee	Chief Executive Officer	Lancashire Teaching Hospitals NHS Trust
Trish Armstrong-Child	Chief Executive Officer	Blackpool Teaching Hospitals NHS Foundation Trust
Aaron Cummins	Chief Executive Officer	University Hospitals of Morecambe Bay NHS Foundation Trust
Martin Hodgson	Interim Chief Executive Officer	East Lancashire Hospitals NHS Trust
Graham Burgess	Chair	NHS Blackburn with Darwen CCG
Peter Gregory	Chair	NHS West Lancashire CCG
Roy Fisher	Chair	NHS Blackpool CCG
Jackie Moran (representing Claire Heneghan)	Director of Strategy and Operations	NHS West Lancashire CCG
Geoff Jolliffe	Chair	NHS Morecambe Bay CCG
Denis Gizzi	Chief Officer	NHS Central Lancashire CCGs
Cllr Graham Gooch	Cabinet Member for Adult Services/County Councillor	Lancashire County Council
Karen Smith (representing Neil Jack)	Director of Adult Services	Blackpool Council
Derek Houston (representing John Readman)	Senior Manager – Health and Care Integration	Cumbria County Council
Mike Wedgeworth	Non-Executive Director	Lancashire and South Cumbria ICS
Ian Cherry	Non-Executive Director	Lancashire and South Cumbria ICS
Isla Wilson	Non-Executive Director	Lancashire and South Cumbria ICS
Eileen Fairhurst	Provider Collaborative Board Representative	East Lancashire Hospitals NHS Trust
David Blacklock	Chief Executive Officer	Healthwatch Cumbria and Lancashire
Dr Stephen Hardwick	Primary Care Provider Professional Representative	Local Medical Committee
Caroline Donovan	Chief Executive Officer	Lancashire and South Cumbria Foundation Trust

In Attendance		
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Nathan Hearn	Partnership and Integration Manager	North West Ambulance Service
Pam Bowling	Corporate Office Team Leader	Lancashire and South Cumbria ICS
Becky Higgs	Business Manager	Lancashire and South Cumbria ICS
Maria Louca	Executive Assistant to David Flory and Andrew Bennett	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Office Co-Ordinator (Minute Taker)	Lancashire and South Cumbria ICS
Public Attendees		
3 public attendees		

Routine Items of Business

1. Welcome, Introductions and apologies

The Chair welcomed everyone to the formal meeting of the Integrated Care System (ICS) Board held virtually via MS Teams. No questions had been received relating to the agenda in advance of the meeting. Members were made aware that this meeting was being recorded.

Apologies had been received from Peter Armer, Denise Park and Jackie Hanson.

The Chair commented on the continuing significant pressures facing the health and care system and thanked all staff and leaders for the work undertaken.

The Chair continued that the Government had recently announced a new target date of 1 July 2022 for establishment of the ICB and dissolution of CCGs. Whilst the reasons for this were recognised, it was acknowledged that this would prove an extra demand on current CCG Governing Bodies and on staff. Discussions were being held with CCG Chairs about how business would continue within statutory bodies in the first quarter of 2022/23, with further discussion to be held at the Strategic Commissioning Committee meeting later this week. It was expected that the ICB would operate in shadow form, prior to the change in statutory responsibilities, enabling a more streamlined beginning for the ICB as a statutory body on 1 July 2022.

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

RESOLVED: No new declarations of interest or conflicts of interest relating to items on the agenda were declared.

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

Subject to an amendment to remove 'Cllr' from 'Cllr Graham Burgess' in item 7, the minutes of the previous meeting were approved as an accurate record, seconded by Roy Fisher,

RESOLVED: The minutes of the meeting held on 3 November 2021 were approved as a correct record subject to this amendment.

Action Log – There were no open actions on the action log.

4. Key Messages

Andrew Bennett (AB) explained that today's meeting would be framed within the context of services under pressure, winter demand and the level 4 national incident due to the pandemic. Numbers of people in hospital had increased and a substantial team effort was underway across all partners represented at this meeting. In

response, a range of activities were taking place to create additional capacity including 'Lancashire and South Cumbria Together', an initiative whereby partners look at flow and discharge, ensuring a range of services are available for access when needed.

It was highlighted that clear communication for members of the public and communities must be maintained to remind people that the NHS and Local Authority services remained open.

RESOLVED: Members noted the verbal report.

Managing 2021/2022

5. Winter Situation Report

Carl Ashworth provided an update on the current operational position across the system and offered assurance to the Board on the actions taken across L&SC in response to NHS directives.

The report provided a 'snapshot' of the system as at 4 January 2021 and many of the issues highlighted in the report had now been resolved. As the nation was now at incident level 4, the paper also focussed on providing assurance to the Board on how pressures in the system were being managed and how actions taking place compared to the national guidance received in December 2021. The system was working well together to oversee, manage and deliver a response to Covid and other winter pressures, and was being developed dynamically with initiatives such as the 'Lancashire and South Cumbria Together' work.

Provider organisations provided the following updates:

Lancashire and South Cumbria NHS Foundation Trust had seen the Covid position spike before Christmas, earlier than acute sector colleagues, resulting in high levels of staff sickness absence, people waiting for beds and challenges regarding right to reside. The service remained fragile with a slight improvement being seen in some areas with a lot of partnership working and transformation focus.

University Hospitals of Morecambe Bay had experienced increased pressure since Christmas, largely driven by staff absence up to around 14-15% in the previous week. Teams were praised for their response in terms of providing cover and working differently. The work undertaken to reduce 'not meeting the criteria to reside' to improve flow had started to have an impact and The Bay had agreed to use facilities in a different way, with some sites taking patients from others to improve flow. Meetings were taking place to ensure surge plans were delivering, whilst also protecting urgent elective requirements.

Kevin McGee provided an update from a system perspective across Lancashire and South Cumbria. Approximately 550 acute beds were currently occupied by Covid-positive patients and ITU capacity was under pressure. Partners across the system including community, primary care and social care were working well on the safe discharge of patients. Additional capacity was required outside of hospitals with Covid virtual wards and additional internal capacity had been identified across acute providers, which could be utilised if numbers translated into more hospitalisation. The Nightingale Hub in Preston would provide up to 100 extra beds. The Joint Cell was monitoring the situation and Gold Command was working to provide mutual aid amongst partners, ensuring the system was kept safe and staff supported. Urgent work was being maintained and the Burnley site had been ringfenced to maintain routine work. It was noted that all partners were pressured by staff absence and systems were working incredibly well together.

Martin Hodgson, East Lancashire Hospitals NHS Trust, reported that Dr Amanda Doyle, NW Regional Director, had written to acute trusts setting out six priority areas. The number of Covid positive patients admitted had increased significantly over the last week and A&E continued to be busy. Work was taking place on admission avoidance between acute medicine and the emergency department, and communication with staff was emphasised to help to retain morale. Staff sickness levels had reached 10-13%.

Blackpool Teaching Hospitals NHS Foundation Trust had continued with the emergency response, with key focus being to ensure staff testing was turned around quickly to free up workforce. Focus continued on the virtual ward, keeping people well and safe outside of hospital. The importance of maintaining staff morale was recognised and Trish Armstrong-Child highlighted the exemplary partnership working that had taken place across all organisations in the system.

Geoff Joliffe (GJ) reported continued high demand in primary care and prioritisation of patients as appropriate. There were workforce issues in both clinical and non-clinical staffing due to sickness absence. The CCG had increased support in primary care for bronze, silver and gold schemes.

Peter Gregory reported that winter access funded schemes and implementation of the contingency plan had contributed to West Lancashire practices remaining stable whilst under significant pressure. Issues relating to testing were improving. The Regional Director, Dr Amanda Doyle, had written to the Primary Care Network Clinical Directors about how primary care could support discharge and reduce admissions which had generated a positive reaction with some simple pragmatic ideas being worked on by primary care staff.

In the Vaccination Programme over 900,000 booster vaccines had been administered and people continued to present for first doses. Immunisation of 5 to 11 year olds had begun, 12 to 15 year olds were due the second dose and 16-17 year olds were now able to receive the booster. There was a focus on engagement and outreach with the easy to ignore communities and to those not formally identified as housebound. Modest numbers were accessing vaccine via drive-through sites. It was noted that the programme was currently compromised by staff absence, however, capacity continued to exceed demand.

Andy Curran added that the Covid Medicine Delivery Units (CMDU's) were being stepped up, to prevent people from becoming ill and taking pressure off acute services.

Karen Smith (KS) commented on the strong system working between the Local Authorities across Lancashire and South Cumbria and at local system level. Pressure remained on packages of care and with care at home providers. However, some capacity was now being found in Blackpool and the Fylde Coast, aided by the holiday season having ended. Care home beds that had been closed over the Christmas period were now opening. There were high levels of Covid outbreaks in Blackpool and on the Fylde Coast and mutual aid had been provided for test results and capacity. Additional work had been undertaken around prevention of admission.

Cllr Gooch reported that Lancashire County Council were keen to get people out of hospital, into care homes and their own homes, however, there were delays in patients receiving assessments. There was some capacity in residential care, however staffing was an issue. Efforts were being made with staff recruitment.

Jane Cass highlighted expected pressure over the coming weeks around the mandatory requirement for vaccination of NHS staff. The Joint Cell had discussed the likely impact and an active programme was being undertaken to support staff, allowing informed choice. Training packs were available for line managers to support staff. In order for NHS staff to be able to continue to work in patient facing areas, they would need to receive their first vaccine by 3 February 2022.

Derek Houston also highlighted Covid outbreaks in care homes in Cumbria County Council, causing issues for safe discharge from hospital. Work was underway in supporting staff regarding vaccinations as 10-15% of staff were currently not double vaccinated.

The Chair acknowledged the outstanding efforts people were undertaking across the system, recognising from discussion that the system was working together as effectively as possible.

RESOLVED: ICS Board members noted the current operational position across the system and the actions taken across Lancashire and South Cumbria in response to the guidance received.

6. ICS Finance Report

Sam Proffitt presented the report and provided an update on the latest reported financial position (month 8), an assessment of the risks and details on the actions required to ensure financial recovery.

A balanced plan for H2 had been submitted to Region and at this stage the ICS was forecasting delivery of the planned position. There was a high level of risk within this position and as such Directors of Finance and Chief Financial Officers had been assigned to lead the work to mitigate the individual risks and support continued delivery of the plan.

The year-to-date position was currently showing a deficit of £5m which was £1.3m better than the year-to-date profiled plan. The key headlines of the position were explained.

SP continued that work was ongoing to turn non-recurrent schemes into recurrent plans with system wide schemes being put in place for the future. Expenditure was being closely monitored and a monthly meeting focussed on mitigation of the plan. Individual meetings were also being held with Directors of Finance to understand the recurrent/non-recurrent position, run rates and the end of year position. The report for the next meeting would include a report on criteria, priorities and focus on saving to enable a more strategic approach to finances.

RESOLVED: Members noted the ICS Finance Report.

Building the system for 2021/22 and beyond

7. National Planning Guidance for 2022/23 and ICS Planning Process

Sam Proffitt (SP) and Carl Ashworth (CA) provided an update to members on the 2022/23 planning guidance, revenue and capital allocations for L&SC and the approach to be taken to the development of the LSC ICS system operational plan.

The '2022/23 priorities and operational planning' guidance was published on 24 December 2021 and continued to support a system-based approach to operational planning for the whole of 2022/23 with a focus on restoration, recovery and transformation at a time of continued management of Covid related demand. A L&SC ICS approach to the development of a system operational plan for 2022/23 was agreed at the December meeting of the System Leaders' Executive. Timescales for the final plan submission had been extended to the end of April 2022, with draft plans due mid-March 2022.

Systems were being asked to focus on 10 priority areas. NHS Trusts would be individually mapped to a single system and the system must achieve breakeven. The system plan submission would be the source of information for the integrated care board 2022/23 budget and revenue allocations were due to be issued for 2023/24 and 2024/25. Trusts would continue to be required to submit operational plans which must be in line with their system plan.

This 3-year revenue allocation would enable more opportunity to look at longer term savings. The allocation for the system was reported as £3.2bn, plus £300m for primary care and £32m running costs for the ICB. Other primary care services and specialised commissioning were outside of this and at this stage, held with NHS England/Improvement, however, it was planned for specialised commissioning to be handed down to the ICB in the future. Systems would continue to receive a Covid costs allocation but this would be reviewed going forward in terms of scaling down. The system would also receive £52m service development funding to support delivery of the NHS Long Term Plan commitments.

It was confirmed that a process had been put in place to develop the L&SC ICS system operational plan for 2022/23 in line with the required timescales. Further technical guidance and templates were due in early January and an update would be brought back to the February meeting of the Board.

RESOLVED: The ICS Board:-

- Noted the requirements set out in the operational planning guidance for 2022/23 and the need to submit draft plans by mid-March and final plans by the end of April.
- Endorsed the planning process agreed with SLE.

8. System Reform Programme Update

Andrew Bennett provided the Board with an update on the work of the L&SC ICS Development Oversight Group and highlighted the change in the national timeline for the new statutory arrangements to 1 July 2022, to allow additional time for the legislation to progress. Collective arrangements already in place would continue in the interim, including the Strategic Commissioning Committee and Provider Collaborative Board, however, in light of the refreshed timeline and additional guidance expected, plans would be kept under review. Staff would be kept informed of timelines.

Graham Burgess (GB) suggested that more thought be given to centralising functions as CCGs were becoming very fragile and he would be raising this at the forthcoming meeting of the Strategic Commissioning Committee in terms of some form of enhanced responsibility for the Committee.

RESOLVED: The ICS Board noted the report, updating on the current system development programme.

Items for Information Only

9. Lancashire and South Cumbria System Development Programme – Highlight Report

RESOLVED: Members received the highlight report for information.

Routine Items

10. Items to forward for the next ICS Board meeting

There were no items notified.

11. Any Other Business

There was no other business.

Date and time of the next formal ICS Board meeting:
Wednesday, 2 March 2022, 10 am – 12.30 pm, MS Teams Videoconference

Integrated Care System Board

Date of meeting	**2nd March 2022**
Title of paper	**ICS Finance Report - Financial Position Month 10**
Presented by	**Sam Proffitt, ICS Executive Director of Finance**
Author	**Sam Proffitt**
Agenda item	**5**
Confidential	**No**

Purpose of the paper
For noting.
Executive summary
This paper reports on the month 10 financial performance for the L&SC system. It covers the revenue and capital positions of all the 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		

Lancashire and South Cumbria
Health and Care Partnership

ICS Finance Report - Financial Position Month 10

1. Introduction

This paper provides an update on the latest reported financial position, an assessment of the risks and provides details on the actions required to ensure the system can achieve its 2021/22 financial targets.

2. Current Financial Performance

As at month 10, the ICS is reporting a year-to-date deficit of £0.4m which is £5.2m better than the year-to-date profiled plan and a £0.9m improvement on month 9.

This favourable year-to-date variance is mainly due to the H1 variance at NWAS (£2.7m) for the receipt of income not assumed or confirmed at the time of planning, There is also a £2.2m favourable variance at UHMB due to elective restoration costs being less than planned and efficiency schemes being ahead of plan. All CCGs are delivering to plan.

The ICS continues to forecast delivery of the planned outturn position. Detailed discussions with DoFs and CFOs are continuing to take place to assess the level of risk within the current forecast and monitor the actions taken to mitigate these risks.

The year-to-date and forecast outturn summary position is provided in **Table 1** below and the ICP performance is provided in **Table 2**.

Table 1 – Summary financial position for month 10

Financial Position Overview - M10						
Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan £m	Actual £m	Variance to Plan £m	Plan £m	FOT £m	Variance to Plan £m
CCGs	(0.0)	(0.0)	(0.0)	0.0	0.0	(0.0)
NHS Providers	(5.6)	(0.4)	5.2	(2.3)	0.0	2.3
System Financial Performance	**(5.6)**	**(0.4)**	**5.2**	**(2.3)**	**0.0**	**2.3**

Table 2 – ICP financial position for month 10

System performance Surplus / (Deficit) - M10						
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)	0.0	0.1	(0.0)	(0.0)	(0.0)
Fylde Coast ICP	(0.0)	(0.3)	(0.2)	(0.0)	(0.0)	(0.0)
Pennine Lancashire ICP	(0.2)	(0.2)	0.0	(0.0)	0.0	0.0
Morecambe Bay ICP	(2.4)	(0.2)	2.2	(0.0)	0.0	0.0
West Lancashire MCP	0.0	0.0	0.0	0.0	0.0	0.0
North West Ambulance Service NHS Trust	(2.2)	0.7	3.0	(2.3)	(0.0)	2.3
Lancashire and South Cumbria NHS FT	(0.7)	(0.5)	0.2	(0.0)	(0.0)	0.0
ICP Financial Performance	**(5.6)**	**(0.4)**	**5.2**	**(2.3)**	**(0.0)**	**2.3**

3. Efficiencies

The month 10 efficiency performance is shown in **Table 3**. Savings of £45.7m have been delivered so far in H2 which is £7.6m behind plan. Of this, £13.1m is recurrent and £32.6m is non-recurrent. The H2 forecast is to deliver £78.5m of savings, which is £6.9 behind plan and a £5m deterioration since month 9.

Full year savings of £129m (H1 and H2 combined) are forecast to be delivered which is £12m less than plan (£5.1m H1 and £6.9m H2).

Table 3 – Efficiency performance by ICP at month 10

Efficiencies : CIPS / QIPPS - M10										
Organisation	H2 Year to Date					H2 Forecast Outturn				
	YTD Plan £m	YTD Recurrent £m	YTD Non-Rec £m	TOTAL £m	Variance to Plan £m	H2 Plan £m	Forecast Recurrent £m	Forecast Non-Rec £m	TOTAL £m	Variance to Plan £m
Central Lancashire ICP	10.8	3.2	6.3	9.5	(1.3)	17.2	4.7	12.5	17.2	0.0
Fylde Coast ICP	7.8	1.2	6.6	7.8	0.0	13.1	5.1	8.0	13.1	0.0
Pennine Lancashire ICP	13.0	1.7	9.7	11.4	(1.6)	19.8	4.1	13.4	17.5	(2.3)
Morecambe Bay ICP	11.0	5.1	3.6	8.7	(2.4)	19.2	8.0	9.5	17.5	(1.7)
West Lancashire MCP	2.0	0.3	0.0	0.3	(1.7)	3.0	1.3	0.0	1.3	(1.7)
North West Ambulance Service NHS Trust	3.6	0.8	2.8	3.6	0.0	5.4	1.5	4.0	5.4	0.0
Lancashire and South Cumbria NHS FT	5.0	0.9	3.5	4.4	(0.6)	7.5	1.4	5.0	6.4	(1.1)
ICP Performance	**53.3**	**13.1**	**32.6**	**45.7**	**(7.6)**	**85.3**	**26.1**	**52.3**	**78.5**	**(6.9)**

Only £38m (30%) of the savings year-to-date are recurrent and £91m (70%) are non-recurrent. This has been a key focus in the monthly assurance meetings with Trusts with a requirement that plans are fully in place by the end of the year to replace the non-recurrent action with recurrent savings.

Of the £78.5m of savings forecast to be delivered in H2, £17.3m (22%) are still unidentified which has improved again from last month's position of £20.9m (25%). The ICP position on unidentified efficiencies is shown in **Table 4** below.

Table 4 – Unidentified efficiencies by ICP at month 10

Unidentified Efficiencies - M10				
Organisation	H2 Forecast Outturn			
	Identified £m	Unidentified £m	TOTAL £m	Unidentified %
Central Lancashire ICP	14.5	2.7	17.2	15%
Fylde Coast ICP	11.1	2.1	13.1	16%
Pennine Lancashire ICP	8.5	9.0	17.5	51%
Morecambe Bay ICP	14.7	2.8	17.6	16%
West Lancashire MCP	0.5	0.9	1.3	66%
North West Ambulance Service NHS Trust	5.4	0.0	5.4	0%
Lancashire and South Cumbria NHS FT	6.4	0.0	6.4	0%
ICP Performance	***61.2***	***17.3***	***78.6***	***22%***

4. Run-Rate Monitoring for providers

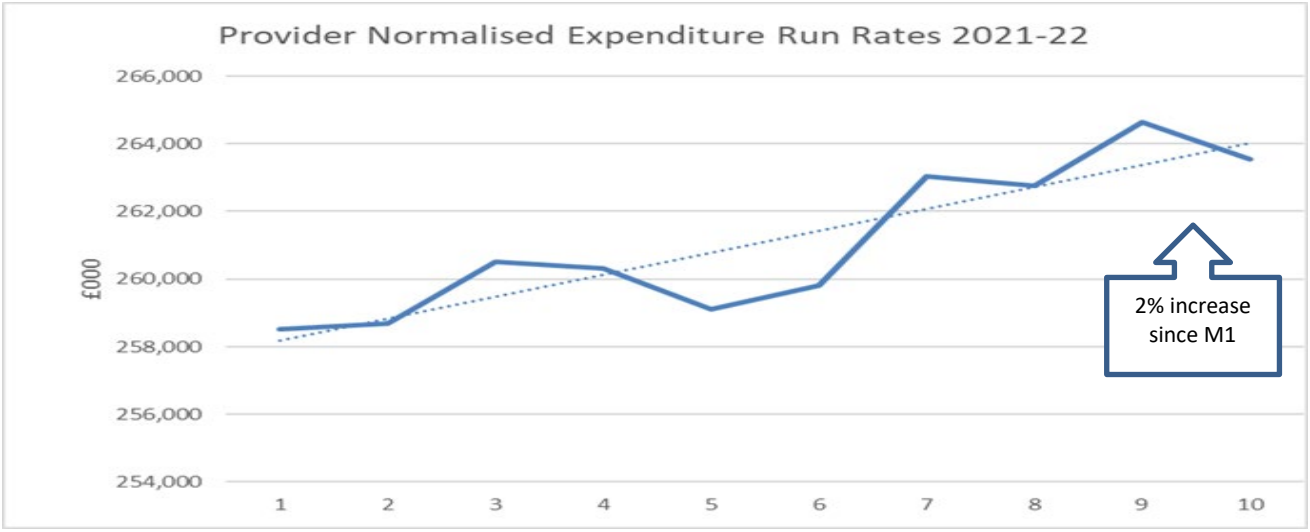
The ICS undertakes a monthly collection of run-rate data to help understand the monthly financial performance of each of the Trusts and to demonstrate the impact of the efficiency programme or other actions taken. The provider summary data for months 1 to 10 is shown in **Table 5** below and the total is shown graphically in **Chart 1**.

The data shows a 2% increase since the start of the year. Normalised costs in month 10 are £4m more than the month 1-6 average and £1m less than month 9. The increase in H2 is partly planned, including winter pressures, CQC related costs and the upward trajectory of mental health investments. In addition, there have been unplanned increases driven by enhancements being paid to specific staff groups to cover significant sickness pressures caused by the Covid surge in January, and these are expected to continue through February and March.

Table 5 – Run-rate data for providers for months 1 to 10

By Organisation	Monthly Run-rate Data										% change since M1
	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	M06 £m	M07 £m	M08 £m	M09 £m	M10 £m	
Blackpool Teaching Hospitals NHS FT	45.7	45.6	47.0	46.0	46.1	46.3	47.5	47.6	48.6	48.5	6%
East Lancashire Hospitals NHS Trust	53.5	53.1	53.1	53.0	52.8	53.0	53.4	53.8	54.0	53.7	0%
Lancashire and South Cumbria NHS FT	35.9	35.7	36.1	35.6	35.4	35.3	36.4	36.4	35.8	36.8	3%
Lancashire Teaching Hospitals NHS FT	54.7	54.6	55.1	55.6	55.8	54.9	55.8	54.7	55.9	54.8	0%
North West Ambulance Service NHS Trust	32.8	33.3	32.8	33.2	32.4	33.0	32.0	32.4	32.7	32.3	-1%
University Hospitals of Morecambe Bay NHS FT	35.9	36.5	36.3	37.0	36.7	37.3	38.0	38.0	37.6	37.5	4%
NHS Provider Total	258.5	258.7	260.5	260.3	259.1	259.9	263.1	262.9	264.6	263.6	2%

Chart 1 – Total run rate data for providers for months 1 to 10



5. Capital

There is a year-to-date underspend against the capital allocation of £22.9m (25%). The forecast position still remains to spend the full £112m allocation. The current levels of capital spend by provider is shown in **Table 6**.

Table 6 – Charge against Capital Allocation at month 10

Charge against Capital Allocation - M10						
Capital	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance to Plan	Plan	FOT	Variance to Plan
	£m	£m	£m	£m	£m	£m
Blackpool Teaching Hospitals NHS FT	17.4	9.8	7.6	21.8	19.9	1.9
East Lancashire Hospitals NHS Trust	9.0	9.9	(1.0)	12.4	14.3	(1.8)
Lancashire and South Cumbria NHS Foundation Trust	6.4	6.1	0.3	8.4	13.2	(4.8)
Lancashire Teaching Hospitals NHS Foundation Trust	20.2	17.7	2.5	23.5	21.9	1.6
North West Ambulance Service NHS Trust	14.6	9.1	5.6	16.9	15.3	1.6
University Hospitals of Morecambe Bay NHS Foundation Trust	24.2	16.2	8.0	29.0	27.5	1.5
	91.8	**68.9**	**22.9**	**112.0**	**112.0**	**0.0**

In addition to the capital allocation, a total of £73.6m of nationally funded capital schemes will be spent by the end of the year bringing our net CDEL to £185.6m. A detailed review and analysis for each capital plan indicates that this will be spent in year with only £2.4m of LIMS funding being deferred until 2022/23, It is essential that Trusts now deliver their forecast spend levels against both allocation and CDEL. The current levels of net CDEL spend by provider is shown in **Table 7**.

Table 7 – Charge against net CDEL at month 10

Charge against Net CDEL - M10						
Capital	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance to Plan	Plan	FOT	Variance to Plan
	£m	£m	£m	£m	£m	£m
Blackpool Teaching Hospitals NHS FT	27.3	21.8	5.5	42.3	40.4	1.9
East Lancashire Hospitals NHS Trust	17.8	17.2	0.6	28.6	30.4	(1.8)
Lancashire and South Cumbria NHS Foundation Trust	18.1	14.9	3.2	20.7	25.5	(4.8)
Lancashire Teaching Hospitals NHS Foundation Trust	25.9	22.7	3.2	40.3	38.7	1.6
North West Ambulance Service NHS Trust	14.6	9.6	5.1	19.1	17.4	1.6
University Hospitals of Morecambe Bay NHS Foundation Trust	26.8	18.7	8.1	34.6	33.1	1.5
	130.6	**104.9**	**25.7**	**185.6**	**185.6**	**0.0**

6. Risks

As previously noted, the System Finance Group (SFG) agreed that individual CFO/DoF's would take an oversight role on the actions required to mitigate the risks identified during planning. Progress updates are monitored at the SFG meetings. Significant progress has been made and work is continuing to ensure the system delivers the required mitigating actions to address the remaining planning risks.

There continues to be a reduction in the level of risk across most of the mitigation plans, which have moved form a red rating to amber assessment in most cases. The largest risk area remains the unidentified gap of £22m but a number of solutions are being developed to close this and enable the system to meet the year-end financial targets. This is continuing to be monitored at the SFG and individual 1:1 assurance meetings with organisations.

7. ICS Central Functions

An update on the financial position for ICS central functions is provided in **Table 8**. As anticipated, the underspend on the nationally funded budgets is now reducing as schemes are implemented across the system. We are continuing to work to identify natural slippage to help mitigate the system risks previously identified and are therefore forecasting that these budgets will be fully utilised.

Table 8 – ICS Central functions summary financial position

ICS Central Functions - M10							
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	261	198	63	313	313	0
	Enabling Functions	1,493	1,539	(46)	6,810	6,810	0
	Executive Functions	2,129	2,173	(44)	2,560	2,560	0
	Other Support Functions	308	349	(42)	369	369	0
		4,191	4,259	(68)	10,052	10,052	0
Nationally Funded Budgets		9,613	7,948	1,665	11,539	11,539	0
System Funded Budgets		687	421	266	824	824	0
	TOTAL	**14,490**	**12,628**	**1,862**	**22,415**	**22,415**	**0**

8. Recommendations

The Board is requested to discuss and note the contents of the report.

Sam Proffitt
ICS Executive Director of Finance
21 February 2022

Integrated Care System Board

Date of meeting	2nd March 2022
Title of paper	System Operational Planning 2022/23 System planning and financial framework
Presented by	Sam Proffitt
Author	Sam Proffitt, Carl Ashworth
Agenda item	6
Confidential	No

Purpose of the paper
To inform ICS Board on the development of system operational plans for 2022/23 and to seek support for the framework within which plans are being developed
Executive summary
In line with the system approach to the development of 2022/23 operational plans agreed with SLE, this presentation provides the ICS Board with an update and recommendations on: • Proposed system planning framework • Proposed system financial framework • Proposed role of SLE at a system check and challenge session
Recommendations
The ICS Board is asked to: • Note the process and timeline for the development of system operational plans • Endorse the proposed system planning framework • Endorse the proposed system financial framework • Support the proposed role of SLE at a system check and challenge session

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

Meeting	**Date**	**Outcomes**
• **System operational planning group**	**07/02/2022**	**Supported**
• **SFG**	**11/02/2022**	**Supported**
• **SLE**	**16/02/2022**	**Supported**

Conflicts of interest identified
None

Lancashire and South Cumbria
Health and Care Partnership

NHS

System Operational Planning 2022/23
System planning and financial framework

ICS Board
2nd March 2022

System approach to 2022/23 planning round

For the development of 2022/23 operational plans, we agreed:

- Continued leadership via System Leaders Executive
- Three strand approach to managing the planning process:
  - System planning team for system oversight - blending and synthesising central imperatives/priorities, place-based/PCB priorities and LA perspectives into an overarching system plan
  - Provider collaborative planning team to ensure
    - consistency across trusts
    - PCB priorities and perspectives are influential in the planning process and
    - communication is coordinated
  - Finance/contracting team to enable financial flows, revenue/capital budgets and contracts to be prepared for 2022/23 taking into account H2 plans and incorporating the requirements of the general planning effort for 2022/23

For discussion with the ICS Board today

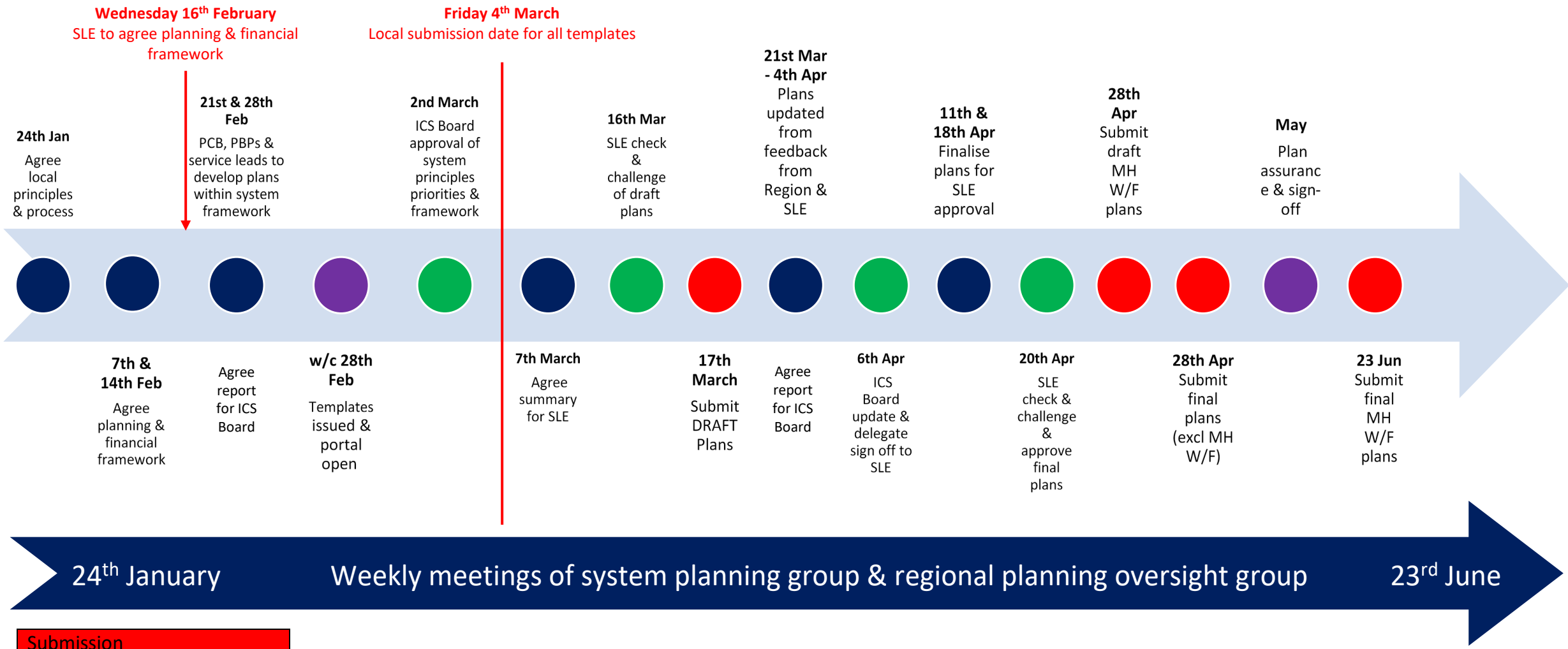
This presentation is intended to update the members of the Board on the process and timeline for the development of system operational plans and to seek support for:

- Proposed system planning framework
- Proposed system financial framework
- Proposed role of SLE at a system check and challenge session on the 16th March

Operational planning 2022/23

Process and timeline

2022/23 Lancashire & South Cumbria ICB Planning Process Map



Operational planning 2022/23

Developing the system planning framework

Developing the planning framework

The planning framework set out on the next slide has been constructed by the system planning group as follows:

- The 10 priorities of the national operational planning guidance have been mapped against the four aims of the new ICB
- Against each ICB aim, a number of principles have been agreed to inform the development of 2022/23 operational plans
- Against each of the 10 national priorities, programme leads have agreed the scope for local focus of plans
- Finally, the framework puts forward a number of steps to be taken to shape the development of the system operational plan – these are set out in more detail on slide 12

ICB aims	Principles
Help the NHS support broader social and economic development	2022/23 is the foundation year of our five year strategy. Shift from reactive response to proactive planning. Build upon the partnerships forged by COVID & establish NHS anchor institution role.
Tackle inequalities in outcomes, experience and access	Deliver on Health Equality Commission recommendations. Focus on delivering impact of integration. Parity of esteem across all ages. Work towards managing COVID proactively not reactively.
Enhance productivity and value for money	Our financial plans balance recurrent CIPs with new investment. Our workforce plans are realistic & affordable & deliver sustainable, resilient & flexible healthy workforce. Both maximise impact of new technologies
Improve outcomes in population health and healthcare	Parity of esteem across services & ages. Tackle all backlogs & long waits. Focus on quality & safety when stepping up throughputs. Maximise impact of integration & innovation

Components of our plans

Establish ICB and collective system working

Shadow ICB @ 1st April with system operational plan for 2022/23 that provides foundation for five-year health & care strategic plan for ICP (developed with LAs & other partners) and NHS 5-year plan to deliver the strategy

Develop clear communications and engagement plan with our population

Establish NHS in L&SC as anchor institution and deliver with partners the Greater Lancashire plan

Set out progressive steps towards compliance with environmental/green targets and develop a system response to the climate emergency

Population Health Mgt & Health Equity

Embedded PHM approach to drive actionable insight . Addressing health and care inequalities through placed based interventions. Co-design rapidly re-configurable care and support . Resource distribution framework. Build capacity and capability through Academy. Re-focus prevention deliverables. Participation and empowerment of communities

Focus – actionable insights/improve access, equity and outcomes

Respond to Covid-19

Booster vaccinations, new treatments and meeting patient need, including for long covid

Focus on a sustainable vaccination programme

Invest in the workforce

MH hub, effective rostering, New ways of working- digital solutions, Appoint permanently, reduce administrative burden on clinicians

Focus on filling vacancies with permanent staff

Exploit Digital Technology

Core level in each system, Transform care delivery and outcomes – hospital at home and other digital solutions. Shared EPR, departmental systems and orchestration layer, PHM system

Focus on support to transformation

Maximise Use of Resources

3 year allocations, fair share via system financial framework. System financial recovery to achieve breakeven, return to contracts with ROI for rev and cap

Focus on system financial recovery & clinical strategy implementation

Deliver Elective Care

Tackle backlog, long waits (eliminate 104 weeks) and improve cancer waiting times Elective plans to be in place, including IS, Green sites, diagnostics hubs. Improve maternity care.

Focus on green sites and use of ERF

Improve UEC responsiveness & build community care capacity

Eliminate 12 hour waits, minimise ambulance handover delays & improve response standards, 150 beds (incl virtual wards) System resilience hub. Build on UEC recovery plans. 2-hour community response, hospital at home, care plans

Focus on admission avoidance and flow

Improve Mental Health, LD and Autism Services

Delivery of LTP ambitions, transform service delivery, improve access and reduce variation.

Focus on reducing inequalities, support in the community

Improve timely access to Primary Care

Capacity increase, Maximise PCNs, increased appointments, integrate at place and neighbourhood

Focus on additional investment to increase capacity/use of technology

Approach to plan development

Deliver the current strategy and build the foundations for strategy for the next five years

Start to invest in the future health and well being of our population and communities

Set out the constraints opportunities and impacts to drive our plans

Be clear on what we can deliver within constraints and on associated risks

Approach to plan development

Those leading the development of each component of the system operational plan have been asked to do so by:

- Taking account of the relevant planning principles for their section
- Ensuring that elements of the current ICS LTP, especially those related to system reform, are delivered and that opportunities to establish our activities next year as the foundation year for the new five year strategy are maximised
- Within constraints, ensuring that we start to invest in PHM and the future health and well being of our population and communities
- Recognising the system's financial constraints
- Recognising workforce constraints, with growth in recruitment focused upon reducing agency staff numbers
- Maximising the impact on both the above constraints of technical/digital advances and thinking more creatively on how services are delivered
- Being clear on what can and cannot be delivered against national priorities in their section of the plan in light of the above constraints
- Work closely with those leading completion of activity, performance, workforce and financial plan templates on the accurate reflection of the assumptions contained within their plans
- Reflecting the above in their section of the system plan narrative

Operational planning 2022/23

Developing the system financial framework

Financial Principles

- System will submit a balanced plan and support delivery of financial balance at organisation level
- Full open and transparent sharing of data
- Alignment with activity and workforce plans that are both realistic and deliverable
- Support transformation with a transformation allocation from the ICB allocation to set up a System Transformation Fund
- Continue to contribute a fund or people to Provider Collaboration support
- Collaborate at scale where clear benefits are demonstrated – eg, system wide efficiencies, transformation, corporate services collaboration, etc
- Keep transactions between partners as simple/streamlined as possible to minimise any administrative burden or perverse incentives
- Aim to get the draft plan submission as close to the final submission as possible to minimise the work required during final accounts
- To consider timing of new investments and impact on full year costs
- To understand all investment decisions at place level (equity/health inequalities impact)

Operational planning 2022/23

Next steps

SLE check and challenge session 16th March

We have agreed with system leaders that:

- we will extend the invitation for the major part of the March SLE meeting to include DoFs/CFOs and system programme leads
- we will present a summary of the draft activity, performance, workforce and finance plans, identifying:
  - Compliance with/variance from national expectations
  - Assumptions and outputs from any relative prioritisation work
  - Key risks and outstanding issues for resolution

The outcomes of the session will be reflected as appropriate in the draft plans submitted on the 17th March

Recommendations

The ICS Board is asked to:

- Note the process and timeline for the development of system operational plans
- Endorse the proposed system planning framework (slide 8)
- Endorse the proposed system financial framework (slide 11)
- Support the proposed role of SLE at the 16th March check and challenge session (slide 13)

Integrated Care System Board

Date of meeting	**2nd March 2022**
Title of paper	**Lancashire and South Cumbria Infrastructure Strategy 2022**
Presented by	**Gary Raphael – ICS Executive Director**
Author	**Alistair Rose – ICS Estates Lead**
Agenda item	**7**
Confidential	**No**

Purpose of the paper

This is an updated strategy that sets out the key strategic points, timescales and investment aspirations for our health infrastructure across Lancashire and South Cumbria.

It updates the Estates and Infrastructure Strategies of 2018 and 2019 and provides a baseline for the ICB to understand the condition, constraints and opportunities of its current infrastructure and sets a framework for the future development of organisational and system-wide plans.

It is intended that this Infrastructure Strategy is reviewed annually to remain up to date with changes to national policy and the on-going development of local clinical and organisational strategies and plans.

This Infrastructure Strategy will also support the development of investment business cases and provide some of the strategic context of these.

Executive summary

The strategy links together the current clinical strategies, Trust strategies and plans, various national NHS policies and guidance. It provides a framework that responds to these from the perspective of Infrastructure (Estates, Digital and Technology) and the investment requirements to deliver these.

The Infrastructure Strategy is structured in a similar way to the previous strategies of 2018 and 2019 as a series of interconnected sections, and provide an overview of our five infrastructure ambitions: Digital, Green, Sustainable system, the right accommodation, and healthier places.

The investment requirements summarised in this strategy are in excess of £3.2bn over 10 years with further detailed planning underway to understand the complexity and cost for the NHS across Lancashire and South Cumbria to get to Net Zero Carbon by the timescales that NHS has confirmed (2040.) These will be shared when the work concludes during 2022/23 and updated into this strategy when agreed.

Lancashire and South Cumbria Health and Care Partnership

The Infrastructure Strategy describes a number of immediate and ongoing activities to develop an Infrastructure Delivery Plan and cites activity into the medium term to develop our infrastructure system, accommodation and system-wide capabilities.
Recommendations
The ICS Board is requested to: 1 **Endorse** this paper and the attached strategy document, The Lancashire and South Cumbria Infrastructure Strategy 2022. 2 **Note** that significant updates to this strategy will be brought back to this Board and there will be at least an annual refresh to this strategy. 3 **Note** that this strategy will be shared with system partner organisations and a copy shared with NHSE/I national estates team and the Project Assessment Unit for the purpose of supporting current or future infrastructure plans and investment (Green Book) business cases.

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

Meeting	Date	Outcomes
SLE	November 2021	Feedback requested and received

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:	Gary Raphael

Lancashire and South Cumbria
Health and Care Partnership

Lancashire and South Cumbria Health Infrastructure Strategy 2022

1. Introduction

1.1 The Infrastructure Strategy for the ICS needs to be updated to keep it current with developments in clinical strategies, service development plans, plans for our new hospitals and the associated consequences for the NHS across Lancashire and South Cumbria, and to provide context for the strengthening and development of national plans and policies, e.g. the Green agenda.

1.2 This infrastructure takes a lead from the previous Estates and Infrastructure Strategies of 2018 and 2019 and follows a similar format which was developed by the NHSE/I national estates team.

1.3 The Infrastructure Strategy has been developed during 2021 with the support of colleagues from across the system including CCG, Primary Care and NHS Trust colleagues. There have been workshops to expand and clarify service and investment requirements across the system and feedback has been received on a draft version of this strategy during November and December 2021. Feedback from system-wide stakeholders has been incorporated keeping to the standard format of the NHSE/I estates and infrastructure strategy template style (2018 / 2019.) Some feedback has supported the separation of the Infrastructure Strategy from the Delivery Plan which in turn will be further developed and updated at the capital workshop (see 3.1 below.)

1.4 There is a new Estates Strategy Lead in the NHSE/I national estates team who has similarly offered feedback on the draft of this infrastructure strategy and in turn this strategy is assisting with the creation of a new national Infrastructure Strategy planning template. The NHSE/I national estates team will be working with ICBs during the latter part of 2022/23 to support each of them update their infrastructure strategies. This 2022 strategy will greatly assist the work to develop an ICB Infrastructure Strategy and our plans for an annual refresh to this strategy should coincide with the timescales for the new ICB strategies.

1.5 We have existing service and investment development plans and will be developing more over the coming year that will need regional and national financial support. It is very important that there is a single strategic document that keeps our plans for development and investment in our infrastructure together and current to maximise our chances for support and to provide strategic context to emphasise that any one organisation's plan is both supported across the ICS / ICB and has a system-wide strategic fit.

2. Key Points from the Infrastructure Strategy

2.1 We need in excess of £3bn investment in our infrastructure over the next 10+ years. The cost and availability of national public funding for all of this remains uncertain and we will need to be flexible and creative with our plans and how we determine and create the right infrastructure (Digital support and Estates Accommodation.)

2.2 We have an understanding about the condition of our estate across Lancashire and South Cumbria and work is underway to have a single and consistent overview to provide a series of common data sets to support planning and prioritization of capital and investment resources.

2.3 We are underway with a standardised review of all of our hospital sites to understand the complexity and cost to get to Net Zero Carbon by 2040 to meet NHS commitments. This should conclude in summer 2022 and support an update to the investment section of this strategy.

2.4 We need to collaborate increasingly in the development and implementation of our plans across the areas affected by and under the control of those responsible for the development of and operational management of our infrastructure.

2.5 There are an increasing number of opportunities that closer collaboration offer including a greater level of oversight and pace in “back-office” service and associated cost and efficiency improvements when taking a system by default approach. These are brought together and under the oversight of the Provider Collaborative Board. This Infrastructure Strategy supports the intentions and ambition of these and future programmes and endorses the collaboration that the programmes require.

2.6 We need to develop our system-wide and organization-wide Infrastructure capability and capacity to respond to the themes identified in this strategy including:

- Business Case writing for infrastructure investment
- System-wide efficiencies in estates operational services
- Development of and implementation of a compelling Green and Net Zero Carbon plans
- Working closer to and in collaboration with our NHS and system partners to mutually support the development of each others strategies and plans.

2.7 We already have the support of the national property companies (NHS Property Services (NHSPS) and Community Health Partnerships (CHP)) who own and support the operational service delivery of a proportion of our Primary Care Estate. Wholly owned by the Department of Health they have a requirement to provide effective landlord service to their buildings. The Infrastructure Strategy identifies that we must develop our support and oversight of these pubic assets to ensure that they are used effectively and support the development of clinical strategies for hospital and out of hospital services.

2.8 It is likely that some of the future development of and investment in the infrastructure of our non-hospital and primary care services will be supported by or led by one of the above property companies and we need to have an effective role as the Informed Client to enable the implementation of this Infrastructure Strategy.

2.9 Our use of office and “back-office” accommodation has changed as a consequence of our responses to Covid and an increase in hybrid and home working. Administrative accommodation is an overhead to the operational costs of NHS service delivery and our use of space needs to be optimized / minimized. A common theme for and planned reduction in this accommodation needs to be determined to ensure that we have a focus on clinical and patient-facing accommodation, right-sizing our administrative accommodation where we are able to and the investment in changing it when appropriate. Changes and reduction in accommodation needs to be planned to take advantage of organisational change and in leased accommodation with appropriate breaks in contract and lease commitments.

3. Next steps

3.1 The Infrastructure Strategy identifies a number of key activities and planning that are already underway or planned to commence over the 2022/23 period, including:

3.11 Capital Prioritisation and Infrastructure Strategy Workshop – this is an annual planning event typically in March of each year. The workshop planned for 3rd March 2022 will consider system and place-based investment plans and priorities to support the development of the Infrastructure Delivery Plan.

3.12 Development of a Commercial Strategy to develop options and opportunities for the investment requirements in digital, technology, equipment and the estate. This needs to include ways that we can make the required improvements to our infrastructure even if NHS Capital is not available to the timescales needed.

3.13 Support for the creation of a single procurement function across the ICS that will support the key priorities of the system and achieve efficient purchasing using the greater buying-power that a larger collaborative approach should achieve

3.14 Develop an Infrastructure Procurement Strategy to support this Infrastructure Strategy and to be used as a template for future infrastructure projects and their associate business cases. This Procurement Strategy will co-exist with, support and be supported by the Procurement Strategy for the New Hospital Programme.

3.15 Update the "Who is available to who" matrix to support the different development opportunities that are available to partners across the ICS. This will include the wider opportunities provided through co-working with Local Authorities and their development partners. Choosing the right infrastructure development partners will be critical to the success of the programmes and projects that use this support.

3.16 Work with colleagues in the National Estates and Commercial teams to bring forward development / investment vehicles to take forward third-party investment where the need is clear and agreed yet held back by the timing of availability of capital

3.17 Develop the ICS Green Plan by the deadline of 31st March 2022 and progress implementation plans from this for 2022/23 and beyond, to link with and support the Green Plans of the five provider Trusts, and to provide a system overview for endorsement by the ICB once it has been established and national timescales for the ICB Green Plan endorsements have been confirmed.

3.18 To enhance Place-based infrastructure planning and oversight and continue to support the local Strategic Infrastructure / Estates Groups and the development of their own Estates and Infrastructure Strategies.

4 Recommendations

4.1 The ICS Board is requested to:

2 **Endorse** this Lancashire and South Cumbria Infrastructure Strategy 2022.

2 **Note** that significant updates to this strategy will be brought back to this Board and there will be at least an annual refresh to this strategy.

3 **Note** that this strategy will be shared with system partner organisations and a copy shared with NHSE/I national estates team and the Project Assessment Unit for the purpose of supporting current or future infrastructure plans and investment (Green Book) business cases.

Alistair Rose – Estates Lead – Lancashire and South Cumbria ICS
January 2022

HEALTH INFRASTRUCTURE STRATEGY

2022-2040

Lancashire and South Cumbria

Lancashire and South Cumbria
Health and Care Partnership

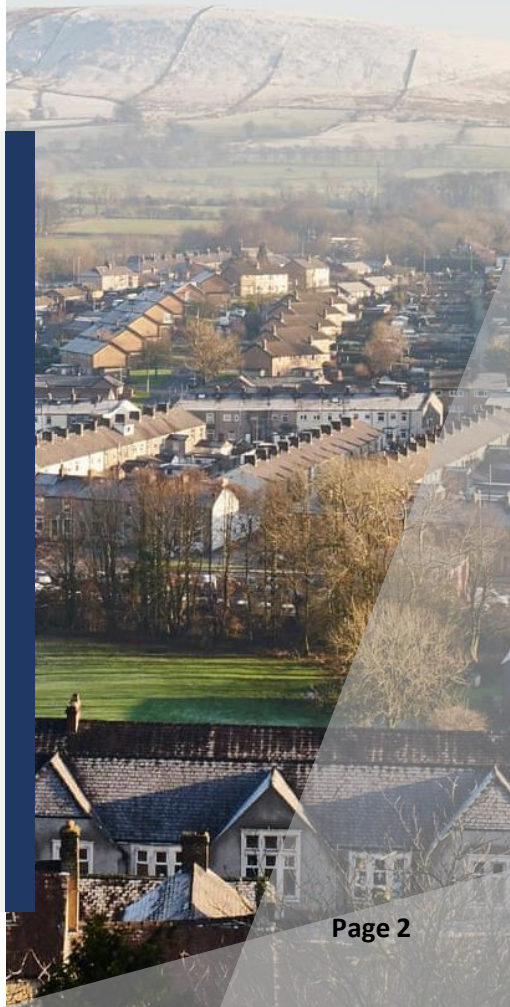
• DIGITAL • GREEN • SUSTAINABLE • THE RIGHT ACCOMMODATION • HEALTHY PLACES •

CONTENTS

CONTENTS

Our Strategy 2022 - 2040

Lancashire and South Cumbria
Health and Care Partnership



FOREWORD

Lancashire and South Cumbria
Health and Care Partnership

Our health infrastructure is fundamental to both the delivery of our health services and to improving population health. It is so much more than 'bricks and mortar'; it is an ecosystem that includes everything from the accommodation we use, our technology, our digital systems, the places we influence, our environmental footprint, the decisions we make, the way we use our land, the innovation we adopt, the way we work collaboratively and beyond. We need so much more than an 'Estates Strategy' and today, we will look at our health infrastructure more holistically than we have ever done before.

Lancashire and South Cumbria has changed significantly since we first developed our 2018 Estates Strategy. We need to review and refresh our thinking as our plans for future clinical services emerge and continue to develop and we become clearer about the impact of having the right infrastructure to support these services in a way that is effective, efficient and sustainable.

This Infrastructure Strategy updates the 2018/19 Estates and Infrastructure strategy and brings together the current thinking and planning for the infrastructure developed during the 2021/22 period. It is likely that this strategy will need to be updated once the ICB has been established and it will be a useful basis for that refresh during late 2022/23.

In this Infrastructure Strategy, we set out our long term vision and how we need to respond to the three different but related key timescales that will challenge our and our partners' priorities for attention.

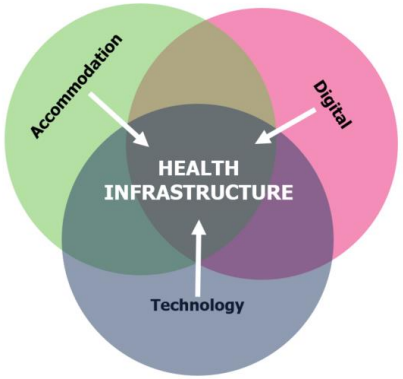
5 Year - We need a five year strategy to determine the next projects and programmes for our capital and development pipeline and our vision to create a network of public assets supporting good health of our citizens.

10 Year - We need to be clear on the impact and implications of the 10 year plans for the New Hospital Programme and how it will affect future service and infrastructure planning across Lancashire and South Cumbria.

18+ Year - We all need to assess the emerging implications for the NHS to be Net Zero Carbon by 2040 and adapt our service and infrastructure plans during the whole of this period.

We know that to achieve this we will need to be creative, we will need to connect the dots in new ways and will need to work together with each other and wider partners to develop our infrastructure that is digital, green, sustainable, provides the right accommodation and that shapes healthy places for local populations and our staff.

What do we mean by health infrastructure ?



INTRODUCTION
Our 2021 Health Infrastructure Strategy

Lancashire and South Cumbria Health and Care Partnership

Our health infrastructure and accommodation gives our health system the places and spaces to do a range of things from delivering services, patients accessing information, to creating places for staff to work. When the way we do things changes, then the accommodation we need is likely to change too – we need to reflect this evolution in health strategy to plan changes to our infrastructure.

The past 24 months

The impact of the Covid pandemic on our future infrastructure and accommodation requirements cannot be overestimated. We have seen services adapt and evolve at an unanticipated pace across Lancashire and South Cumbria. We have seen changes in the places our clinical and non-clinical workforces are based and have many staff working from home, from new sites and now across pop-up health facilities in our various Covid vaccine centres. We have seen a 'digital revolution' and an associated fundamental shift in our use of technology by both our workforce and people who use our health services, which will forever change our infrastructure and accommodation requirements.

During the Covid pandemic, we have worked together as organisations in an unprecedented way; making decisions at pace and with a shared and collective goal. We has seen our procurement, estates and digital teams deliver new infrastructure at scale and pace in ways we may never have considered in the past. We must not lose these ways of working and ways of thinking. We will build on our existing cross-organisational partnerships and examine the way we work across our infrastructure disciplines to maximise the use of our collective resource and expertise.

Healthy populations

Our infrastructure and accommodation can, and should, do so much more than just provide us with bases for staff and patients; it should actively contribute to reducing health inequalities in local places and improve the health and wellbeing of our staff. The connection between good health and the right infrastructure can be overlooked, but we will have started to imagine the possibilities if we were to think more holistically about 'health infrastructure' and use our role as anchor institutions to make our infrastructure be more productive and influence others and address our health inequalities. By working with partners, using our property and land assets differently and thinking in a more connected way today, we can build the foundations for a healthier population in the future.

INTRODUCTION
Our 2021 Health Infrastructure Strategy

The future of buildings – thinking differently; user-ship, not owner-ship

Health infrastructure is about more than just bricks and mortar, yet we know that accommodation and buildings are important; from how they function, the way they look and feel, to how well utilised and financially sustainable they are. Having the right accommodation can support service delivery, staff wellbeing, patient access, workforce retention and future recruitment. We must think about less traditional options that we currently have and continue to explore more of these solutions in the future; we have vaccine sites in shopping centres and on high streets, why not extend this even further?

We will shift our narrative from buildings being something that we own as organisations to accommodation being something we use and we will look at new and creative options around user-ship of the right buildings. Whilst we may not need to own buildings, we do need user-ship to be flexible and locally controlled and buildings must be fit for purpose, safe and effective. As we look to new solutions, we need to start further building on our understanding of what accommodation we can use, and developing a set of common standards to ensure appropriate 'user-ship' of public assets.

Doing more with less

Our current Lancashire and South Cumbria financial position means that we need to do more within the funding available to us. This may provide some constraints that will need collective endeavours to address and we will be more imaginative in developing our infrastructure solutions; challenging our status-quos and re-thinking what our future 'health infrastructure' will look and feel like, with the intention of enabling us to make our money go further.

There may be new things we need to look at, we may look at making investment into other assets that improve our clinical flows, enable people to live independently for longer and give us "pop-up" locations for a range of service delivery options. We will continue to consider new ways to use space, maximise the value of our land and work collaboratively with each other and wider partners.

INTRODUCTION
Our 2021 Health Infrastructure Strategy

Our accommodation is not a 'free good' but a significant overhead and therefore we need to ensure that we are both efficient and effective in its use. We will make the best use of our accommodation, always considering factors such as sharing space with others, maximising flexibility of use and multi-session working. Having the right accommodation enables us to have better operational and organisational efficiency. Constraints on our capital means this is more important than ever.

We know will still need significant financial investment to make our infrastructure fit for the delivery of our existing services and planned clinical strategies and this investment requirement is outlined in this strategy including our new hospital facilities. Some of the investment requirements we outlined in 2018 have changed and where needed changes have been made.

A healthier planet

We must think beyond our own local boundaries and to the global climate emergency. We cannot ignore the environmental crisis and we need to start collectively thinking about our journey to a Greener NHS and a net-zero-carbon future. This will affect our existing infrastructure and all our investments and decision making. It may be a challenging journey, but as with each of our infrastructure ambitions – when each component part (individual, organisation and system) is moving towards the same goal we can succeed.

Green plans

We will be developing a Lancashire and South Cumbria Green Plan during the first half of 2022 that will support and be supported by this Infrastructure Strategy and encompass the Green Plans recently completed by the provider Trusts.

We know our future infrastructure and accommodation must be efficient, effective, and enable us to deliver care as well as create healthier places and a healthier population. Our infrastructure of the future will be different to our estate of the past if we are to improve the health of both people and our planet.

OUR INFRASTRUCTURE VISION

Our health infrastructure will actively contribute to creating a sustainable health system and a healthier population.

We will invest and develop long-term plans to ensure we have the right digital infrastructure, technology and accommodation to deliver our clinical strategies.

We will improve existing accommodation, develop new facilities, think differently and use our influence to shape wider infrastructure working with partners from across the NHS and public / private sectors to maximise the opportunities that collective agreements and decision making can bring.

We have collectively identified five health infrastructure ambitions. These five ambitions will guide our strategies, investments and the development of our supporting plans. Everything we do should take us a step closer towards realising our infrastructure ambitions.

Our future is digital

Our future is green

Our future is sustainable

We have the right accommodation

We shape healthier places

Whilst evolution is inevitable over the next eighteen years, we expect our infrastructure ambitions to remain relatively unchanged.

Our clinical plans and strategies will have strong links and a clear understanding about the implications, requirements and investments needs of our infrastructure.

Our known capital requirements captured in this strategy are in the order of **£3bn**, the source or availability for much of this is unclear at the moment and having a longer term prioritised pipeline will be critical to support service developments and associated business planning and business cases over coming years.

Having accurate and consistent data is essential to support our infrastructure investment decisions. All Trusts across L&SC are now progressing a single data capture to better understand our current estate condition and backlog maintenance requirements.

The Green agenda is in its infancy not just in the NHS but globally, however, the government and NHS have made some clear commitments with some long-term deadlines to achieve these. We all need to develop our “green-literacy” and how we are progressing with our plans to decarbonise our services and buildings will need to be understood and communicated. We are shortly to commission a single consistent review of all our hospital sites to understand the implications, costs and options to make our NHS Net Zero Carbon within 18 years – this ambition on its own will require regular and ongoing focus by all organisations and supporting prioritised investment.

OUR GUIDING PRINCIPLES

QUESTION – we will ask ourselves how we can do things better and never just do something because it is what we have always done.

COLLABORATION – we will always take a system-by-default approach. We will ask if we can do more by working together with others.

INNOVATION AND LEARNING – we will bring new thinking and learning to the work we do. We want to learn from others who are doing things well.

INFLUENCE – we will use our influence to help create the infrastructure we need for the future health of our population

OUR 5 AMBITIONS

Our future is digital

Our ambition is to have a digitally mature health system, supported by appropriate digital infrastructure. We will have accessible, usable, integrated and effective systems, technology and equipment to support future health services provision, management and prevention for everyone, everywhere. We will work collaboratively across our organisations to ensure that patients and staff receive a consistently high standard of care and access to that care.

Our future is green

Our ambition of having a green infrastructure is central to all our future plans. We have until 2040 for our NHS to reach net-zero carbon, and infrastructure will play a significant role in achieving this – whether this is changes we make to our buildings, the energy we use or how we use our land. But a greener infrastructure is not just about delivering the commitments government and the NHS, our green plans are essential to plan and determine where investment needs to go and how we shape the communities that we support.

Our future is sustainable

Our ambition of having a sustainable infrastructure is not just about environmental sustainability. In order for us to have a sustainable future, we must think about the economic and financial sustainability of our infrastructure, as well as its impact on our workforce, our services and our system. Building local supply chains and creating circular economies will support our communities, local businesses and the public that we serve.

We have the right accommodation

We will have the right accommodation for delivering our services and our clinical strategy; it will be right for our services, for patients and for our staff, though we may not need to own accommodation. Over the strategic timeframe we will replace older, not fit for purpose infrastructure with high quality and appropriate accommodation and will consider different solutions to meet our future needs – this could be anything from mobile facilities to high street 'health-shops'. We will need significant investment to deliver the right accommodation across our system as we are starting from a low base.

We shape healthier places

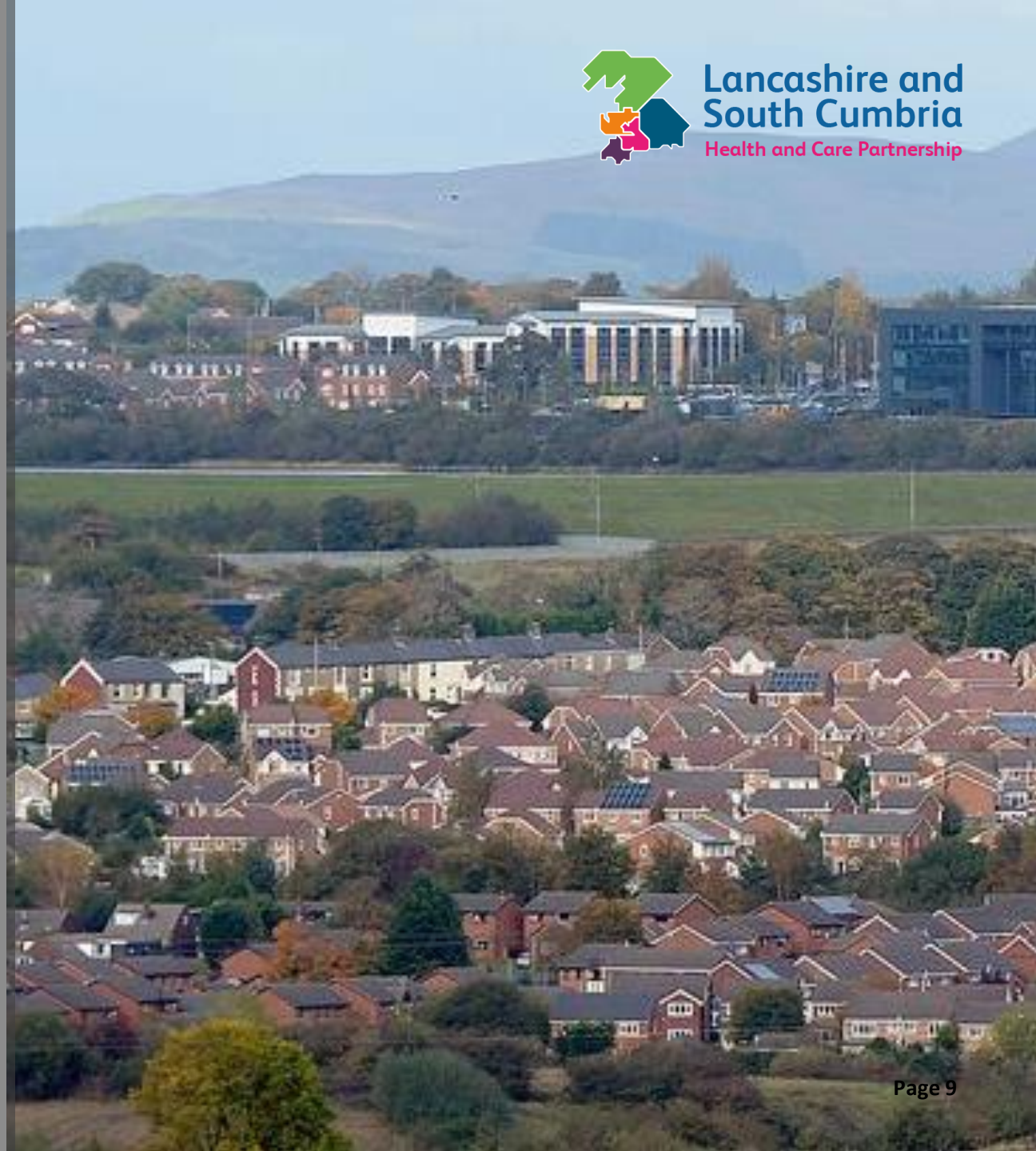
Infrastructure for good health begins in the places we spend our time; at home and in our local communities. Our hospitals and health centres are there for when people need support, but there are things we can also do to shape healthier places and prevent people falling into poor health in the first place. Our health organisations are all anchor institutions; we will use this influence, our infrastructure decision making, and our land and buildings to shape a healthier Lancashire and South Cumbria and create a healthier population.

CHAPTER ONE

WHERE WE ARE IN 2022

In this chapter, we start to consider the infrastructure conversations we will need to enable our clinical strategy and think about how we use infrastructure to support the delivery of our clinical priorities.

We will then look at the milestones we already have over the next 18 years and why we must use the next 5 year capital planning cycle to position ourselves to respond to these.



LANCASHIRE AND SOUTH CUMBRIA CLINICIAL STRATEGY

What does this mean for our health infrastructure?

Lancashire and South Cumbria Health and Care Partnership

Our Lancashire and South Cumbria Clinical Strategy was approved in December 2020. Subtitled 'Creating a Healthy Population', the strategy outlines the direction of travel that Lancashire and South Cumbria Health and Care Partnership will take over the next 10 years to reduce health inequalities and to improve health. Our vision is summarised below:

Our vision for Lancashire and South Cumbria

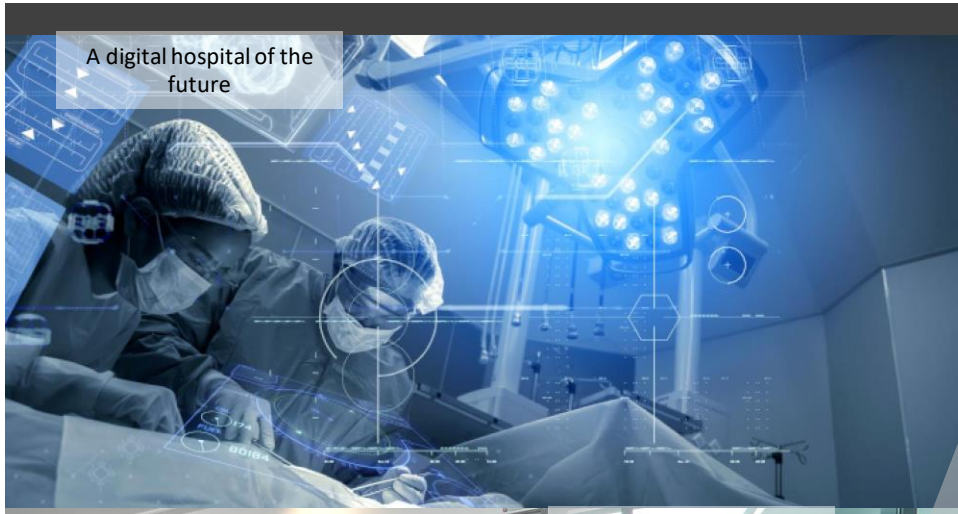
At the heart of this are the following priorities:

- Improving the health and wellbeing of local communities
- Delivering better, joined-up care, closer to home
- Delivering safe and sustainable, high quality services

APPENDIX 1
Lancashire and South Cumbria Clinical Strategy: Creating a Healthy Population.

Our health infrastructure strategy will echo the priorities of our clinical strategy including; being led by population need, having infrastructure that is shaped by clinicians and care professionals, and building on our system collaboration that strengthened during the pandemic. We will ensure we apply system-level thinking to all we do, whether this is sharing skills, creating the right spaces for our workforce or in how we make best use of our collective estate. Finally, we will embed digital solutions in everything that we do and consider the impact of this on our physical estate and accommodation.

Within our clinical strategy, there are 6 key medium to long term strategic priorities identified that our health infrastructure will need to enable over the next 5 years and we will look at the impact of each of these on the following page.


A digital hospital of the future


The Harbour, Blackpool

LANCASHIRE AND SOUTH CUMBRIA CLINICIAL STRATEGY

How our health infrastructure will enable our strategy

Our key medium to long term strategic priorities are set out below, along with our infrastructure response for each priority :

1 Health and Wellbeing of Our Communities
- Prevention and Health Education
- Population Health Management
- Anticipatory care

We will consider opportunities and ways we can more actively both use our own, and influence other's infrastructure to support health and wellbeing and address the wider determinants of This must include us thinking more holistically about 'place' and infrastructure and considering areas linked to prevention, population health management and anticipatory care such as housing, community digital connectivity, green space, and community. We have started to consider this detail in PART FIVE of this strategy.

2 Living Well
- Self and Personalised Care
- Integrated Place-Based Care
- Intermediate Care
- Mental Health
- Learning Disability and Autism
- Maternity and Children's Services

We will consider the impact that the shift from hospital based care has on our infrastructure requirements locally. We will invest to enable this shift, putting a greater emphasis than ever before on our out of hospital infrastructure – this will form the basis of our future place based infrastructure strategies and plans. We will ensure that we create infrastructure that supports us to reduce our demand on hospital services. We will optimise our existing estate to enable intermediate care, self care and place based care. We will invest in new health facilities and/ or new types of infrastructure either on our own or working in collaboration with local partners to support a place-based, population health approach to health. We will create the right spaces and places for the delivery of learning disabilities and mental health across our local places, including housing options.

3 Managing Illness
- Collaboration, Shared Services and Networks
- Planned and Elective Care
- Specialist and Acute Care

We will ensure we have the right buildings, technology, equipment and digital infrastructure to support the management of illness for our local populations. This will include improving our existing acute and inpatient sites as well as shaping our new hospital(s) programme and delivering new world-class infrastructure for our local population. We will create the infrastructure we need to support increased collaboration across our Trusts to support improved patient pathways and services sustainability.

4 Urgent and Emergency Care
- Emergency Care
- Urgent Care
- Mental Health Urgent Assessment Centres

We will make the required investments so that our emergency care, urgent care and urgent mental health patient pathways are supported through infrastructure to deliver excellent care to patients. We will ensure we have the right accommodation to provide these services where we need them.

5 End of Life Care, including Frailty and Dementia
- Care of the Elderly
- Ending Life Well
- Palliative Care

As we invest in and change our infrastructure, we will consider any requirements for investment that supports people so they can live well, before dying with peace and dignity in the place of their choosing, supported by the people important to them.

6 Workforce
- A healthy and happy productive workforce
- Development of clinical services in lockstep with the People Plan

We will assess the impact that providing the right infrastructure and accommodation has on our workforce; considering workforce sustainability and staff wellbeing. We will ensure that our infrastructure provides optimum and productive working environments.

LANCASHIRE AND SOUTH CUMBRIA

The purpose of our infrastructure strategy

Lancashire and South Cumbria Health and Care Partnership

As we set out in our introduction, there have been many changes since we completed our last Lancashire and South Cumbria estates strategy. We now have our Lancashire and South Cumbria clinical strategy (2020) and therefore more clarity around our medium-long term strategic clinical priorities. We know that our organisational structures will change with the Health and Social Care Bill and so our ways of working across our system will evolve further. We also know that many of our 2018 programmes, projects and investments have evolved.

This strategy reflects our system ambitions and priorities as well as priorities outlined nationally for the NHS and the public sector. It sets our direction of travel for the next 18 years, focusing on our collective ambitions and the way we will work together to achieved these, making the best use of what we already have.

Providing context for clinical development plans - Our infrastructure will always be an enabler for our clinical strategy, with our infrastructure needing to reflect and respond to our service delivery needs. However, it is important to ensure that in considering the development of more detailed clinical plans that these are developed with an awareness of built and digital infrastructure opportunities and constraints (including capital) and we will work together to find a balance that enables service transformation in a way that is deliverable. As we set out in our introduction, we know we have many questions to ask, one of which will be to translate clinical thinking, programmes and projects into more detailed infrastructure and accommodation requirements, where this has not already been done. It is intended that this strategy be used as a prompt to start new conversations with clinical teams and the outcomes of these discussions will be reflected in our plans and any refreshed strategies.

A framework for our local Integrated Care Partnership (ICP) infrastructure strategies - This strategy will set the context, framework and strategic direction for local ICP strategies across Central Lancashire, the Fylde Coast, Morecambe Bay, Pennine Lancashire and West Lancashire. These will be developed during 2022 and will both be informed by this strategy and in turn inform our developing plans and investments across Lancashire and South Cumbria.

Individual organisational estates strategies – Each accountable organisation will continue to develop their own estates strategies setting out Trust priorities and investment plans. The purpose of this strategy is not to duplicate or repeat detail from within the Trust estates strategies, rather it is to provide the framework for collaboration and integration across infrastructure work streams.

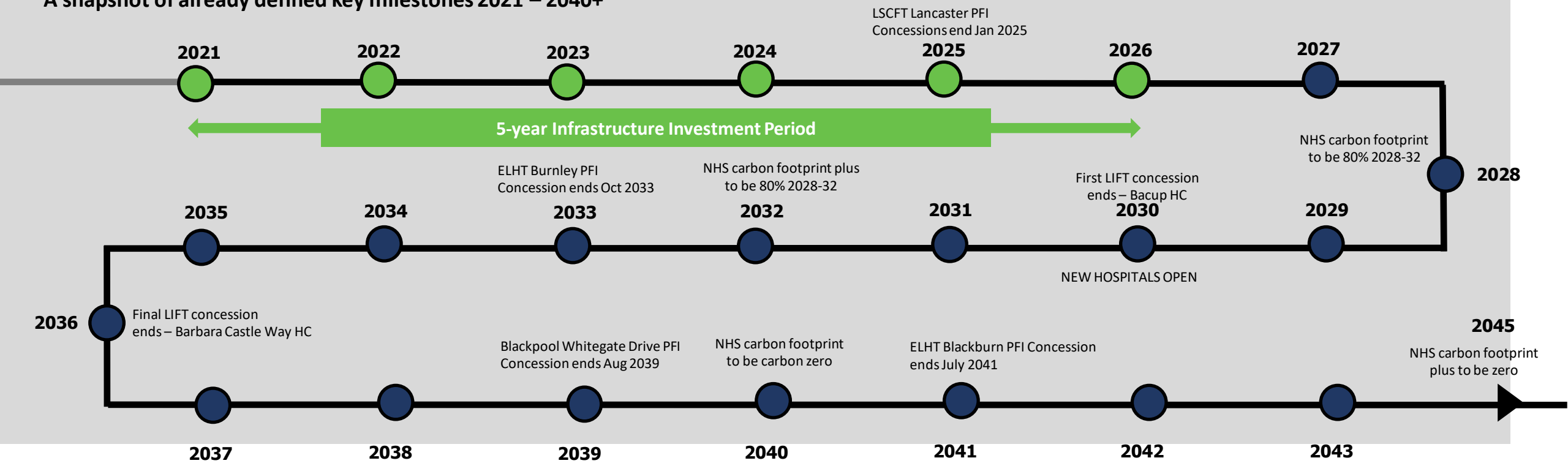
Blackpool beach

Using the next 5 year planning cycle (2021-26) to position us for 2040 and beyond

Lancashire and South Cumbria Health and Care Partnership

We have our vision for health infrastructure in 2040 across Lancashire and South Cumbria; an infrastructure that is digital, green, sustainable, has the right accommodation and that contributes towards creating healthier places. Our future operational plans needing to detail what we intend to do over the next 5 year capital planning period. We cannot allow our infrastructure thinking and planning to become focused only on the next 5 years and we must look at what we need to do to 2040 and beyond. On the timeline below we have identified key dates – this is simply a snapshot of already defined milestones across the next 20+ years that we will need to consider, plan for and work towards. Some of these milestones such as beginning our net-zero carbon journey, our new hospital(s) programme (and the resulting out of hospital requirements) and what happens at the end of our multiple LIFT and PFI concession periods will need to be considered over the course of the next five years.

A snapshot of already defined key milestones 2021 – 2040+



CHAPTER TWO

OUR AMBITIONS

In this chapter, we will discuss our five principle ambitions in more detail.

- Our future is digital
- Our future is green
- Our future is sustainable
- We have the right accommodation
- We shape healthier places

Lancashire and South Cumbria
Health and Care Partnership

PART ONE OUR FUTURE IS DIGITAL

In Part One, we examine the issues relevant to the development and implementation of our digital infrastructure.

Our ambition is to have a digitally mature health system, supported by appropriate digital infrastructure. We will have an integrated digital platform which is accessible, usable and with effective systems, technology and equipment to support future health services provision, management and prevention for everyone, everywhere. We will work collaboratively across our organisations to ensure that patients and staff receive a consistently high standard of care and access to that care.

We want our infrastructure across Lancashire and South Cumbria to be digitally connected and digitally mature for the health of our planet and for the health of our people.

Lancashire and South Cumbria Health and Care Partnership

In the context of our health economy, technology should be there to make our lives easier, healthier and support us to make better decisions. Across Lancashire and South Cumbria, we are working towards a digitally enabled and digitally mature system where infrastructure and technology effectively and efficiently connect our people, places and services together.

When we talk about 'digital', we really mean the way we use technology to deliver our clinical strategy and create a healthier population. We must no longer think about computers, cabling and server rooms when we refer to digital infrastructure, and must collectively start to prioritise the importance of having a digitally enabled, connected and mature system as the bedrock for the creating a sustainable system. Our health accommodation and wider healthy infrastructure will be shaped by our digital services and the technology we use and we need to consider this impact.

We have all seen the unprecedented shift towards an increasingly digital system over the course of the pandemic and we must continue this momentum. Over the next 18 years, technology will evolve further; across our whole health economy we need the technology, digital infrastructure, skills, tools and partners to improve our services today and to ensure we are set-up to respond to the new digital world of tomorrow.

There are a number of accommodation and built-infrastructure led digital areas of focus that will influence this strategy; out of hospital accommodation, existing acute estate, the new hospital(s) programme and 'place' – place being the natural communities and homes where people live. We will determine how we better use these, connect across these areas and how we digitally enable people and places in a way that is truly beneficial.

Digital technology is going be fundamental to our green ambition, to having a sustainable infrastructure, creating the right accommodation and to shaping healthy places where we live and work.

A digital future

OUR DIGITAL FUTURE

What does this mean across Lancashire and South Cumbria?

Lancashire and South Cumbria Health and Care Partnership

Across Lancashire and South Cumbria, there are a number of digitally related programmes currently underway within our health economy. A digitally mature and connected system will allow us to completely re-imagine what is possible and enable us to develop flexible services that respond to local population needs. Increasing digital maturity will radically transform the way we can work as a health economy.

A common electronic patient record (EPR) will be developed to improve access and improve our pathways to benefit our patients and our staff – this is the first and possibly most significant step in our journey towards becoming a digitally mature system and sufficient investment and prioritisation is required to achieve this. We will develop a clinically shared and person-held records system to enable the flexibility to be able to access patient records and data anywhere, at any time, on any device. We are developing a common system roadmap to support our digital journey and cloud based and internet first services.

The way and location that we deliver services will dramatically change and this will have an impact on our infrastructure, both within our hospitals but likely more radically out of hospital across local places. We will assist people to develop their digital skills and manage their own health and at the same time ensure we do not exclude those who cannot use digital tools and services.

We are continuing our work in telehealth and telecare. We are assessing the possibilities surrounding virtual and augmented reality, machine learning and artificial intelligence and are already working on programmes across Lancashire and South Cumbria in collaboration across organisations and with other partners. The equipment and connected devices needs of patient empowerment, citizen and person centred access and remote assistance will be robustly assessed.

Future healthcare; VR and technology

Digital service development will be considered alongside our infrastructure data and information, particularly in relation to programmes such as population health management – as we progress with our plans, we will use our estates data in a more connected and intelligent way.

More immediately from an accommodation perspective, we will implement digital tools to enhance our current work streams and better support our organisations to collaborate and integrate. The use of technology to create our offices and workspaces of the future, underpinned by a common booking platform is already in train.

APPENDIX 2
Lancashire and South Cumbria: Our Digital Future

EQUIPMENT AS PART OF A DIGITAL INFRASTRUCTURE

The technology we will require

We cannot talk about a digital infrastructure within looking at technology and equipment.

Connected medical equipment and devices via the internet is an essential aspect of our strategy.

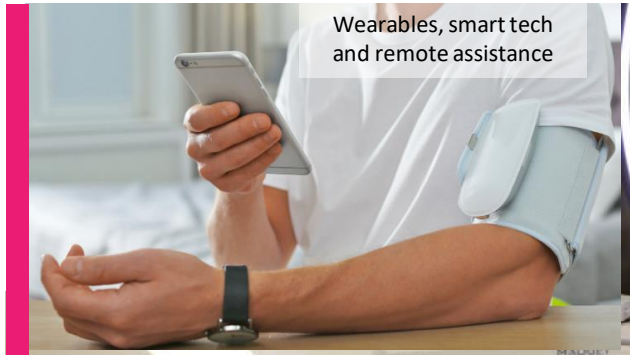
Investment in major equipment, such as theatre robots, diagnostic equipment and our pharmacy robotics is an essential feature of our digital world.

Technology will impact on our service and accommodation needs – for example, solutions and advancements in technology enable us to move diagnostic facilities closer to home, perhaps even in the home.

We may not currently have access across the market to the type of equipment we require in the future and the market will need to respond. As a system, we will clarify our requirements and enter into negotiations with manufacturers, suppliers and application developers.

Implementation of a common technology platform for our equipment should lead to cost benefits through economies of scale for maintenance and servicing.

And we cannot forget the smaller equipment needed to deliver care closer to home. Digital equipment, technology, wearable and other connected devices will be fundamental to support the delivery of effective place based models of care – improving choice and access for people and enabling more anticipatory care, prevention and self-care.



Wearables, smart tech and remote assistance

MRI scanner

A surgical robot

THE FUTURE OF ACCOMMODATION

The impact of a digital health system and technology on estate

Lancashire and South Cumbria Health and Care Partnership

An increasingly digital and technology-focused system will inevitably have an impact on our estate and accommodation requirements today and in the future. With the right connectivity in place, digital technologies will also force a shift in the type of accommodation we consider our 'health estate'. Supermarkets, shopping centres, community centres, pods in local parks, houses, schools, businesses, train stations – anywhere can potentially be considered as part of the health infrastructure and accommodation of the future.

Our hospitals and health centres in future will be both smarter and greener. New technologies will enable improvements in transport and logistics (perhaps autonomous vehicles to support transport and logistics across our bigger sites, smart technology such as smart mirrors and health-check pods to support staff health and wellbeing and smart technologies used in ways we cannot even yet consider as part of our journey to net-zero).


A connected place

Across our hospital and health facilities, as we shift to increasing digital service models, these accommodation requirements will need to shift in response. In the same way that our high street banks have changed as banking evolved to be overwhelmingly a digital service, we too must consider how our own health accommodation will need to evolve to work for all of us in a digital work – whilst we may not see the radical consolidation that we saw with banks, a change is inevitable. Today, we see the shift in our office needs; our workforce has become increasingly agile and home will become a core part of people's workplace and we therefore need a different type of accommodation. If digital services and our use of technology help us to consolidate and reduce our accommodation footprint, then this will help us in meeting our carbon targets (PART TWO).


A smart mirror


A mobile health pod

We will explore opportunities for digitising our estate and developing intelligent and smart buildings that work better for us. We can better use technology across our estates management, for instance intelligent asset tagging and augmented reality for maintenance and FM.

We will see more patient monitoring and delivery of consultations via digital channels and increased use of online meetings, and this too will all reduce our need for physical accommodation. Today, we are already seeing the tangible impact of increased technology on the estate – because of digitisation of records programmes, we have rooms in GP premises and wings in buildings that will be freed up, spaces we can use in different ways, optimising the use of these spaces across our neighbourhoods. We will also need to consider this across our acute accommodation as we develop our EPRs.

PART TWO

OUR FUTURE IS GREEN

In Part Two, we consider the issues to make our infrastructure 'green'.

Our ambition of having a green infrastructure is central to all our future plans. We have until 2040 for our NHS to be net-zero carbon, and infrastructure will play a significant role in achieving this – whether this is changes we make to our buildings, the energy we use or how we use our land. But a greener infrastructure is not just about meeting targets; it is Lancashire and South Cumbria making a difference to planetary and population health.

We want our infrastructure across Lancashire and South Cumbria to be greener- for the health of our planet and for the health of our people.

Lancashire and South Cumbria Health and Care Partnership

In October 2020, 'Delivering a 'Net Zero' National Health Service' (APPENDIX 3) was published. The vision of a Greener NHS is to 'deliver the world's first net zero health service and respond to climate change, improving health now and for future generations'. In Lancashire and South Cumbria, we will need to meet these targets and achieve 'net zero', that is reducing our carbon emissions from their current levels to zero by 2040. **We have to do this** and we can no longer ignore the need to create a greener NHS – if we do not, the problem will only get bigger and the challenges more significant.

2040 is only 18 years away. Whilst nearly two decades may seem like a long time, when we consider how much we need to do and how systemically we will have to change the ways in which we work to become carbon net zero, 18 years is no time at all.

As we work together towards a greener NHS, we will undoubtedly need to focus on innovation, learning, sharing information and partnering with people across the public sector and beyond. **We will have to 'think big' and realise we cannot achieve this alone.**

On a smaller scale, we will consider ways we can positively impact on the environment, regardless of whether these impact on our carbon performance. We have opportunities to use our infrastructure and green areas to support nature and biodiversity as well as staff, patient and citizen wellbeing.

There will be many things we need to do over the course of the next 19 years, many of which we are unlikely to be able to imagine today, but we cannot use these unknowns as a reason not to begin.

We need a better understanding of our current performance and will ensure we are effectively benchmarking ourselves as we progress on our journey to a greener NHS. Each of the five provider Trusts in Lancashire and South Cumbria have produced a Green Plan to cover the next three years, we will incorporate these into an NHS Lancashire and South Cumbria Green Plan during the first few months of 2022.

We need to start our journey to Net Zero Carbon now.

A 'NET-ZERO' NATIONAL HEALTH SERVICE

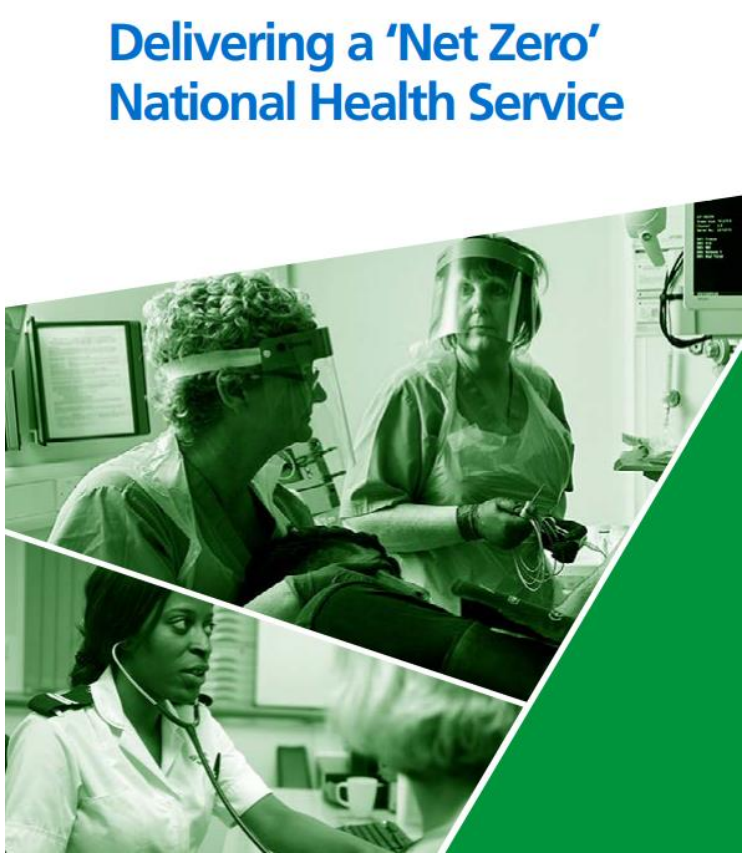
Delivering a 'Net Zero' National Health Service

Lancashire and South Cumbria Health and Care Partnership

APPENDIX 3
Delivering a 'Net Zero' National Health Service

NHS

The vision of a greener NHS is to "deliver the world's first net zero health service and respond to climate change, improving health now and for future generations". Every part of the NHS will need to act both in the short- and long-term to meet this ambition, with three priorities to the programme, outlined below.



1. Meeting the NHS net zero targets

- **NHS Carbon Footprint** – the emissions we control directly assessed as **153,500 tCO2e** (tons of carbon)
  - 80% reduction by 2028-2032
  - 100% reduction to **Net Zero by 2040**
- **NHS Carbon Footprint Plus** – our entire emissions profile assessed as **a further 571,470 tCO2e** (tons of carbon)
  - 80% reduction by 2036-2039
  - 100% reduction to **Net Zero by 2045** **IE a reduction of 724,970 tCO2e**

2. Improving health and patient care and reducing health inequalities

3. Building a more resilient healthcare system that understands and is responding to the direct and indirect threats posed by climate change

In order to create our greener NHS and meet these targets we need to make brave (low regret) decisions on infrastructure use and investment. The NHSE/I Board have approved a roadmap from April 2023 that the NHS will adopt the Government's "Taking Account of Carbon Reduction Plans".

We will focus on the green agenda within both statutory organisations and across our Lancashire and South Cumbria system so we can share learning, expertise and deliver the change required at scale. Whilst meeting national NHS net-zero targets at both a national and local level, reaches far beyond the estate and our infrastructure, we know that the contribution of our infrastructure to the NHS's carbon footprint is significant and in accordance with National Policy **we must consider the net zero target in ALL of our estates and infrastructure decisions.**

A 'NET-ZERO' NATIONAL HEALTH SERVICE

Moving to carbon net-zero in Lancashire and South Cumbria

Lancashire and South Cumbria Health and Care Partnership

Before we begin to consider some of the infrastructure related projects and ongoing discussions, there are a number of areas that we need to recognise, consider and develop plans for if we are to meet national targets and deliver our ambition of a green health infrastructure for Lancashire and South Cumbria.

To reach net-zero by 2040, a paradigm shift in how we think about almost everything that we do across our infrastructure work streams and beyond is required. We have no choice but to refocus our plans and programme to create a greener NHS, knowing that this will benefit our patients, the planet and future generations. We must also recognise that this planning will force new innovation as well as opportunities for efficiencies and cost-avoidance. The following issues are relevant for our future infrastructure:

Role of the ICS - Agreement of its role in supporting, coordinating, leading on and facilitating work across organisations.

Leadership, governance and Exec support - Identification of the right leadership to take forward our green ambition. Executive leaders will be required for a Greener NHS within each organisation by the end 2021 and they will drive the green infrastructure discussion at Board level

Collaboration & Partnerships – We must look at this regionally and nationally – working with other ICS leads, providers, LAs, academia, PCNs, businesses etc. We will learn as much as we can from others and share our learning in return.

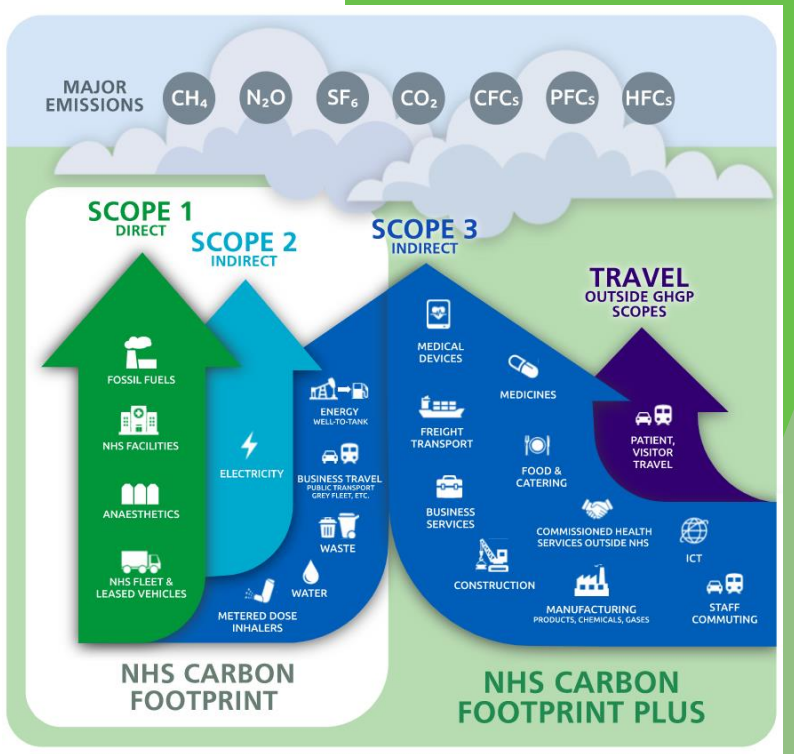
Innovation – Technological and digital innovation to ensure we understand 'what's next'.

Communication – Run events and campaigns to encourage positive activity – initially, we will look at this across our ICS workspaces and how we embed more environmentally-positive ways of using space.

Procurement & Suppliers – Deliver social value, local & environmentally responsible suppliers.

Individual responsibility – There is a significant piece of work to be completed around raising awareness and we cannot ignore the culture change that is required to support a greener NHS. We will work collaboratively to embed best practice across all our staff and teams. Everyone has the power to contribute and everyone should be able, and be enabled, to play their part.

Funding and investment – We will not be able to do this without the right investment. We will first identify the investment we require and then develop a plan for securing funding. We will look at opportunities for grant funding where possible, but we will need to ensure that our green infrastructure requirements are captured as part of our investment plans and return on investment assessments. We will link this closely with the identification of our long term core buildings as part of our local ICP infrastructure strategies, so we focus our limited funding and investment on those sites we know we will need in 2040 and beyond.



This will be measured in accordance with the Greenhouse Gas Protocol (GHGP) which covers a wider set emissions, inducing GHGP scope 1, GHGP scope 2 and GHGP scope 3. There are still some emissions that fall outside these scopes. As agreed with the NHS Net Zero Expert Panel, the NHS will also work towards net zero for a NHS Carbon Footprint Plus that includes all three of the scopes above, as well as the emissions from patient and visitor travel to and from NHS services and medicines used within the home.

A 'NET-ZERO' NATIONAL HEALTH SERVICE

Infrastructure work streams that we will focus on

There are a number of areas where we are already doing a lot of work and others where we have started cross organisational collaboration in relation to greener infrastructure discussions.

A plan for decarbonising our buildings and the investment required needs to be developed. We have commissioned a review of all the hospital sites across Lancashire and South Cumbria with the first three of these reporting during Q4 of 2022. This approach and the interpretation of our findings will support some of the conclusions in the L&SC Green Plan and also to fine tune the reviews of the remainder of the hospital sites during Q1 2022/23. From this review we should understand the cost and complexity of the challenge and the impact of additional electrical requirements per site as existing gas and oil boiler plant is decommissioned. We need commitments from the electricity grid providers to service the new hospital demand as the sites infrastructure is adapted to be Net Zero. Where we lease estate, we will engage with landlords and the NHS property companies to understand their own net-zero plans and investment strategies and to ensure they are taking responsibility for their estate.

We have already made some steps in the right direction, the majority of NHS organisations across the North West and all but one Trust across Lancashire and South Cumbria are now purchasing 100% renewable electricity and the outlying Trust has confirmed they will be purchasing 100% renewable electricity as soon as their current energy contract ends. We will continue to explore efficiencies in relation to energy, waste and other areas across our infrastructure. When we are undertaking our planned maintenance and refurbishments, we will ensure we take every opportunity to make positive improvements such as new light fittings and improved insulation all with the intention to work towards Net Zero. All larger (over £15M) capital schemes will be 100% Net Zero from the start of 2022/23.

We will continue to review efficiencies on transport, travel and fleet. Shifting ways of working during the pandemic has reduced commuting and we would expect a return to work for office-based staff to continue to be on a hybrid basis into the future. We will review and where necessary update our clinical strategies for hospital, non-hospital and primary care to minimise patient and staff travel. We will actively promote 100% electric vehicles and our travel, transport and staff benefits arrangements will be adjusted to remove the use and availability of petrol and diesel vehicles. We will invest in each site to ensure there is sufficient EV charging capability for vehicles and where relevant the new electric ambulances that NWAS are planning.

One of the simplest ways we can reduce our carbon emissions is to reduce our estates footprint. When we are thinking about creating the right accommodation for the future (see PART FOUR) we will ensure our buildings are appropriately sized. This is particularly important in the context of not only financial sustainability, but against our ability to meet our net-zero targets. We should not be paying for space we are not using and in the same way, we do not wish to be emitting carbon against space we are not using.

Alongside new buildings we need to start to think more radically about what we can and perhaps need to do with our own estate and land. This includes requirements in the future for our carbon zero journey and that could include the use of land for greener energy generation, micro-grids, energy storage, and potential offsetting (eg wetlands, re-wilding, tree planting etc). Partnerships and innovation are essential and we will collaborate with our academic institutions to identify radical, yet deliverable solutions that help us towards our net-zero targets.

We will evaluate whether any of our existing and future NHS sites may be able to play a part in the national NHS Forest programme. https://nhsforest.org/

PART THREE

OUR FUTURE IS SUSTAINABLE

In Part Three, we consider sustainable infrastructure.

Our ambition of having a sustainable infrastructure is not just about environmental sustainability. In order for us to have a sustainable future, we must develop economic and financially sustainability infrastructure, as well as its impact on our workforce, our services and our system.

We want our infrastructure across Lancashire and South Cumbria to be sustainable and to support a sustainable health system for the benefit of people and patients, our workforce and our services.

When we use the term sustainability, we mean much more than a greener NHS and environmental sustainability.

Our infrastructure must support the delivery of our clinical strategies and provide the right buildings, digital systems and technology to create a healthy population and reduce demand on our services in the medium to long term for a more sustainable health system.

The ICS's infrastructure sustainability ambition consists of a number of interlinked strands which include:

- Environment
- Society and health promotion
- Economy
- Finance
- Social value
- Workforce and service delivery

Sustainability will need to underpin everything that we do.

The organisations within and supporting the NHS are well placed as Anchor Institutions to be able to support and develop the broader economy and society as the requirement and activity becomes clearer.

We will develop the organisations we commission services from and our supply chain of service and product providers to be best placed to support our and their sustainability.

We will develop a series of stakeholder engagements over the coming year to regularly communicate our sustainability plans and intentions.

A SUSTAINABLE SYSTEM
Using infrastructure to create a healthy population

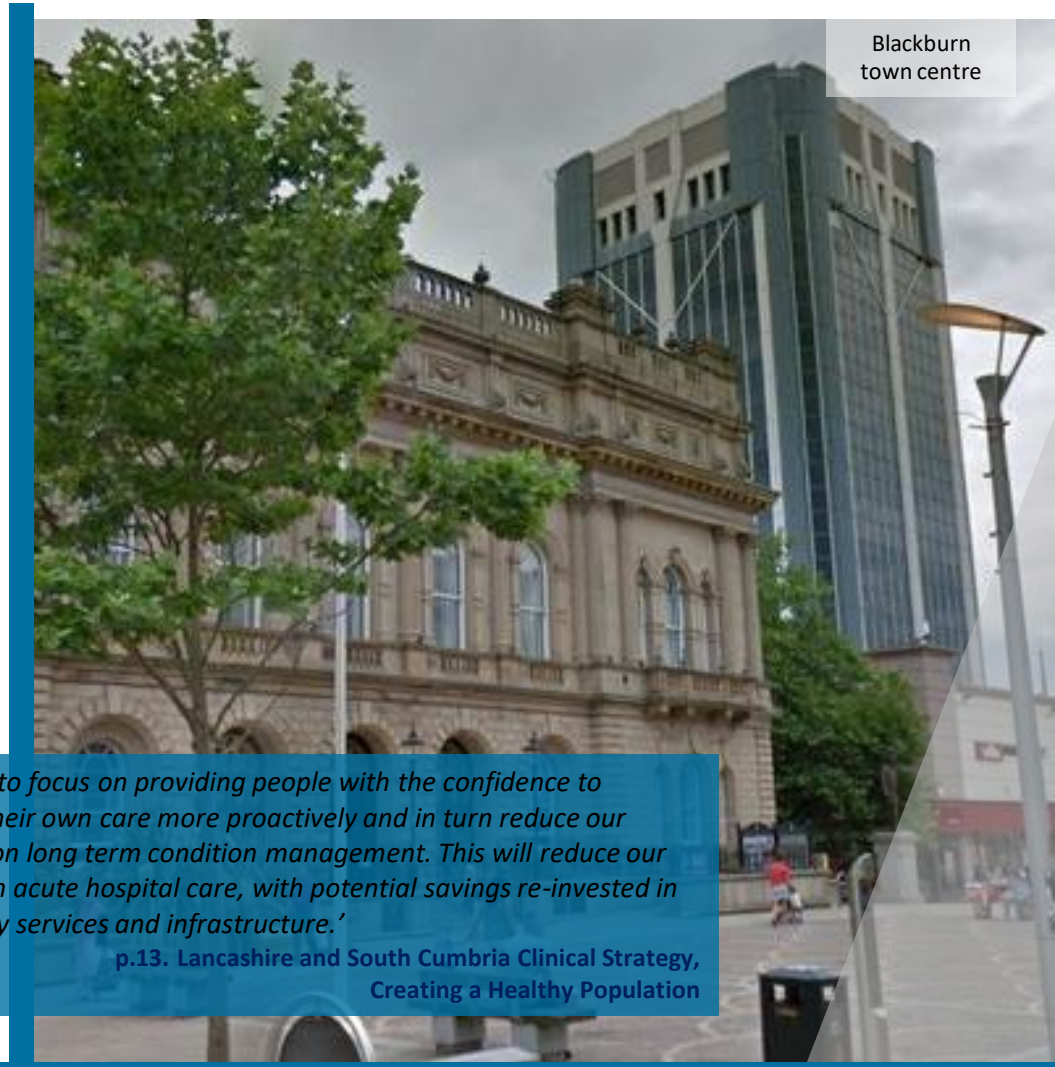
In our clinical strategy the main focus is on creating a healthy population and a more sustainable health system. The same thinking applies to our infrastructure.

Our health infrastructure should support the long term sustainability of our health system and we always will consider infrastructure in the context of improved socio-economic prosperity for our local places and long term improvements to health and wellbeing that in turn reduce demand for healthcare. As a local anchor institution, we will use our influence and decision making to support local places and local businesses. In supporting the region's economy we help to generate income and wealth and, in reducing deprivation, we can help keep our population healthy and reduce the demand for services.

It is also about planning how, through procurement, we set up a local supply chain that supports the region's small to medium businesses, building a circular economy and sustainable business models. Greater social value will underpin all our estates and infrastructure decisions. We will ensure that any development, refurbishment or repair is designed to be compliant with extant climate change consequences.

At the same time as we create infrastructure to manage illness, so too will develop our infrastructure for health prevention and good health. We may have direct opportunities here through digital infrastructure and in considering new ways to use our strategic sites, land and accommodation to support a more holistic and place based system of care, helping people to live well locally. We will explore more of this potential in PARTS FOUR and FIVE, but influencing, supporting and working in collaboration with our public sector partners and other local stakeholders will be essential here.

Across our directly controlled health infrastructure, we will put more focus on our out of hospital infrastructure, as providing more services in non-hospital settings will be essential to our long term system sustainability. We will consider this in the context of our investment prioritisation. In some instances this might mean that we need to invest in additional and new types of accommodation and digital infrastructure – sometimes it may cost more in infrastructure to enable a more sustainable service model.



Blackburn town centre

'We want to focus on providing people with the confidence to manage their own care more proactively and in turn reduce our spending on long term condition management. This will reduce our reliance on acute hospital care, with potential savings re-invested in community services and infrastructure.'

p.13. Lancashire and South Cumbria Clinical Strategy, Creating a Healthy Population

A SUSTAINABLE SYSTEM

Using infrastructure to create a healthy population. How we will develop this aspect of our strategy

Lancashire and South Cumbria Health and Care Partnership

We cannot simply build a new building each time our services change, so we must consider designing flexibility into our accommodation; this is likely to mean across function, management, ownership and tenure:

- Our infrastructure must be strategically sustainable in that it provides **flexibility and adaptability** and is therefore responsive to future service changes. We will consider the relationship between built and digital infrastructure in the context of sustainability, and what the increasing move towards technological solutions will mean and what opportunities it may present us with.

- We will assess the opportunities to work collaboratively across our partners to make **better use of our collective public estate** in order to; reduce overheads, maximise benefits to patients to achieve the greatest return to health, drive efficiencies and work more efficiently and effectively.

- We will **develop our own infrastructure expertise**, resource and management requirements for the medium-long term to enable our accommodation needs to be designed with sustainable objectives at the fore.

- We will design and develop infrastructure and accommodation that creates the right environment for our workforce; that enables effective working and contributes to staff health and wellbeing. We want to help make Lancashire and South Cumbria an attractive place to work for our staff; both for our current and future workforce. **We will consider our future workforce** and how we can use our infrastructure to contribute to attracting the talent of the future.

- We will ensure a reduction in estates costs. We will face a very challenging financial climate going forward, and we **must ensure that our infrastructure is affordable and financially sustainable** and that we have appropriate accommodation that is efficient, effective and well optimised in its use so we are not paying for space we do not use.

- We will continue to **think holistically, 'join the dots' across our programmes of work** and embed sustainable thinking at the heart of our strategies. Our planning, decision making, governance and systems must support this in the future.

PART FOUR

WE WILL HAVE THE RIGHT ACCOMMODATION

In Part Four, we discuss what having the right accommodation means.

We will have the right accommodation for delivering our services and our clinical strategy; it will be right for our services, for patients and for our staff.
This section brings together current strategies and plans of our system partners and outlines future service development plans linked to investment and challenges with the Infrastructure.

We will have the right accommodation for our services, patients and staff – the places we deliver our services from and the buildings we own, lease and use across our organisations.

We will develop accommodation that enables us to treat patients and manage illness across all our patient pathways. This means we will have to improve our acute facilities and at the same time make further investment into our out of hospital accommodation to provide care closer to home and to support increased choice for where and how people access services. Our clinical strategy talks of 'patients and staff having equality of access to high-quality facilities and equipment' and we will need to ensure we have this equality.

We know we will need significant investment to improve our health infrastructure and to create the right accommodation. Yet we also know that financial investment on its own is not the answer.

We will work with partners to support more effective infrastructure work streams (such as back-office efficiencies as well as better utilisation and consolidation of the estate) so we can re-invest savings into making further infrastructure improvements. We will ensure that our accommodation is supporting clinically driven collaboration. We will also consider what accommodation is needed to respond to national programmes including community diagnostics and Cavell Centres.

When we talk about accommodation, we do not only mean places we would traditionally consider to be part of the NHS estate and we do not always need to have ownership of accommodation, only effective 'user-ship'. We will create options for where and how we provide accommodation in the future, especially for our out of hospital services, linking this to place-based planning and living well. We will also consider what other accommodation we may need to provide in support of improving our hospital flow and patient pathways. Equal consideration will be given to non-hospital, primary care and acute services in future investment decisions.

Identification of the accommodation required for the medium and long term will inform our investment strategies. We will begin by better defining what we mean by the 'right accommodation'.

Barbara Castle Way
Health Centre, Blackburn

THE 'RIGHT ACCOMMODATION'
What do we mean?

Outdoor space at The Harbour, Blackpool

When we say the 'right accommodation', we mean that we will create and provide places across Lancashire and South Cumbria to support our clinical strategy. Our accommodation requirements should be led by population health need and we must recognise this will mean we need different accommodation solutions in different places.

But as a minimum we can broadly define the right accommodation as being:

Somewhere that provides a welcoming environment - providing places that people feel safe and supported in visiting, using and working in. We will look at this in more detail later in our strategy.

Spaces that gives us the right 'user-ship' - We do not need to always own accommodation, but we do need have autonomy over how we use it, so it can be flexible and respond to our changing needs.

Well sized - We need enough space, but not too much as we cannot be paying for space we do not use.

Appropriate for its use - The appropriateness of space is very important – we neither need hospital suites to deliver GP appointments and online consultations, nor could we undertake complex surgical procedures from a pop-up health space on a high street.

Good condition and quality – We need accommodation that gives us quality spaces that are in a good condition so we can deliver services effectively.

Accessible – The accommodation itself must be accessible for everyone. And more holistically, we should think about what this means when we are providing care closer to home and does this challenge our traditional view of infrastructure

Somewhere that contributes to the delivery of our 4 other infrastructure ambitions – is the accommodation digitally enabled and connected, does it contribute to our green plans (especially if this is a long term accommodation option), is it sustainable and does it help shape healthier places?

We will start by evaluating existing health accommodation - our current health estate is those health premises that we collectively own or directly lease from a landlord.

OUR CURRENT ESTATE

Lancashire and South Cumbria Health and Care Partnership

382 health premises

223
In the freehold or direct leasehold of an NHS organisation or Prop Co

159
GP owned or leased premises (from a non-NHS organisation or Prop Co)

Plus other premises we deliver services from that we use from other partners - TBC

Our existing NHS health estate across Lancashire and South Cumbria is summarised on this page and is based on the information available during 2021. It is summarised in our Health Asset Database

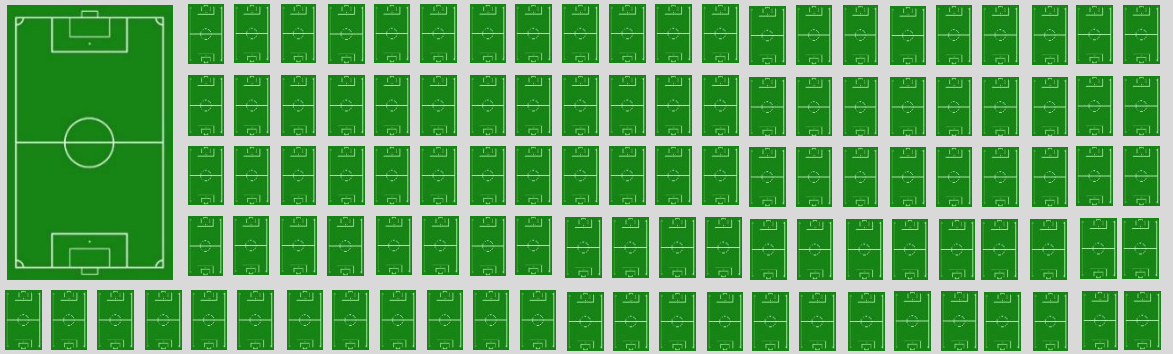
Together, these premises have an annual occupancy cost of

£227m

- **£18m** Mental health, LD & autism *(excluding Whalley)*
- **£150m** Acute
- **£45m** Community
- **£4m** GP owned
- **£7m** Staff accommodation
- **£3m** Other

With an internal area of at least 824,000 m²

Which means our health accommodation footprint is greater than the area of 115 football pitches!



£300m

Is the investment we need to make to address our backlog maintenance*

**all our other investment requirements are outlined in Part Six of this document.*

RE-SHAPING OUR NHS ACCOMMODATION FOR THE FUTURE

A welcoming place for patients and for staff

Lancashire and South Cumbria Health and Care Partnership

We cannot underestimate the impact of our accommodation on both patient and staff experience. Our 2019 Local Asset Review identified the need for our accommodation to feel friendly and welcoming and we will continue to put this at the heart of our accommodation planning.

Appropriate consideration should be given to patient experience and how our infrastructure both positively and negatively impacts on the experience of someone visiting our accommodation. We want to make things simple and easy for people and we want them to feel safe and supported whilst accessing services and we do not want to create problems.

We also need to make it clear where and how people can access health services and ensure we are using our NHS brand and strong signage and messaging to make it clear where our services are, especially across our communities and away from our hospital sites.

We will consider a more strategic and system-wide approach to creating a more consistent identity across our accommodation where the look and feel of our accommodation is more standardised.

There are ways we can consider using the physical buildings we have to support clarity for patients around access and identifying where people should go for what service. This will need to be part of wider communication and engagement programmes as part of our delivery of our clinical strategy.

Entrance artwork, Clitheroe Community Hospital

IMPROVING OUR NHS ACCOMMODATION

Out of hospital and community accommodation

Lancashire and South Cumbria Health and Care Partnership

We need to ensure we have the right accommodation across our communities to offer out of hospital care to improve access for patients and to reduce the demand on hospital services. We need to consider how using our out of hospital estate can support people to live well and to improve the health and wellbeing and we must create an infrastructure that is driven by our population health needs. This cannot be a one-size-fits-all approach and we have started a radical re-think around our accommodation needs.

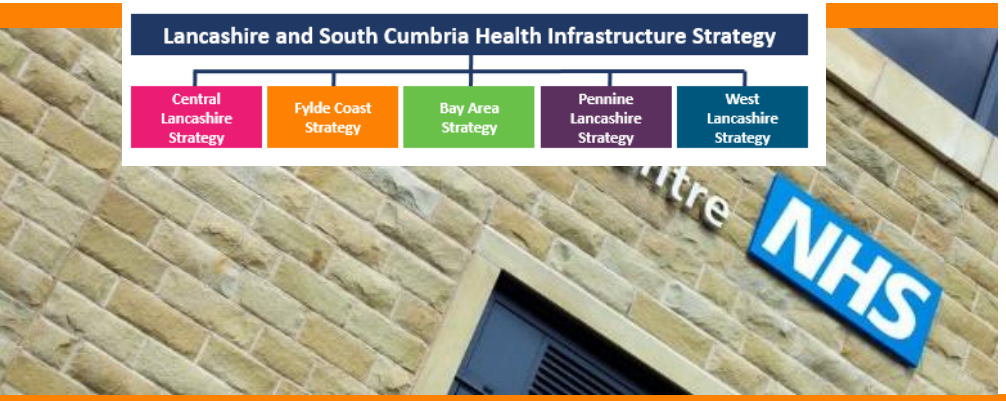
Many requirements for our integrated community accommodation are driven by our commitment to better population health and need for care closer to home. Delivering this enables us to right size the hospitals. We must have equitable provision of quality estate across Lancashire and South Cumbria. There will be excellent opportunities to bring innovation and creativity to our out of hospital accommodation, especially when we think about infrastructure in the context of place – see PART FIVE 'Shaping Healthier Places'. In order to create holistic and place-based accommodation, we must continue closer and proactive cross-partner collaboration, including increasing system-wide collaboration between digital and estates teams to ensure we create the right future accommodation locally.

*'The **role of non-acute or out of hospital services in providing a future health and social care system that is sustainable in the long term cannot be over-emphasised**. We must align our clinical priorities to reduce demand on our hospitals with a focus on self-care, integrated place-based care and intermediate care.'*

p.13. Lancashire and South Cumbria Clinical Strategy, Creating a Healthy Population

Local ICP Infrastructure Strategies

We will develop our population focused visions and local strategies for out of hospital and community infrastructure and accommodation as part of our local ICP infrastructure strategy development. We refine our out of hospital requirements in line with our new hospital(s) programme.



We will think about the impact of integrated place-based care (primary care, primary care at scale), intermediate care and self care and what that is likely to mean for our accommodation and occupancy requirements for staff and patients. We must also consider that having parity between our acute and our community services means that this will need to be reflected proportionately in our infrastructure and our investment – and we know we need significant investment into our out of hospital accommodation (summarised in PART SIX).

There are two main areas we will need to focus on now and in the development of our local infrastructure plans:

- How we transform and reimagine **our existing accommodation** through using/ occupying space in different ways, remodelling and redevelopment
- How we **create new accommodation for the future** through the development of new specialist health facilities, less traditional types of accommodation and providing right staff accommodation

IMPROVING OUR NHS ACCOMMODATION

Our existing out of hospital estate

Lancashire and South Cumbria Health and Care Partnership

The majority of our **community health accommodation** is currently owned or leased by one of the two national property companies, NHS Property Services and Community Health Partnerships (both wholly owned by the Department of Health and Social Care).

NHS Property Services

chp

Other accommodation is owned by our Trusts, including health centres and community hospitals, or in the direct freehold/ leasehold of GP practices.
In the future, our ICB will be able to own property and this is something we will explore further.

We have disparity in the condition of our community estate across our ICPs and our neighbourhoods – some areas have had significant investment in local neighbourhoods, through Local Improvement Finance Trust (LIFT), Private Finance Initiative (PFI) and Third Party Development (3PD) programmes.

Other areas have not had the same level of investment and have overall poorer quality accommodation. We are still building a full understanding of community and out of hospital accommodation and the ongoing Primary Care Data Gathering programme is helping us better understand our primary care buildings and the required investment requirements.

We will optimise our best accommodation and not waste money on funding under-used or un-used space.
We will work with the property companies to find ways to increase our local control over accommodation and address issues in relation to complex finance, tenures, lack of influence and difficulty in achieving building optimisation and increasing utilisation.
Where we have PFI and LIFT agreements in place, we will develop plans for what will happen at the end of concession, with the first one due to end in 8 years time (2030).

Our long term 'core' accommodation

We are identifying our 'core' buildings and 'strategic assets'– our best accommodation and/or those sites that are in the right location and we know strategically that we will need to use for the long term. We will focus investment as well as our resource towards achieving net-zero carbon here.

The Alfred Barrow Centre, Barrow

Heysham Primary Care Centre

South Shore Primary Care Centre, Blackpool

IMPROVING OUR NHS ACCOMMODATION

Out of hospital and community accommodation

Lancashire and South Cumbria Health and Care Partnership

We will make significant changes and improvements to our out-of-hospital accommodation and have identified at least £293m of investment required to both improve our existing estate and for the provision of new facilities and accommodation. Where we need new health centre facilities, we will develop delivery plans and will continue to work with NHSE/I to develop opportunities including the Cavell Centres and Community Diagnostic programmes. Where we are investing in new facilities, we will ensure we are creating flexible buildings and taking a consistent approach, whilst recognising that it will not be a one-size fits-all solution. There will be a number of challenges to delivery that we will need to work though, including the ability to identify the right funding options, being able to deliver at pace and to address challenges around existing GP owned estate linked to valuations and ownership structures.

As well as thinking about more traditional 'health centres', we will develop options for the creation of a different type of accommodation where this helps us deliver our clinical strategy and gives us a sustainable option. We will consider all accommodation options including using space on the high street, in supermarkets, across wider public sector accommodation, within our communities, create mobile solutions and look at setting up 'pop up' facilities. We develop some of these themes in more detail in PART FIVE.

Use of the estate

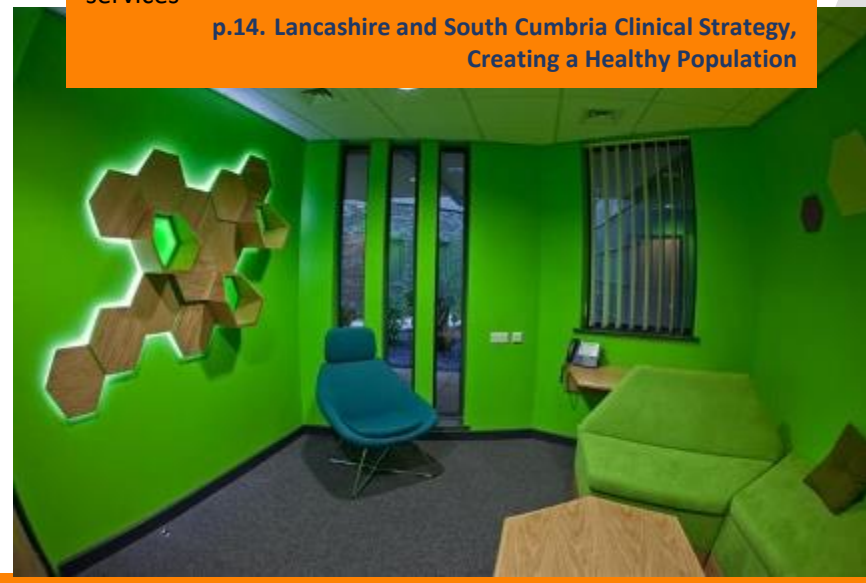
An overwhelming requirement for our out of hospital accommodation is **flexibility and responsiveness** so it can evolve and adapt as our population health needs change over time. This will support increased utilisation as will flexibility of user-ship so we have local control and autonomy over our accommodation. We need to create spaces across our accommodation for patient activation and empowerment – this could be as simple as providing space for non-clinical activity; including clinical support activities, social prescribing, prevention or digital learning. We will develop our understanding of our hospital accommodation and how its potential capacity can be used for cross-system healthcare planning, develop our collaborative plans to include for any financial or contractual implications if we were to consider 7 day working with the community.

Place-based care

We will develop better connections with and information about primary care capacity across our 41 primary care networks; for service delivery, community services, mental health and wider initiatives around prevention and supporting self care. We will include these in our planning for accommodation requirements for health hubs and to deliver primary care at scale and support population health management work streams. These themes will be developed further in our ICP Estates and Infrastructure Strategies during 2022/23.

'Through our estates strategy **we will invest in a place-based neighbourhood accommodation offer**. This will support our neighbourhoods to become a social movement with residents and staff…building a Lancashire and South Cumbria 'deal' with communities and a positive and responsible interaction between the citizen and local services'

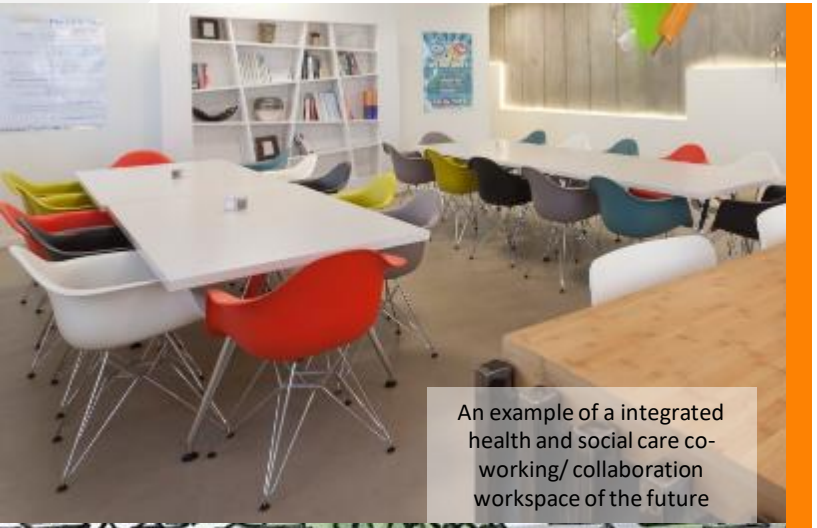
p.14. Lancashire and South Cumbria Clinical Strategy, Creating a Healthy Population



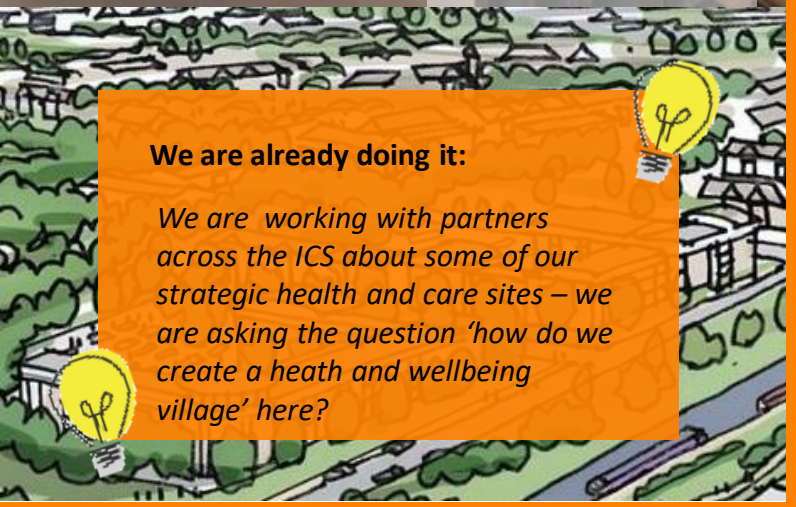
IMPROVING OUR NHS ACCOMMODATION

Out of hospital and community accommodation

Lancashire and South Cumbria Health and Care Partnership



An example of a integrated health and social care co-working/ collaboration workspace of the future



We are already doing it:

We are working with partners across the ICS about some of our strategic health and care sites – we are asking the question 'how do we create a heath and wellbeing village' here?

We need to progress our plans to create a place-based 'health campus' approach where we have a range of health accommodation on a single site that could include infrastructure such as as primary care, housing with care, community centres and cafes, leisure, in-community observation facilities and frailty and complex elderly hubs.

We already have a number of sites across Lancashire and South Cumbria where work is ongoing to re-imagine existing accommodation/ sites as health and wellbeing villages and campus that provide mixed use and holistic health infrastructure as well as accommodation for service delivery. We have excellent opportunities to develop true healthy and place-based developments that support people to live well.

We will develop options that identify what services we can move out of hospital and what accommodation we need for this; some of this will be informed by our new hospital(s) programme and associated work streams. We will identify where we already have capacity across our out of hospital accommodation, especially where we know we have under-optimised core estate and need good quality consistent data to assist our planning. We will ensure we get support from the property companies to help us unlock space and create capacity to relocate services from our acute sites.

Re-thinking staff accommodation for place-based care and integration

We need a different type of staff work accommodation to support our out of hospital work streams. If we look at intermediate care, the intention of the patient pathways are to utilise wrap around support via integrated teams. These services support people locally to avoid admissions and support discharge to take pressure off our hospitals. The ability for cross-organisational teams to be able to co-locate, collaborate, have 'corridor conversations' and to work effectively is key to future system sustainability. We will need appropriate capacity across our local areas for our integrated workforce and will create consolidated central staff office "hubs" within our ICPs – we will review the principles from our NHS workspaces of the future document (APPENDIX 5) to support this work.

Intermediate care

As well as staff workspaces, we need to plan our services more broadly around the opportunities that our infrastructure plans can enable. Across intermediate care, we will be delivering more services in the home, and so holistically we should consider the suitability of our home settings – housing, extra care and residential care homes (see PART FIVE). Where we do need a bed-base, we will need to ensure this is suitable.

IMPROVING OUR NHS ACCOMMODATION
Nationally driven programmes

Lancashire and South Cumbria Health and Care Partnership

We will reflect the local impact of nationally driven programmes, including community diagnostics and Cavell Centres on our service planning:

Community Diagnostics Centres (CDC)

The need for investment and reform of diagnostic services was recognised at the time the NHS Long Term Plan was published in 2019. Following the work of Sir Mike Richards the following key actions were defined:

- Acute and elective diagnostics should be separated wherever possible to increase efficiency.
- Acute diagnostic services (for A&E and inpatient care) should be improved so that patients who require CT scanning or ultrasound from A&E can be imaged without delay. Inpatients needing CT or MRI should be able to be scanned on the day of request.
- Community diagnostic hubs should be established away from acute hospital sites and kept as clear of Covid-19 as possible.

We will support the further planning and development of CDC across Lancashire and South Cumbria following the time requirements of the programme and infrastructure principles set out in this strategy.

Cavell Centres

The condition and configuration of much of our primary care estate is outdated and the current ownership and payment / lease reimbursement models do not assist the redevelopment of this infrastructure.

Subject to funding and approvals we need to progress with the following:

- **The model**: System owned and controlled assets, utilising emerging powers through ICS / ICB legislation;
- **The product**: Cavell Centres for in-community care; a standardised, repeatable design that enables commissioner to respond with greater agility to changing population health needs, support co-location of NHS and non-NHS services and address the social determinants of health;
- **The programme**: Rollout of a significant number of new Cavell Centres across England over the next 10 years, subject to CSR submission and outcome;
- **The opportunity**: Significant improvement in the quality of patient facing estate; the ability to deliver joined up clinical and non-clinical services that support patient health and wellbeing; high-street regeneration which supports economic growth, job creation and post-COVID recovery

IMPROVING OUR NHS ACCOMMODATION

Mental health, learning disabilities and autism

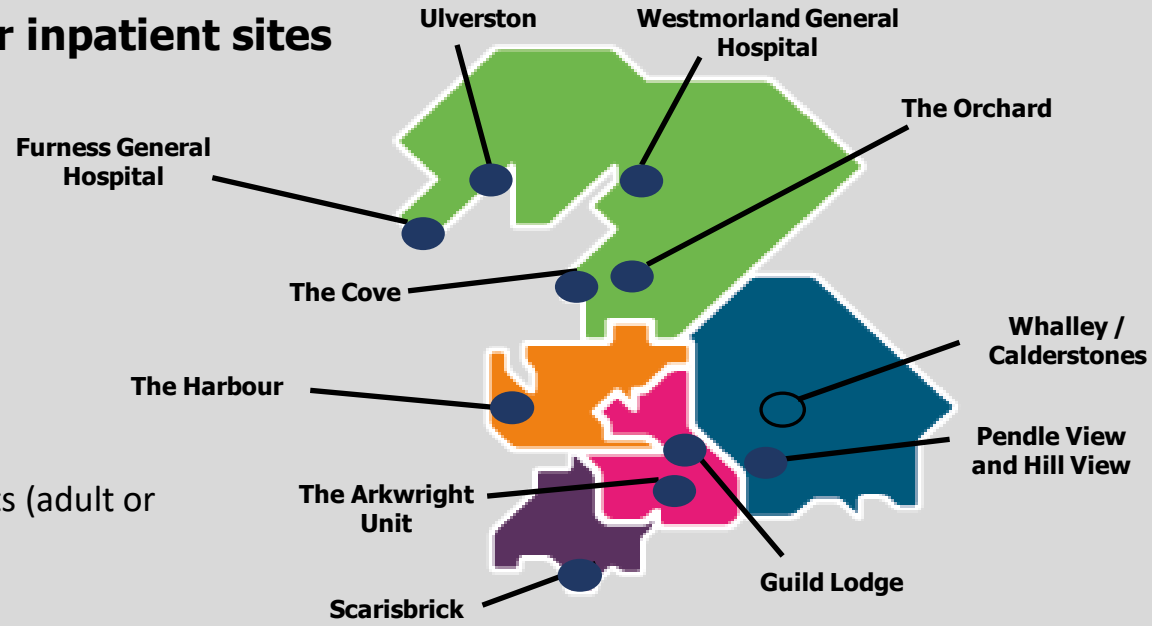
Lancashire and South Cumbria Health and Care Partnership

Lancashire and South Cumbria Foundation Trust (LSCFT) are the principle provider of mental health services across our ICS footprint, the Trust are developing their own Estates Strategy that will set out how the estate can enable the Trust's vision for delivery. We intend to create parity of esteem for mental and physical health services and we will reflect this in our infrastructure planning. We need to conclude the Whalley site transfer from Merseycare to LSCFT and progress with the planning for the site redevelopment.

NHS Lancashire & South Cumbria NHS Foundation Trust

Currently, our mental health accommodation covers everything from our secure facilities, inpatient units, to our outdoor gardens, to our local communities, to the places we deliver services and initiatives, such as Brockholes Nature Reserve in Preston.

Map of our inpatient sites



Internal area, The Harbour

IMPROVING OUR NHS ACCOMMODATION

Mental health, learning disabilities and autism

Reception, The Harbour

Locally, much of our community mental health services are delivered from leased accommodation. Specific programmes of infrastructure development and the supporting detail in respect of community requirements and mental health promotion and prevention will be incorporated in our out of hospital accommodation requirements, developed as part of the Lancashire and South Cumbria's five local ICP infrastructure strategies during 2022/23.

Investment requirements

When we evaluate our NHS mental health facilities, we have some excellent estate, however we still have significant investment we need to make. These required investments include £12.7m improvements to our inpatient mental health estate (creating additional capacity and eradicating dormitory accommodation), the £16m development of a new children's and adolescent (CAMHS) unit and £26m for the re-provision of adult secure beds. LSCFT also require £50m to improve the Trust's accommodation, including addressing backlog maintenance, provision of staff facilities to support wellbeing and a range of environmental and therapeutic improvements. Appropriate digital investment will also be required. We will need £26m to develop a learning disabilities assessment and treatment unity locally.

We will continue to develop our non-estate initiatives and look at ways we can use our land to support people's mental health and wellbeing and further promote the Green Agenda. As we move into 2022/23, we will progress options for the future of system-strategic sites such as the Whalley site and how these deliver our broader ICS estates vision – this is likely to include consideration of providing the right accommodation for mental health services, as well as for community and out of hospital and other partners. We must progress detailed planning work around the future of our PFI sites.


Grow Your Own, Guild Lodge

Across our learning disabilities pathways, we intend to reduce the need for residents to be in hospital and this may mean we need increased community provision that may include the need for additional housing based models. We will look at the future capacity we need across Lancashire and South Cumbria as we repatriate more patients so they can receive the support they need closer to home, their friend and their families.

IMPROVING OUR NHS ACCOMMODATION

Our existing Acute Hospital Estate

Lancashire and South Cumbria Health and Care Partnership

Our acute hospitals are where we manage illness and acute and emergency care. We have four acute hospitals Trusts who are working more closely together to transform ways patient pathways are organised and services provided.

Across Lancashire and South Cumbria, we are developing 'collaborative/shared services' or 'specialty networks' and this will look at the infrastructure that is required; collectively ensuring optimum use of physical assets, equipment and the estate as well as developing a new hospital archetype as part of our New Hospitals Programme.

Our acute Trusts collectively own a significant proportion of our estate in Lancashire and South Cumbria, with the map indicating our main hospital sites.

Our hospital estate will be influenced by both increased provision of services in the community as well as the implementation of a single electronic patient record (EPR).

We will always need efficient, safe and effective accommodation to manage illness and provide acute and emergency care and we need investment to ensure this is the right accommodation for our patients and staff.

Our Lancashire and South Cumbria acute hospital Trusts:

NHS Blackpool Teaching Hospitals NHS Foundation Trust

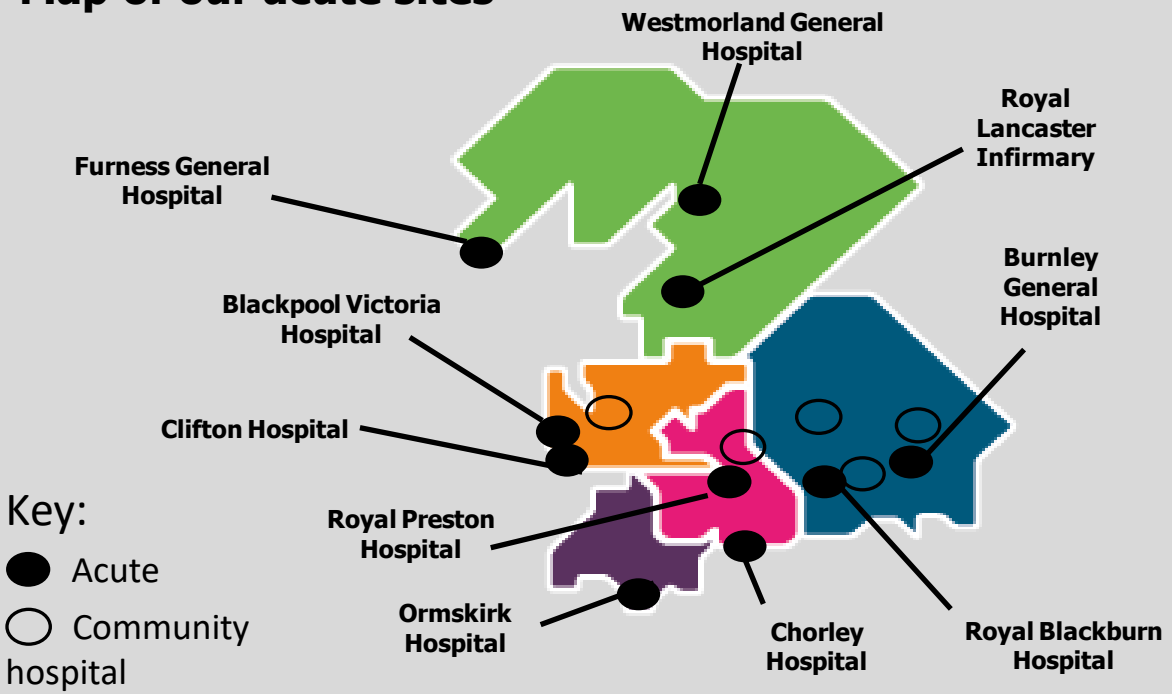
NHS University Hospitals of Morecambe Bay NHS Foundation Trust

NHS Lancashire Teaching Hospitals NHS Foundation Trust

NHS East Lancashire Hospitals NHS Trust A University Teaching Trust

Blackpool Victoria Hospital

Map of our acute sites



IMPROVING OUR NHS ACCOMMODATION

Our existing acute estate

Our acute accommodation is where we provide our most complex medical services. It is where we have our critical and intensive care units, where we house many of our specialist diagnostics services, where our operating theatres are, where the majority of our inpatient bed base is and it is where people come when they have a medical emergency. Our acute hospitals need to be high quality and safe and be able to provide the very best medical care for our populations when they need them.

We need to make investment across our existing acute estate, beyond the investment we require as part of our new hospital(s) programme, to ensure that our acute estate is delivering the priorities within this strategy as well as effectively being able to enable the delivery of our NHS services. An overview of some of the investments we need to make is covered on the following pages.

As well as investments into our buildings, we are developing options for how we use digital infrastructure and technology to support service delivery and the running of our estate; we will plan for the opportunities and challenges of a digitally mature hospital system and how this may impact our buildings in the future. We will also need to make investments across our acute estate to support our journey to a greener NHS; some will be small time investments of resource and skills, others will require significant capital investment and we will identify these as we develop our ICS green strategy and plans.

There will also be a requirement to look at our use of land across our acute sites and explore innovation and partnership opportunities and we will look at some of the potential and examples across Lancashire and South Cumbria later in this strategy.

Westmorland General Hospital

Ormskirk Hospital

Royal Blackburn Hospital

IMPROVING OUR NHS ACCOMMODATION

How do we need to improve our acute estate?

Lancashire and South Cumbria Health and Care Partnership

We have a range of investments that we need to make across our acute estate :

At Blackpool Victoria Hospital, we need to make improvements to our emergency department, deliver a £16.3m critical care scheme and invest in a new MRI suite (see further summary regarding equipment in section 'major equipment and technology'.)

In Central Lancashire we need to make significant investments into vascular, thrombectomy and endoscopy accommodation. There will also need to be significant investment at both Chorley and Royal Preston Hospitals to make required improvements as well as to support major transformation across the acute sites – some of the specific investment requirements include £10m for the development of a new medical assessment unit, £25m to support a new elective/ diagnostics centre and £10m for upgrades to the cancer unit. There will also need to be investment into critical infrastructure as well as major equipment replacement across Lancashire Teaching Hospital's sites.

In Pennine Lancashire, £14m investment is needed for ward renovations at both Royal Blackburn and Burnley General Hospitals as well as capital to support diagnostics at Burnley General Hospital and £10m for the development of an emergency village at Royal Blackburn Hospital.

Across the Morecambe Bay geography, investment is required across its 3 hospitals, including £50m for a new build modular block for the emergency department and medical wards at Royal Lancaster, £14.5 for day theatres at Westmorland General and £12m for intensive care improvements.

Plans for Central Lancashire and Morecambe Bay will need periodic review as our New Hospital Programme Plans progress and the associated costs and timescales are agreed.

Moving services into the community - There will also be some services we currently deliver across our acute sites that we will increasingly deliver within the community in the future and as we develop our plans over the next few years, we will focus on identifying what these are, how this will change our acute accommodation and what opportunities this may present.

Royal Preston Hospital

IMPROVING OUR NHS ACCOMMODATION

Our New Hospital(s) programme

Lancashire and South Cumbria Health and Care Partnership

Alongside investments across our out of hospital accommodation and required improvements to our existing acute estate, we will also focus on the development of new hospital facilities. Our new hospital(s) programme will look at re-designing our acute service models and then re-provide some of our existing hospital facilities. These will be cutting edge green, digital and sustainable hospitals of the future for Lancashire and South Cumbria; providing the accommodation to offer a range of services to our populations and contributing to shaping healthier places across our whole geography. We intend to open our new facilities by 2030 and will see a far-reaching range of benefits.

Ageing hospital buildings are causing issues in terms of condition and layout, longer waiting times, risks to patient safety and are making life harder for staff. Covid has stress-tested the system; uncovered weaknesses in basic services like oxygen and electricity supply and we are unable to deliver new therapies or treatments to the level of service required.
Because of our poor accommodation, we have challenges in attracting new staff and we need the kind of new, advanced facilities that our patients and staff deserve.

An example of what a hospital of the future may look like

The right accommodation will enable us to build on what we are great at and offer the best in modern healthcare including digital services and facilities, utilising artificial intelligence and robotics.

We will create a great environment to work in and provide space and facilities to deliver better treatment, care and experience for patients and families. The right accommodation will enable faster access to healthcare colleagues and clinical expertise for patients and improve access to and choice of specialist acute services.

Our new hospital facilities will support our network of healthcare providers and help us to make our region a centre of excellence for education and research. We want to use infrastructure to attract the best people to work and study in our area and expand the NHS role as major employer within our communities. We will use the development of our new hospital facilities for sustained economic benefit, attracting investment and new jobs.

We will need to consider a number of significant infrastructure projects as part of the new hospital programme that will need coordination with multiple partners; this includes land acquisition, transport connections (road and other links) and utilities and grid capacity to meet our longer-term system wide intentions.

IMPROVING OUR NHS ACCOMMODATION

The wider accommodation impact of our new hospital(s) programme

Lancashire and South Cumbria Health and Care Partnership

As we have previously outlined in this strategy, we need investment in all our hospital and community infrastructure over the next 10 years to provide state of the art facilities and technology to improve health outcomes, reduce inequalities in accessing acute and specialist care and delivering services flexibly and sustainably.

The new hospitals programme will apply demand and capacity modelling assumptions and this will include assumptions for the % of activity that will move from hospital to community based care. These assumptions will make a direct ask of the system to make ready the necessary community infrastructure and care pathways. We will include our requirement within our ICP infrastructure strategies and any later iterations of this document. Our out of hospital service models and accommodation solutions will need to be embedded and mature by the time the new hospital facilities open no later than 2030, so we must start planning these today.

By 2030, when our new hospital facilities open, our pathology collaborative will be complete with a state of the art pathology centre serving the whole region. Community diagnostic hubs will be established. Elective care will be provided at leading elective cold/green centre (Burnley, Westmorland, Chorley). Blackburn Preston, Blackpool and Furness will retain inpatient elective capability based on clinical need. Some day case provision will be retained if travel to the leading elective centres negatively impacts inequalities.
A fully modernised, digital outpatient system will have been implemented. Where investigations are required, this will be provided in community diagnostic hubs (one stop shop). We will have implemented a more responsive and better UEC (inc. A&E) model, transforming integrated community care via ICPs. A&E departments will operate geographically across our region and we will provide the population with a wider range of specialised services from our hospital facilities.

As our infrastructure and accommodation requirements are further determined, we will continue to refine our strategies and develop investment and implementation plans. We will develop plans over this period to meet available finances and delivery models as they become available.

Digital technology and equipment

Existing acute accommodation at Blackpool Victoria

IMPROVING OUR NHS ACCOMMODATION

North West Ambulance Service (NWAS)

The North West Ambulance Service NHS Trust (NWAS) was founded in 2006 following a merger of the Cumbria, Lancashire, Cheshire & Mersey and Greater Manchester Ambulance Services.

NWAS provide 999, 111 and Non-Emergency Patient Transport Services to a population of 7 million people across the North West of England. The NWAS vision is to be the best ambulance service in the UK, providing the right care, at the right time, in the right place; every time.

The environment is one of the Trust's strategic priorities and is delivered via the Trust Green Plan. NWAS were the first UK Ambulance service to have electric vehicles on the front line, are the only one to declare a climate emergency (via the Greater Manchester Health and Social Care Partnership), and designed and delivered the first ambulance-specific Carbon Literacy training program in the world.

Burnley Ambulance Station

The NWAS estate has already implemented an array of energy saving technological initiatives including renewable energy sources. NWAS is redeveloping its Blackpool site with a new Ambulance Hub designed to as near Net Zero standards as is practicable and is planning a similar project to be delivered to a site on the outskirts of Preston.

NWAS are already investing in electric RRV vehicles and will evaluate the outcome of the trials for the prototype electric ambulance being carried out in London. As part of general capital works NWAS will continue with a programme to achieve 100% LED lighting across all sites, install the infrastructure for staff/visitor EV charging and consider the most energy efficient plant and equipment for undertaking any routine replacement requirements.

NWAS' EV ambulances will need rapid charging at locations that they arrive at and wait, such as hospital sites and A&Es.

IMPROVING OUR NHS ACCOMMODATION

Major equipment and technology

Lancashire and South Cumbria Health and Care Partnership

Along with having the right spaces and accommodation to provide health services to our populations, we also need to have the right equipment across our accommodation to enable us to diagnose illness and provide ongoing care. When we talk about 'major equipment and technology', we include items such as the MRI scanners, linear accelerators and x-ray machines that we need across Lancashire and South Cumbria. Our clinical strategy states that people across our geography should have equality of access to high quality equipment.

Much of our equipment needs to be upgraded and replaced to ensure we are providing effective and efficient care as well as provide equity of access and services. We have identified £99m of required investment into major equipment across Lancashire and South Cumbria. We need to ensure appropriate investment and purchasing to create a cost effective equipment system where equipment and technology have a suitable level of prioritisation to support the improvements in services and their support.

Technology

We will also need other investments in technology; we will need to invest in pharmacy manufacturing across our ICS along with improvements to mechanise production and distribution via robotics where optimal, and we will need new technology to support our existing and planned pathology services. We will need to develop our plans and options for other areas of investment needed to be able to deliver our clinical strategy.

Collaboration opportunities

We are already working across the ICS on a number of collaborative work streams in relation to major equipment and technology. We will continue to plan and change our support services to deliver economies of scale to procure, manage, maintain and service equipment in a consistent way across our ICS.

Linked to the Collaboration Workstream we are currently working on plans and opportunities for standardising contracts and providing comparable equipment across our various sites. We will also consider mobile options and non-capital purchase solutions where this is feasible, to give us increased flexibility for the future.

Example of a LINAC (Linear Accelerator) machine

IMPROVING OUR NHS ACCOMMODATION

Support accommodation

We will develop plans and options around our support accommodation; generally non-clinical accommodation either within our clinical health sites or in separate buildings or the accommodation of partner organisations. These options will include accommodation for staff offices, meeting rooms, training spaces, back office functions or storage.

We develop opportunities for consolidating back office and support functions and the associated accommodation – we are already doing this through our pathology collaboration and will continue to identify new opportunities eg Pharmacy, Sterile Services, Catering Services etc.

We will also build on the early work around staff workspaces to inform our local staff accommodation requirements, the detail of which will need to be developed as part of the ICP infrastructure strategies.
We will create new types of office space that enable us to work more effectively and reduce our overall office footprint.
We will develop options with local authorities and other public sector partners and take a one-public-estates approach where possible and practicable.

We will review and reduce our storage needs. There are opportunities to re-think and re-use our storage options, consolidating where it makes sense and where storage is a requirement with no other viable option eg paper record digitisation.
We will develop a proposal and associated programme for the digitistion of paper records to both improve the mobility of patients between hospitals and non-hospital settings and free up accommodation space for reuse or disposal.

We will continue to consider Carter and will reduce our non-clinical space across our clinical accommodation as and wherever we are able.

Our NHS workspaces of the future

Earlier in 2021, a piece of work was carried out by Lancashire and South Cumbria ICS around the vision for their staff accommodation/ staff workspaces for the future. This accommodation review covers all existing CCG accommodation and on on-line booking system will be used by staff to book workspaces. This booking system and process creates system wide benefits for provider trusts into the future.

APPENDIX 5
Our NHS workspaces of the future

How our future workspaces may need to look

A network of digital, green and sustainable workspaces across Lancashire and South Cumbria

Modern, friendly places with flexible options for working and meeting.

Spaces for our people, teams and ideas to come together; today and in the future

CONSOLIDATING OUR NHS ESTATE

Surplus sites and disposals

Lancashire and South Cumbria Health and Care Partnership

As well as investing in our existing accommodation and creating new accommodation, we will also review plans for consolidating our NHS estate; disposing of those buildings that we no longer require because they are either no longer needed and/or do not provide us with the right accommodation to deliver our clinical strategy.

A site showing the land boundary

The summary gives an overview of the L&SC disposals and identifies potential areas of surplus land and projected potential housing units, where appropriate. The figures below are based on disposals in Lancashire and South Cumbria ICS, and/or owned by trusts based in L&SC, only.

- Land and buildings area =16.8 Ha for disposal between 2022 to 2025
- Reduction in backlog maintenance through disposal £500K
- Reduction in estates running cost through disposal £770K
- Possible gross sales receipts £8M *(if disposed rather than redeveloped or developed with or by partners)*

The ICS, through the other elements of this strategy, will challenge the need for holding surplus property, especially where any land/building could add socio-economic benefits to the local population – some of the ways we may need to use our surplus land and property have been suggested in PARTS TWO and FOUR and are further picked up in PART FIVE. As part of the development of our ICP infrastructure strategies and our resulting system infrastructure plans, we will clearly identify any potentially surplus sites that are recognised as strategic sites for creating a healthier population. Where appropriate, planning will be sought for the most financially advantageous use, this must be judged against the social benefit mentioned above. Some of our sites have the potential to be developed by partners to assist our emerging plans to achieve Net Zero Carbon.

Land Values

Our land values across Lancashire and South Cumbria are among the lowest in the country and disposals proceeds, whilst being noted, will not materially affect the capital requirement across Lancashire and South Cumbria ICS.

PART FIVE

SHAPING HEALTHIER PLACES

In Part Five, we look at how we can use our infrastructure to shape healthier places.

Infrastructure for good health begins in the places we spend our time; at home and in our local communities. Our hospitals and health centres are there for when people need some support, but there are things we can also do to shape healthier places and prevent people falling into poor health in the first place.

We need our infrastructure across Lancashire and South Cumbria to be actively shaping healthier places across our five ICPs.

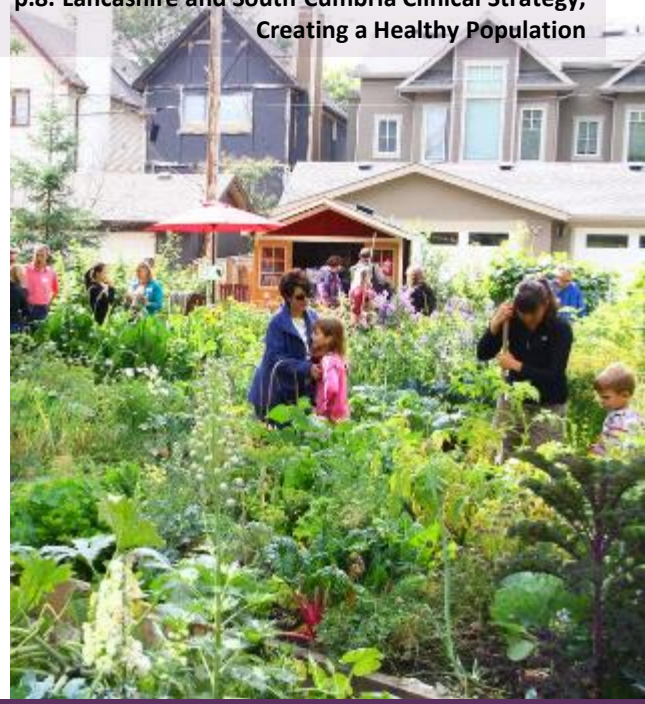
Health infrastructure, or perhaps we should think of this as 'healthy infrastructure', or 'infrastructure for health' is so much more than the places we manage illness and provide acute and emergency care. We have already started to develop our plans for how we think about our infrastructure and can create accommodation locally that supports people across Lancashire and South Cumbria to live well. The environments in which we live, work and play have a huge impact on our health and wellbeing and we should take a more coordinated approach across our system to support a healthier infrastructure conversation.

We started the infrastructure review around shaping healthy places during our 2019 Local Asset Reviews, and we need to build on this, think more holistically about infrastructure, use our system-wide influence and that of our partners to start to address health inequalities more formally through different infrastructure work streams and more consistent collaborative working.

What is PLACE?

'Our communities or our place are the interactions we have in our daily lives. Place is different for all of us; it is the local shops, schools, businesses, our employment and the environment in which we live'

p.8. Lancashire and South Cumbria Clinical Strategy, Creating a Healthy Population

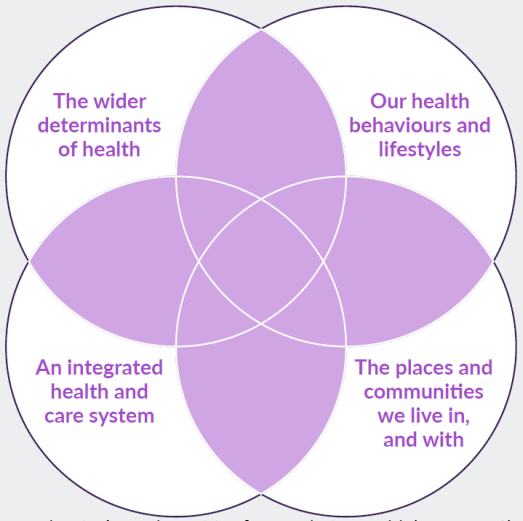


Shaping healthier places is key to the delivery of our clinical strategy and if we are serious about creating services for prevention, then all partners must radically re-think our/their place-based digital and built infrastructure.

We will develop our collective intentions to directly impact and start creating healthy places through our public-sector owned and leased infrastructure – including re-imagining how we use our land and buildings. We will work more collaboratively with our wider public and third sector partners and take a one public estate approach. We will use our influence with local partners and businesses to support the development of their plans and similarly, communicate what our plans are for others to influence and support.

In this chapter, we bring attention to some key areas such as housing, closer collaboration with Local Authorities around design and development, partnership working, health on the high street, closer working with the academic sector and more.

Shaping Healthy Places
Health infrastructure is more than our health estate



From The King's Fund – A Vision for Population Health (APPENDIX 8)

'Taking a whole systems approach means working across traditional sector boundaries on common goals; addressing immediate needs but importantly, too, the root causes and wider determinants of preventable health conditions and poor wellbeing.

*This includes **addressing the role of the built environment and the way new places are planned and shaped.** This is recognised in both the NHS Five Year Forward View, the NHS Long Term Plan, and the National Planning Policy Framework. **For it to become a reality, it will require significant further focus from all players in shaping the places we live in '***

p.6. NHS Putting Health into Place, Executive Summary

The NHS Long Term plan stresses the importance of the NHS and the built environment sector continuing to work together to improve health and wellbeing beyond the provision of hospitals, health centres and the accommodation that we need to manage illness.

Putting Health into Place was a national NHS programme that took the learning from the 2015 Healthy New Town's 10 demonstrator sites, including Wyndyke Garden Village on the Fylde Coast. We used the resulting principles (APPENDIX 7) to frame our Local Asset Review during 2019, where we started to think differently about what constitutes 'health infrastructure'. Today, the Putting Health into Place programme and principles remain as relevant as ever before. These principles have been built on and further developed in the recent NHS Confederation 'Health on the high street' report (APPENDIX 9).

There is some exceptional place-based work taking place locally with local authorities and a range of other partners.

We will bring forward plans for a system-wide, holistic review of infrastructure and its link to the wider determinants of health. If we are to create a population health led infrastructure that supports the delivery of our Lancashire and South Cumbria clinical strategy, then we will also need to ensure we have the right forums to progress and develop our strategies, intentions and plans.

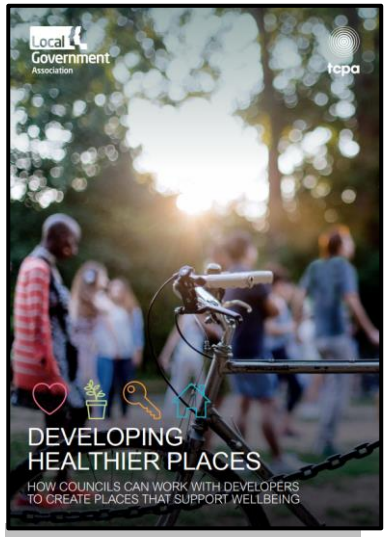
We must acknowledge that many of the solutions we may need sit outside of our direct influence and control. By creating an environment of collaboration and co-production we will be best placed to create the best solutions for our citizens.

Shaping Healthy Places
What can we do?

Lancashire and South Cumbria Health and Care Partnership

We must progress our plans to start actively shaping healthier places. We will continue to work closely across all public sector organisations to make best use and optimise all public assets, thinking about collaboration opportunities across accommodation and digital work streams. We must re-purpose our ICP Strategic Estates / Infrastructure Groups to be the key forum for these conversations.

We will work more closely with Local Authorities on our health infrastructure requirements, looking at everything from joint planning, to policy frameworks to influencing development decisions. We need to better progress opportunities to access Section 106 and Community Infrastructure Levy (CIL) monies to support our required health accommodation investments locally. Through a nationally led programme ICSs are encouraged to engage more in the planning process, both to influence healthcare planning, and to argue for health to be a consideration in the formulation of local plans. Guidance is due this year, and will also cover the need to engage on major housing development to ensure that health takes a fair share of developer contributions by way of s.106 agreements and CIL, where this has been adopted. There will be an expectation for each ICP to appoint a planning lead. We will work with local authorities to support their plans and programmes to improve the health and wellbeing of **our** citizens.



APPENDIX 10
Local Government Association – Developing Healthier Places

We will develop opportunities to support local places and provide health on the high street. We will agree our strategy for how we use our surplus land differently, thinking about the potential for health campuses and health and wellbeing villages and also link with opportunities to link with wider system plans for Net Zero Carbon. We will take the one-public-estate approach to our infrastructure decisions. We will support our partners to develop ways the community can use our infrastructure differently – whether this is through using space in a health centre for evening sewing classes or digital skills sessions, using our green spaces to support local wellbeing initiatives (like at Guild Park, Preston) or providing guided walking routes to and from our health accommodation in partnership with primary care networks and others.

We will develop programmes for work for greater digital community connectivity and how we create connected communities. We will also work with partners who can help us locally in creating healthier places and whether this opens up new opportunities for collaboration around a healthier future infrastructure. **As we begin to work in closer collaboration with others, we will need to ensure that we are not inadvertently adding complexities to others' programmes – we want our input to be enhancing and creating opportunities, not stifling progress.**

Principles for healthy places

We should continue to look at using the 10 principles form the Putting Health into Place programme as a basis for our thinking

APPENDIX 7
Putting Health Into Place Executive Summary

HEALTH BEGINS AT HOME

Why the relationship between health and housing is so important

Lancashire and South Cumbria Health and Care Partnership

We have long known the link between housing and health and it has been a key focus for public health since the 19th century. We know that nationally the cost of poor housing to the health service is significant and we need in increase our efforts to actively promote improving local housing in a coordinated way across our health and care organisations.

Everyone in their life spends a lot of time at 'home', and the correlation between good health and good housing is well known, So too is the negative impact that poor housing can have on our health. Areas such as cold homes, poor air quality, hazards, loneliness and tenancy concerns impact on poor physical and mental health, which in turn increase demand for services.

We will use our voice and role as Anchor Institutions to shape local policy, influence initiatives that improve existing housing stock and to support and endorse the building of a better standard of new homes that improve health for future generations. This work started with the **NHS Healthy New Towns Programme** and we need to take positive steps to understand and support how this can work across Lancashire and South Cumbria.

'A growing and ageing population and a significant programme of house building planned and underway across the country has created an opportunity to address some of the causes of these inequalities for these communities for generations to come…'

p.6. NHS Putting Health into Place, Executive Summary

We are increasingly using technology to monitor and support people in their own homes rather than in hospital, we deliver more services in the home and increasingly our staff use their homes as a place of work.
Self-care, patient assessment using smart technology and anticipatory care will take place at home and living well across local communities will be core to our future system sustainability.

We will include housing in our local Place-Based Infrastructure Plans and our ICP/PBP strategies must ensure that housing starts to be become part of our local solution where appropriate.

We will continue to work with Local Authorities and Registered Providers (RPs) to link together the increases in housing supply, the additional support that PCNs will need for this growth in population, and how we can all address the quality and suitability of housing for our citizens.

The Housing LIN have some excellent resources: www.housinglin.org.uk

SPECIALIST HOUSING & HOUSING WITH CARE
What do we need across Lancashire?

Lancashire and South Cumbria Health and Care Partnership

We will develop plans for our wider requirements in respect of specialist housing, particularly as part of our **social care, learning disabilities and autism and mental health** programmes of work. There are likely to be occasions when we can or should use housing-based models to support our non-hospital / non-inpatient work streams which must be considered. We will develop opportunities for how we can better use our existing health accommodation to create the health and social care infrastructure of the future – developing opportunities to use surplus land and/or strategic sites to bring forward specialist housing developments that support people to live well in the community.

We will encourage and where necessary lead plans across Lancashire and South Cumbria with local organisations who are looking to work with partners to use NHS land for the development of housing-based health and social care solutions.

We are already doing it:

In Burnley, East Lancashire Hospitals Trust have worked alongside a local housing association, selling surplus land at the hospital site to be developed to help shape healthier places. Potentially, this land could have been sold and developed into higher-cost homes – instead, it will provide a range of facilities, including extra care housing to enable people to live more independently as they age. This directly contributes to the delivery of Lancashire County Council's Housing with Care Strategy.

Extra Care Housing

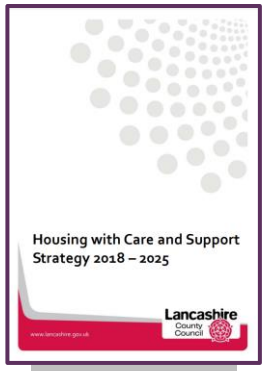
Extra care housing is for people who wish to continue to live independently, but who find themselves needing a little more support. It is usually designed for older people, but is also occupied by younger people living with learning disabilities or other health needs. With 24/7 support and care staff on hand, extra care enables people to live happily and independently in their own home whilst having their care needs met.

Our Tier 1 local authorities are working to ensure there is provision of affordable and high quality housing with care across Lancashire and South Cumbria to reduce the reliance on residential care – this both provides increased choice for individuals and a solution to address increasing demand and financial pressures (extra care is a more financially sustainable option than residential care).

We already have a number of affordable extra care schemes across Lancashire and South Cumbria that are operated by local RPs, with recently completed schemes including Albion Mill in Blackburn and The Lighthouse in Fleetwood. **We will work collaboratively with our local authority partners to actively find ways to support the delivery of further extra care schemes.**

The potential benefits of housing with care
The 2019 Housing LIN study indicated a health care system benefit of c. **£2,000* per resident per annum** for people living in an extra care facility. This is in addition to the system benefits for social care

**based on length of stay, DTOC, community health visits, GP appointments, ambulance call outs and non-elective admissions*



APPENDIX 11
LCC Housing with Care and Support Strategy 2018-2025

APPENDIX 12
Housing LIN Identifying the health care system benefits of housing with care

HEALTH AND THE HIGH STREET
Thinking differently about our accommodation

Lancashire and South Cumbria Health and Care Partnership

One of the areas we shall focus on in more detail is the potential for health and care services **on many of our high streets** across Lancashire and South Cumbria. With recent retail trends reducing requirements for high street stores, we see more and more challenges across our high streets with vacant units and less activity and footfall. With health and economic prosperity so intrinsically linked, highlighted in the recently published Build Back Fairer: The COVID-19 Marmot Review. **We will support our partners and Local Authorities with the development of plans for our localities to be socially and economically prosperous to support better health in the medium to long term.**

Our Covid vaccine centres

We have already piloted a number of locations for health on the high street through our Covid vaccine programme. We have used vacant shops and shopping centres to establish 'pop-up' vaccine centres across our high streets.

Our high streets present us with a range of opportunities to create the health infrastructure of the future, especially with our increased focus on out-of-hospital / non-hospital-based infrastructure and place-based, population led services.

We will develop plans with appropriate options / business cases for taking leases in retail units to create capacity for our primary care networks, co-working and collaboration workspaces and relaxed café style environments for mental health services.

We will include the infrastructure to maximise the benefit of digital services and support and consider whenever appropriate how and where we can deliver in these settings without requiring very specialist clinical space. Where we need more specialist health accommodation, we will include options to convert existing retail accommodation in into health centres in our plans.

Working with our partners we will continue to develop and communicate our plans and assess how these can benefit our local towns through our infrastructure decisions and look to consider making accommodation decisions that will contribute to increased footfall and activity that indirectly influence local prosperity and health.

'[There is an] increasing appetite within and outside the NHS to realise the role of health in supporting economic and social recovery and to reimagine our relationship with the high street.'

'Developing a healthier high street does not have to cost more than the current system and could have significant economic advantages for local communities, local authorities and property owners.'

p.3. NHS Confederation, Health on the high street,

APPENDIX 8
NHS Confederation Health on the high street

CHAPTER THREE

HOW WE WILL DELIVER OUR STRATEGY

The preceding chapter 2 sets out our ambitions and how they focus around five interlocking themes – digital, green, sustainable, having the right accommodation and shaping health places.

In this chapter we highlight the areas we need to focus on to effectively deliver our ambitions and this ICS / ICB strategy.

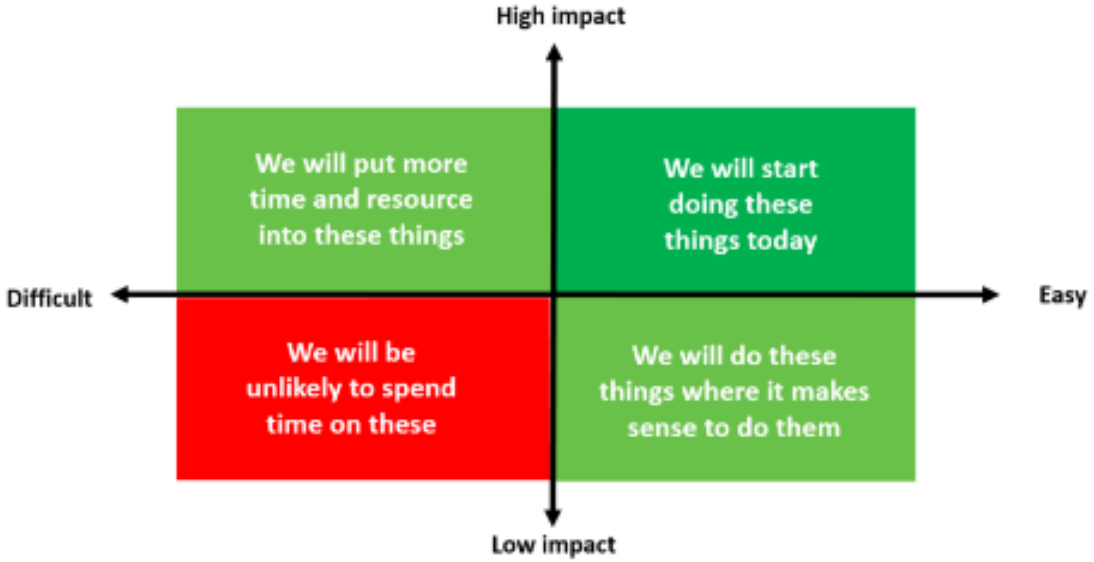
DELIVERING OUR STRATEGY
An introduction

Lancashire and South Cumbria Health and Care Partnership

We have an ambitious vision and strategy and we have a lot of work to do over the coming years to deliver it. We need to continue to answer the questions that emerge as a consequence of this strategy and future developments of the clinical strategy to help inform our programmes of work and implementation plans.
We must focus on **1)** planning how we are going to deliver our strategy, **2)** develop creative options for the financial and investment implications of our requirements, **3)** work with partners from all sectors for the commercial delivery and procurement elements of our plans, **4)** increase and improve our partnership working and collaboration, **5)** streamline our Infrastructure "back office" management, **6)** simplify our governance whilst providing improved assurance, and **7)** improve and simplify our data & intelligence to provide a consistent and clear overview.

We must develop options for new accommodation to support our new hospital(s) programme and its consequences for the development of more non-hospital services, planning for the end of the PFI and LIFT concessions and planning our medium to longer-term journey to net-zero.

We develop our priorities, with sessions to update our plans for capital and investment at least every year and need to use a simple framework to guide our thinking. Where things are 'easy' to do, affordable and high impact, we will start doing these things immediately. These are the things we should be doing anyway and where development of new services require significant investment we will develop a process whereby we can all agree the prioritisation of that investment in an equitable and sensible way.



We will not leave planning for longer-term (+ 5 year) investments for the future and will develop plans and agree how we bring forwards programmes and projects that have a longer-term delivery date so that we have an agreed pathway to achieve these without "back-loading" the issue for others in the future eg PFI / LIFT concession end dates or the Green / NZC agenda.

We have commissioned a Net Zero Carbon review of the hospital estate and will communicate the findings of this during the summer 2022 so that our next update to this strategy can be suitably informed. We will also consider how we support the wider NHS (non-hospital) system to develop their own understanding and plans to similarly get to NZC by 2040.

We will need to consider how we best use our limited resource as we move forward and develop our delivery plans both in the immediate context of the requirement to make substantial and recurrent savings set against the growth and aging of our population and commitments to improved their health and wellbeing (and consequently update, change or improve our aging infrastructure.)

PART SIX

FINANCE AND INVESTMENT REQUIREMENTS

If we are going to provide the health infrastructure to deliver our ambitions and enable our clinical strategy, we are going to need significant financial investment and a commitment to a long-term capital approach to provide confidence in our plans and resourcing for significant longer-term programmes.

We know we need to make significant investment in technology, digital infrastructure and buildings - we have already **identified circa £3.2B of investment requirements** and we understand that we are likely to need even more, particularly in relation to digital investment, investment to achieve our Net Zero Carbon into decarbonisation and into creating the right hospital and out of hospital accommodation.

We know that public dividend capital will be limited compared to the investment requirements across Lancashire and South Cumbria and that we will need to find alterative funding sources to NHS capital and will need to develop and evaluate options including pension funds, social funders and other institutional finance.

We will need to consider and seek support for the revenue impact of these options as well as considerations of limits in relation to Department of Health and Social Care CDEL (Capital Departmental Expenditure Limits).

We are also acutely aware of the comparative low value of land and assets across Lancashire and South Cumbria compared with many other parts of the country when planning for disposals to support future investment requirements.

We have set out an overview of our investment requirements on the next slide.

INVESTMENT REQUIREMENTS

Our Lancashire and South Cumbria Health and Care Partnership NHS investment requirement is

£2,915m

Lancashire and South Cumbria Health and Care Partnership

Further detail and detailed information on each project included in our Lancashire and South Cumbria Health Infrastructure Project Tracker (APPENDIX 13)

£300m	Digital, technology and major equipment
£310m	Community and primary care accommodation
£80m	Mental health
£35m	Learning disabilities and autism
£600m	Existing acute estate
£1,100m	New Hospitals Programme (options up to £2.2B)
£150m	Ambulance services
£300m	Backlog maintenance
£40m	Other
£TBC	*Decarbonisation investment* *(outcome of review expected summer 2022)*

PART SEVEN

DELIVERY & PROCUREMENT

If we are to deliver the ambitions we set out in this strategy, we will need to develop our skills in planning, delivery and procurement.

Lancashire and South Cumbria Health and Care Partnership

This Infrastructure Strategy will be underpinned by a **Delivery Plan** to be developed during **2022/23.**

The development of the Delivery Plan will require the collaborative support of the NHS organisations across Lancashire and South Cumbria and include the following:

- Capital Prioritisation Workshops – this is an annual planning event typically in March of each year.
- Development of a Commercial Strategy to develop options and opportunities for the investment requirements in digital, technology, equipment and the estate. This needs to include ways that we can make the required improvements to our infrastructure even if NHS Capital is not available to the timescales needed.
- Create a single procurement function across the ICS that will support the key priorities of the system and achieve efficient purchasing using the greater buying-power that a larger collaborative approach should achieve.
- Develop an Infrastructure Procurement Strategy to support this Infrastructure Strategy and to be used as a template for future infrastructure projects and their associate business cases.
- Update the "Who is available to who" matrix to support the different development opportunities that are available to partners across the ICS. This will include the wider opportunities provided through co-working with Local Authorities and their development partners. Choosing the right infrastructure development partners will be critical to the success of the programmes and projects that use this support.
- Work with colleagues in the National Estates and Commercial teams to bring forward development / investment vehicles to take forward third-party investment where the need is clear and agreed yet held back by the timing of availability of capital

As we further develop our plans, we will need to ensure that we have the right delivery mechanisms, resources and internal skills in place to support our local transformation requirements.

PART EIGHT

PARTNERSHIP AND COLLABORATION

We need to increasingly work in partnership and collaboration if we are to achieve the delivery of our clinical strategy and supporting infrastructure ambitions.

Lancashire and South Cumbria Health and Care Partnership

We will take a whole-system approach to our challenges, operating as a single system delivering across multiple providers – everything from creating a standard estates condition and backlog data-set, understanding the implications and cost for the NHS across Lancashire and South Cumbria to become net-zero carbon to developing our estates and facilities workforce to respond to the challenges identified in this strategy and to be set out in the Delivery Plan.

We must continue to work across our organisational boundaries – this will be essential for our future health systems sustainability. We are working with the planners/other partners to maximise accessing other capital/growth funds, for example Northern Powerhouse funds. We will build on the momentum of working together that built during the pandemic, refocusing our shared goal around 'creating a healthy population.'

We will develop plans for how we work together to share resource, capacity and expertise across our organisations. And we must work beyond the public sector and work with local voluntary groups, charities, businesses, our universities and the wider private sector to maximise our opportunities.

We need to continue our partnerships locally with local authorities and ICP stakeholders and strengthen these in relation to infrastructure so we can provide the right accommodation and shape healthier places. We will start doing some of this work in reviewing our strategic sites (e.g. Whalley) to develop a shared public sector vision, developed by Trusts, local authorities, primary care networks and local providers and stakeholders.

We will work with local innovation and academic partners, local and regional pioneers and businesses and, most importantly, our communities to shape our infrastructure of the future.

We will engage with the market to ensure the solutions we need are out there and our partners and the wider market are aware of what we are trying to do - this may mean discussion with developers, tech providers, equipment manufacturers and electricity companies.

PART NINE

MANAGEMENT

We must ensure we have effective management resource, capacity, capability and systems in place if we are going to effectively deliver our infrastructure strategy.

As well as looking at how we deliver our infrastructure ambitions from a funding, procurement and supplier point of view, so too must we consider how we will manage the changes we need to make.

We will take a system-wide / system-first approach to oversight of delivery and management as well as ensuring we are utilising, enhancing and developing our collective expertise and capabilities. We have some brilliant people who work across our various infrastructure fields and we must ensure that we as a system of health and public sector partners work together as efficiently and effectively as possible.

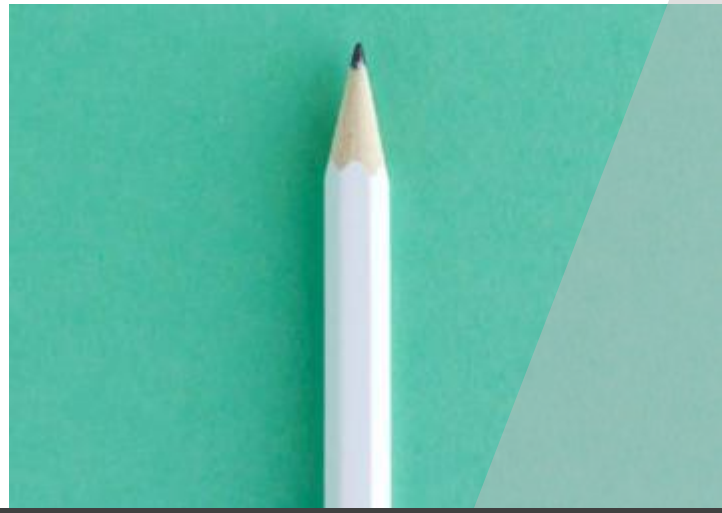
We need to be able to optimise the use of our resource and capacity by taking this system approach and collaborating, sharing both skills and ideas. Our emerging governance structures will strengthen and refine the forums in which we are able to do this. There will also be times when we will bring in additional capacity and expertise, especially where these skills are project or skill specific.

We will continue to **develop our business case capability** across all our organisations, ensuring we are taking an increasingly standard approach to business case development, from initial proof of concept work to SOC to OBC and FBC. Support and oversight will be provided by the ICS to help unblock any issues, to maintain momentum and to ensure consistent quality in order to secure success.

We must ensure that we are the informed client and we will need to bring in the right resources to support this.

We will develop an **Estates Blueprint during 2022/23** which will support the Delivery Plan and map current NHS Estates and Facilities staffing across Lancashire and South Cumbria and identify where shared, different or additional resources may be required.

And finally, we will need to have local autonomy and control over the management our digital systems, technology and buildings in order to deliver our infrastructure ambitions.



PART TEN

DATA AND INTELLIGENCE

Our collection, analysis and use of data will be increasingly important as we move forward. We will get better at using our data to help inform, guide and challenge our decision making in respect of our infrastructure.

Lancashire and South Cumbria Health and Care Partnership

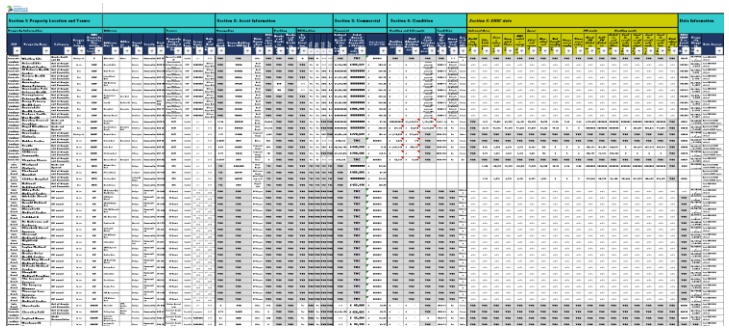
There are extensive amounts of information already available and we will start by reviewing what data we have and need, so we are not collecting information that is of no use to us. In order to inform this strategy, we have developed a Lancashire and South Cumbria Health Asset Database that includes estates information on all our NHS health assets. We will need to continue to update and improve this information and manage it on an ongoing basis, including using it to capture information around our carbon emissions and carbon footprint(s).

We have already started work across our Trusts to ensure we are taking a consistent approach to how we collect and report our information and have standardised our approach to this year's ERIC returns for the first time; we will continue this collaboration across our Trusts. We will also refine our approach for how we use data to inform our investment requirements, from the work being completed on our New Hospital(s) Programme to reviewing potential investment opportunities in Primary Care. The recent NHS England and NHS Improvement Primary Care Data Gathering Programme and update of Public Health England's SHAPE system will help improve our picture of local primary care estate. We will focus on baselining our carbon position so we can plan for our journey to net-zero and be able to measure progress along the way. We will agree how we use our growing levels of consistent data to increase our estates optimisation, thinking about space management and room booking systems and actively analysing the information we have available to us.

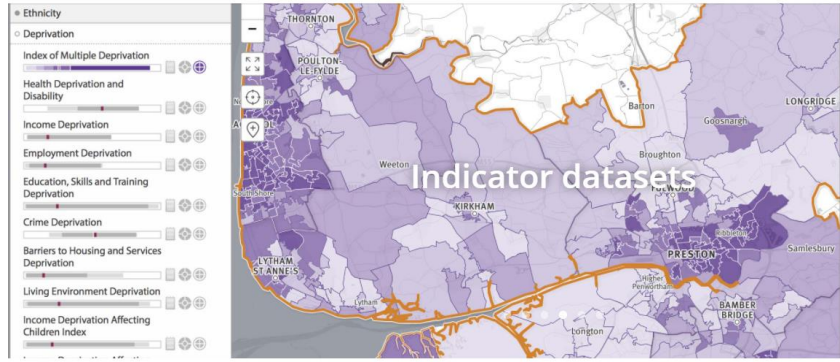
We will continue to consider how we use our data more intelligently, looking at how we align our infrastructure data to other assets and datasets so we can increase optimisation of assets and better transform patient pathways.

Our Lancashire and South Cumbria Health Asset Database

(APPENDIX 4)



SHAPE Strategic Health Asset Planning and Evaluation



PART ELEVEN

GOVERNANCE, REPORTING AND DECISION MAKING

Over the next 12 months, we will continue to develop our governance that we will need to support effective discussion and decision making in respect of our health infrastructure locally and across our system.

Lancashire and South Cumbria Health and Care Partnership

We have a number of unknowns in respect of our future organisational structures and we will develop our governance in more detail as these become clearer. We do know, as we move forward and through the evolution of Lancashire and South Cumbria ICB that we need to be communicating clearly our position and decisions as we become a statutory authority – both strategically and in our planning. We need to be making the right decisions, both collectively across our system and as the accountable bodies within it. We will continue to refine how we create appropriate structures that support collaborative and effective system-wide working and consistency in decision making, whilst ensuring that our statutory organisations area accountable.

We will evolve and refine our existing forums and groups, including our Lancashire and South Cumbria Estates and Infrastructure Group, across our system footprint. More locally, we will work across our local ICP/PBPs to continue to develop, re-focus and re-profile the Strategic Estates Groups into Strategic Infrastructure Groups, using some of the longer term visioning in this strategy to support the work of these groups and the development of their Estates and Infrastructure Strategies. As part of developing our governance, we will also further develop our connections with and support of other existing infrastructure groups such as the Lancashire Property Board, that we will need to both influence and be influenced by.

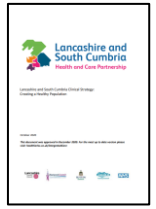
We will also complete further work to map and understand what decision making, discussion and development happens at place level and what across the whole system footprint.

APPENDICES

Lancashire and South Cumbria
Health and Care Partnership

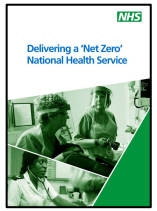
APPENDICES

The documents we reference within our strategy:

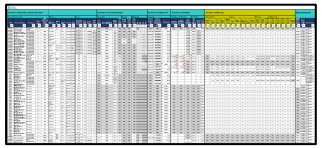


APPENDIX 1: Creating a healthy population
https://www.healthierlsc.co.uk/application/files/6116/2193/4706/LSC_Clinical_Strategy_v_2.3_final.pdf

APPENDIX 2: Our digital future
https://www.healthierlsc.co.uk/digitalfuture

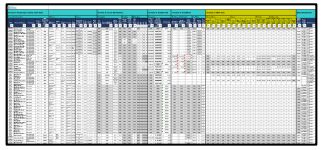


APPENDIX 3: Delivering a 'net-zero' NHS
https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2020/10/delivering-a-net-zero-national-health-service.pdf



APPENDIX 4: Asset Database
Attached

APPENDIX 5: Staff accommodation visioning: Our NHS workspaces of the future
Attached

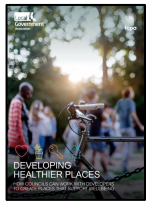


APPENDIX 6: Disposals Summary
Attached

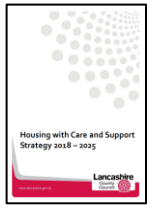
APPENDIX 7: NHS Putting health into place
https://www.england.nhs.uk/wp-content/uploads/2019/09/phip-executive-summary.pdf

APPENDIX 8: Health on the High Street
https://www.nhsconfed.org/sites/default/files/media/Health%20on%20the%20High%20Street.pdf

APPENDIX 9: The Kings Fund A vision for population health
https://www.kingsfund.org.uk/sites/default/files/2018-11/A%20vision%20for%20population%20health%20online%20version.pdf



APPENDIX 10: LGA Developing healthier places
https://www.local.gov.uk/sites/default/files/documents/22%2018%20Developing%20healthier%20places_06.pdf



APPENDIX 11: Lancashire County Council Housing with Care Strategy
https://www.lancashire.gov.uk/media/912048/housing-with-care-strategy.pdf

APPENDIX 12: Housing LIN Identifying the health care system benefits of housing with care
https://www.housinglin.org.uk/_assets/Resources/Housing/Support_materials/Reports/HLIN_SouthamptonCC_HwC-Health-Care-System-Benefits_Report.pdf

APPENDIX 13: Lancashire and South Cumbria Health Infrastructure Project Tracker
Attached

Integrated Care System Board

Date of meeting	**2nd March 2022**
Title of paper	**New Hospitals Programme Quarter 3 Board Report**
Presented by	**Jerry Hawker, Programme SRO**
Author	**Rebecca Malin, Programme Director** **Matthew Burrow, Project Manager**
Agenda item	**8**
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 3 period; October – December 2021. This quarterly report is presented to the following Boards; • University Hospitals of Morecambe Bay NHS Foundation Trust • Lancashire Teaching Hospitals NHS Foundation Trust • East Lancashire Hospitals NHS Trust • Blackpool Teaching Hospitals NHS Foundation Trust • Lancashire and South Cumbria NHS Foundation Trust • Lancashire and South Cumbria Integrated Care System (ICS) • Provider Collaborative And the Strategic Commissioning Committee.
Recommendations
It is recommended the Board; • Note the progress undertaken in Q3. • Note the progress in developing key products to support business case (section 3). • Note the activities planned for the next period namely appraising the longlist to a shortlist of options.

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 Q3 BOARD REPORT

1. Introduction

1.1 This report is the 2021/22 Quarter 3 update from the Lancashire and South Cumbria (L&SC) New Hospitals Programme.

2 Background

2.1 Lancashire Teaching Hospitals NHS Foundation Trust (LTHTr) and University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) are working with local NHS partners to develop a case for investment in local hospital facilities. The programme is part of the Government's commitment to build 40 new hospitals by 2030. Together with eight existing schemes, this will mean 48 hospitals built in England over the next decade, the biggest building programme in a generation. Further information can be found on the **'Our NHS buildings' website (opens in new window).**

2.2 The L&SC New Hospitals Programme (NHP) offers a once-in-a-generation opportunity to transform the region's ageing hospitals and develop new, cutting-edge hospital facilities that offer the absolute best in modern healthcare.

2.3 This is a national programme, which continues to shape and develop. The national New Hospital Programme team continues to work with schemes to determine the best national and local approach to demand modelling, clinical vision and strategy, assessing benefits of new hospital facilities as well as understanding the most effective commercial framework that can be applied. The national team continue to visit schemes across the country and L&SC look forward to welcoming colleagues in the near future.

2.4 Whilst the L&SC programme and extended team work through the complexities that come with such a programme, it remains an exciting opportunity to secure significant investment in our ageing hospital facilities and region as a whole.

3 Progress against plan (for the period October – December 2021)

3.1 In Q3, ICS leaders and NHSEI met to discuss wider system delivery, focusing on achievement of sustained operational, quality and financial improvement. This has enabled the NHP to be firmly placed in the scope of longer term system improvement.

3.2 Given this context, the programme has provided input to the review led by the PCB Clinical Integration Group to develop a strawman Hospitals Clinical Strategy for 2030 and beyond. This is an item of significance for the NHP given the interdependency between hospital sites and services. This important work will continue to be led by our clinicians and is embedded in the vision for L&SC hospitals to work in a networked way, enabled by digital technologies. The NHP will receive ongoing updates throughout Q4 to ensure hospital facilities are designed in line with the Hospitals Clinical Strategy.

3.3 Our hospitals are just one part of a health and care system and can only provide high quality, efficient care in partnership with colleagues from across L&SC. As the NHP progresses the detail around the longlist of proposals - including the size of new hospital facilities, it is clear the hospitals can only be rightsized for future demand if our Primary and Community care services and infrastructure are developed in parallel. This is both an interdependency and risk for the NHP. An ICS primary and community strategy group has recently been established and will start to create a case for change and strategic plan during Q4.

3.4 **Key products to support business case development –** During Q3, a number of key products have been developed. These products represent key building blocks in the development of the business cases. The products are:

3.5 **Site solutions** – this has been an energetic and intensive period where our clinical, operational and estates/site professionals have worked together with architects and other technical experts to understand the art of the possible for rebuild/partial rebuild and refurbishment on the existing sites. This has resulted in realistic examples and designs of where and how the existing sites could be developed, grouping clinical services and buildings for maximum benefit. Colleagues have relished this challenge and opportunity, bringing professional input and enthusiasm to working through such a complex jigsaw puzzle. The output will be used in Q4 to help narrow down the longlist of proposals to a shortlist.

3.6 **Longlist of proposals –** following approval of the longlist of proposals in Q3, the programme has held several workshops with our clinical, operational, estates/site, finance and infrastructure colleagues. These have focused on developing the required detail of the estates options, socio-economic value, aligning the NHP and the ICS Clinical

Strategy and benefits identification. This has provided real and tangible information regarding each proposal, which will now be used to appraise the longlist.

As part of the programme's continued commitment to communicating and listening to our staff, public, patients and wider stakeholders, a series of engagement events regarding the longlist of proposals have taken place. Section 4 provides more detail on these activities. The insight gained from such activities is invaluable and will be used as a key input to the workshop to appraise the longlist.

3.7 **Identification and quantification of benefits –** work has commenced with clinical and estates colleagues, supported by external advisors, to create a log of benefits and associated risks. Whilst this is a formal and somewhat technical element of the business cases, this important step allows the programme to capture and quantify the true impact of our ageing estate and the benefit new hospital facilities will bring.

3.8 **Assessing the options workshop –** this is a significant milestone for the programme as the longlist of proposals is narrowed to a shortlist. The first of two workshops was held in October 2021, where patient representatives and wider stakeholders positively worked alongside clinical, operational, estates and finance colleagues to discuss the longlist of proposals and Critical Success Factors (CSFs). Such workshops allow for a really important wide range of perspective. The programme is pleased to report workshop attendees formally approved the longlist and CSFs, subject to some recommended amendments to the CSFs.

The second workshop will take place in February 2022, when the programme is looking forward to another session of positive and lively input from attendees. This workshop will use the CSFs to appraise the longlist. The output of this will be a shortlist of options, which the programme looks forward to announcing in Q4.

4 Public, patient and workforce communications and engagement

4.1 A number of key communications, involvement and engagement activities have taken place during this period namely:

4.2 Ongoing proactive communications to encourage local people, staff and stakeholders to get involved and have their say, well supported by all Lancashire and South Cumbria

NHS partners through internal and external communications channels.

4.3 A range of new blogs and updates have been published on the NHP website and shared through NHP and partner social media channels, to raise awareness about the programme, explain the process that is being followed and encourage people to share feedback. The programme launched a NHP Programme Director blog to describe how the longlist was developed.

4.4 Through October and November 2021, an advertising campaign was delivered to promote the New Hospitals Programme and encourage local residents to get involved – including local print and online media, radio adverts and social media advertising.

4.5 A wide range of proactive engagement on the longlist of proposals has been conducted, including market research; public roadshow events; workshops and focus groups with under-represented communities; online surveys; stakeholder meetings; online discussion on the NHP Big Chat; staff meetings and briefings; and social media. Reporting on the longlist engagement to date has concluded and an insight synthesis report has been shared with the Communications and Engagement Oversight Group.

4.6 Engagement highlights to date are summarised below at an engagement mechanism level:

- 3,824 responses to NHP online surveys;
- 22,374 visits to the Big Chat website (12,586 unique visitors), with 3,000 people joining the online discussion;
- Two waves of market research completed, with 1,000 people interviewed in each (telephone, in-person and online);
- 879 staff attended two dedicated colleague summits;
- Social media reach of 720K; 1,258 followers across Facebook and Twitter;
- 11,713 people have visited the NHP website to date; with 4,503 page views for the longlist blog update;
- 234 participants from 29 different groups have participated in Healthwatch Together focus groups;
- Face-to-face conversations held with 796 local people through Healthwatch-led roadshow events, which visited 16 local community sites;

- Across all engagement channels, 4,689 seldom heard group representatives have become involved; and
- In total, 12,281 unique individuals have been engaged with online and face-to-face, including 6,470 members of the public and patients.

4.7 This important stream of work continues throughout Q4, including sharing and discussing the shortlist of options and a follow up colleague summit providing an opportunity for NHS colleagues across L&SC to receive an update on the programme and take part in another engaging question and answer session.

5 Stakeholder management

5.1 Board members will recognise there is a breadth of stakeholders in such a programme. During Q3, there has been a continuation of stakeholder updates, meetings and correspondence with MPs, local authorities and community groups. Work on the socio-economic benefits of new hospital facilities continues, working closely with the Lancashire Local Enterprise Partnership (LEP). The programme looks forward to continuing this important strand of the programme in Q4, in particular sharing the shortlist of options.

6 Programme governance and risk

6.1 During Q3, MIAA (Mersey Internal Audit Agency) Advisory Services have undertaken an independent review of the programme governance and assurance arrangements across the NHP. A draft report has been issued for comment with the programme and Governance Advisory Group providing initial comments. An updated version will be presented to the group in January 2022. The final report will include an action plan and decision making matrix in line with programme and statutory body governance frameworks, as well as that of the business case processes.

6.2 Throughout Q3, the programme has strengthened the risk register and progressed interdependency mapping. The full risk register is reviewed and reported to the various groups within the programme governance framework. Risks scoring 15 and above are then reported and discussed at the Strategic Oversight Group (SOG) each month.

An interdependency workshop has taken place with ICS colleagues, producing a draft map of all interrelated projects and programmes. This then allows active management of dependent relationships.

7 Next period – Q4 2021/22

7.1 The key focus of Q4 will be preparing and delivering the formal appraisal of the longlist of proposals, which will establish a shortlist (as per section 3.8) of options which will progress towards the SOC or PCBC stage. This is a significant milestone for the programme and will involve a formal workshop (February 2022) with wide ranging attendees, including patient representatives and stakeholders. The short listing process will use information comprising, but not limited to, the Framework Model of Care, estates/buildings solutions, benefits assessment, reports into net zero carbon, a digital blueprint and the output of the public and staff engagement undertaken to date, with each proposal being appraised against the Critical Success Factors evidence.

Following the workshop, the programme will publish the shortlist of options and welcomes discussions with wider stakeholders, including Health Overview and Scrutiny Committees, community groups, MPs etc.

It is worth noting formal approval from statutory bodies is required ahead of submitting business cases and the programme will continue to keep Boards sighted on progress and provide assurance on the process being followed.

8 Conclusion

8.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 3 2021/22.

9 Recommendations

9.1 The Board is requested to:

- Note the progress undertaken in Q3.
- Note the progress in developing key products to support business case (section 3).
- Note the activities planned for the next period namely appraising the longlist to a shortlist of options.

Rebecca Malin **Jerry Hawker**

Lancashire and South Cumbria
Health and Care Partnership

Programme Director **Programme SRO**

January 2022

Integrated Care System Board

Date of meeting	**2nd March 2022**
Title of paper	**System Reform Programme – General Update**
Presented by	**Andrew Bennett, Interim Chief Officer, LSC ICS**
Author	**Dawn Haworth, Senior Programme Manager Victoria Ellarby, Programme Director Steve Christian, Chief Integration Officer (LSCFT) Ed Parsons, Programme Director, Provider Collaborative Board Debra Atkinson, Head of Corporate Business (EL & BwD CCGs) Cath Owen, Strategic People & OD Lead Neil Greaves, Head of Communications & Engagement**
Agenda item	**9**
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 and focusses specifically on the following key areas of work: • Implications of *Health and Social Care Integration: joining up care for people, places and populations* • National guidance • Readiness to Operate Statement • ICB Governance • Provider Collaboration • Communications & Engagement
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	Yes			
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

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. **Implications of *Health and Social Care Integration: joining up care for people, places and populations***

   In February 2022, the Integration White Paper (IWP) entitled '*Health and Social Care Integration: joining up care for people, places and populations*' was published, which sets out the Government's thinking on the next stage for how NHS and local government partnerships can go 'further and faster' across the country, building on existing legislation and reform, including the creation of Integrated Care Systems, the Health and Care Bill and Thriving Places.

   Key policy proposals within this publication are:

   (i) A **framework for local outcome prioritisation** focused on individual health and wellbeing and on improving population health in addition to nationally set priorities (e.g. the mandate). There will be a further consultation on the detail in due course, with implementation from April 2023. Robust regulatory mechanisms, including CQC to assess outcomes and delivery of integrated care at Place level. There will be specific criteria for place-level governance which will be accountable for **delivering improved outcomes** – a clear push away from organisational focused performance, **towards population outcomes which NHS and local authority leaders will be empowered to deliver against.**

   (ii) Health and care services in local communities ('Places') to be strengthened. By Spring 2023 **all 'Places' should adopt a leadership and governance model with a single point of accountability (SPOA) across health and social care**, accountable for developing a shared plan and demonstrating delivery against agreed outcomes. The plan will be underpinned by pooled or aligned resources, including an extensive proportion of services and spend held by the Place-based arrangement by 2026

   (iii) Further **progress on the key enablers of integration** (financial alignment; workforce, digital and data)

   - Review of legislation underpinning pooled budgets to simplify and update to better facilitate aligned financial arrangements.
   - Every health and care provider within an ICS to reach a minimum level of digital maturity by March 2025
   - Review of regulations that prevent the flexible deployment of health and social care staff across sectors

  - Local leaders to consider what workforce integration looks like in their area and the conditions and practical steps required
  - Guidance for ICPs to produce integrated workforce plans across the whole of systems, including more collective promotion of careers across health and social care and making it simpler for people to move between sectors

The implications for ICSs are:

- Building on Thriving Places, the expectation is that all areas will have plans for their Places agreed by April 2023, with the delegation of services and finances to Places by 2026. This will include a single point of accountability across health and social care for each Place.
- While the White Paper will set out an illustrative example of Place-based governance, the precise governance model is **to be agreed locally**. Where strong partnerships already exist, DHSC does **not** want to unwind these.
- Where systems and places are effectively the same geography, there will be no need for both place-based and ICS arrangements.
- ICSs should **not** pause the process of setting up Place based partnerships and/or recruitment to wait for the White Paper.
- There are no national plans for further changes to ICS boundaries.
- The Accountable Officer role of the ICB and Chief Executive will **not** change. Any local arrangements will still need to be mutually agreed, including any aligning and/or pooling of budgets.
- There will be a subsequent consultation on a new local outcomes framework that will allow for variation in priorities between Places (for example to reflect different demographies) that will sit **alongside national priorities**. These national priorities will continue to be set, for example, in the mandate and planning guidance.

A summary slide set outlining the main points in the White Paper is included at appendix A. This also includes the consultation questions contained in the document.

Lancashire and South Cumbria (LSC) is well placed to respond to these expectations and ambitions, given the work that has been underway through the Place-Based Partnership Development Advisory Group and various development programmes that have been agreed via the ICS Board. Examples of this alignment are:

- LSC's strategic narrative for place-based partnerships strongly aligned with the Thriving Places guidance published in 2021.
- Governance arrangements for PBPs agreed as initially Committees of the ICB, with aspirations for Joint Committees with the ICB and Local Government from April 2023.

- Financial delegations from the ICB to place from April 2023, with aspirations for delegations from Local Government and pooled budgets in future years.
- Place-Based Leaders to be recruited during Q4 of 2021/22
- Establishment of shadow/transitional operating model and resourcing model for the place-based team of the ICB during Q4 of 2021/22
- Work underway to agree common priorities across all five PBPs and those bespoke to each PBP, along with the development of balanced scorecards in PBPs and across the system. These will be aligned to the four core aims of ICSs and delivery of the ICB's five year plan.

3. National Guidance

No further guidance has been published since the January ICS Board update.

Approximately twenty further guidance documents are still awaited. Our summary of national guidance continues to be maintained and is available from the ICS Corporate Team.

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

4. Readiness to Operate Statement

The *ICS implementation guidance: ICS readiness to operate statement (ROS)* (published 19th August 2021), describes how the ROS checklist should be used to enable system leaders to assess progress and transition towards establishment of the Integrated Care Board (ICB) and its associated governance arrangements from the date on which the new statutory arrangements take effect. The ROS checklist requires the Lancashire and South Cumbria system to provide a RAG rating against 12 sections, each containing a number of elements that are drawn from national legal/policy requirements. These RAG ratings are required for both the current position and for the projected position as at the go live date.

The new target date of 1st July 2022 for the statutory arrangements means that activities within the ROS are now subject to revised timeframes, along with future ROS submissions of the ROS checklist itself. Further iterations of the ICB Establishment timeline are being published, which confirm new dates for completion of key tasks along with a number of new actions.

The change of target date to 1st July 2022 for the new statutory arrangements take effect has removed the most significant areas of risk, as these were associated with the tight timeframes for completion of key tasks during quarter 4 of 2021/22. However, as further guidance is yet to be received, linked to the progression of the

Bill through Parliament, there is a residual risks that similar capacity / demand challenges may occur during quarter 1 of 2022/23.

Key tasks for quarter 4 of 2021/22 are:

- Recruitment of ICB Executive roles
- Recruitment of Place-Based Leaders
- Further development of the ICB Constitution and governance arrangements, taking into account national guidance that has recently been published (with further expected in later March 2022)
- Ensuring safe and effective transfer of staff, service provision and governance arrangements from multiple organisations into the ICB, with work underway to describe 'what happens where' and to develop a shadow/transitional resourcing model.
- Supporting our Place-Based Partnerships and Provider Collaboratives to be ready to operate in conjunction with the ICB.
- Working with local government to establish the Integrated Care Partnership, agreeing shared system-wide priorities.

5. Integrated Care System Governance

Each Integrated Care System is required to establish the following:

- An **Integrated Care Board**, which is a statutory organisation that brings the NHS together locally to establish shared strategic priorities within the NHS, connecting to wider partnerships across the ICS, and to improve population health
- An **Integrated Care Partnership**, which is a broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS. Locally, we are describing this as the Lancashire and South Cumbria Health and Care Partnership.

Integrated Care Board (ICB)

Further to the recently amended ICB Establishment Timeline, all ICSs are under an obligation to continue with the development of the new ICB's Constitution and to engage with partners to seek views on the proposals. Members were updated at the last meeting on the second submission in early December, which included a small number of updates -all of which were approved.

A further updated ICB Model Constitution Template was published by NHSEI on 11th February. The main national updates relate to:

- A new mandatory statement highlighting the core purpose of ICBs has been included within the Foreword
- Amended disqualification criteria to allow a member of London Assembly or Member of a Local Authority to become a member of the ICB.

- Specific arrangements for appointing of ordinary members made at establishment (all members other than the Chair and Chief Executive). This section also includes confirmation that Partner Member joint nominations must be **after** the H&SC Bill receives royal assent.
- Changes to the requirements for which Board and Committee meeting must be held in public, to be those composed entirely of board members, or which include all board members, will be held in public.

Sections of the draft LSC constitution have, therefore, been reviewed to reflect these changes and other areas such as board composition and quoracy, following the successful appointment of five Non-Executive members to the board.

The next full submission is due on 28th February, and members will be updated on this and any other specific amendments once feedback is received from NHSEI NW regional team.

Recruitment

Recruitment to key roles within the ICB is progressing as follows:

Chief Executive Officer – the recruitment of the new Chief Executive Officer for the Integrated Care Board (ICB) has now been completed with the appointment of Kevin Lavery who is expected to formally commence in role in March 2022. This appointment is an important step in the development of the ICB towards statutory establishment in July.

Non-Executive Directors – Non-Executive Member appointments have now been confirmed with appointees expected to commence in role on 1st July 2022.

Other executive posts – the posts of Chief Medical Officer, Chief Finance Officer, Chief Nursing Officer and Chief People Officer have been advertised externally and with the support of a search agency. Interviews and assessments were scheduled to be completed by the end of February 2022.

Place leadership roles - It is expected that the process to appoint to Place Based Leadership roles will commence in March 2022 subject to final agreement on the role profile. Work is ongoing to understand the requirements of these roles and significant engagement with stakeholders in each place has taken place.

6. Provider Collaboration

Provider Collaborative board (PCB) development

A PCB business plan is currently being developed which documents the work of the NHS Trust provider collaborative. The business plan sets out the work the PCB

has progressed to date, areas for future focus, and documents the detail of each area in an appendix. This is being developed collaboratively within the PCB and aligns with wider system business planning.

A provider collaborative development programme is currently being designed which will see targeted support given to PCB stakeholder groups; this support will focus on how to deliver various aspects of the business plan in collaboration with our system partners. We envisage a number of sessions in this programme being undertaken with partners from across the ICS in order for us to work together effectively in delivering against the key priorities.

The PCB clinical vision is progressing with a first round of priority services to be agreed at the Clinical Integration group in March. The clinical strategy will pull together work that has already been undertaken in a number of specialties to determine future service models, along with progressing development of new models of care in other areas, seeking to right-size our clinical services across the ICS.

Mental Health, Learning Disabilities and Autism Provider Collaborative Arrangements – commissioning and transformation

A separate paper updating on the development of collaborative arrangements for Mental Health, Learning Disability and Autism has been included on the ICS Board agenda.

7. **Communications and Engagement**

Senior leaders have acknowledged that the change in national timelines relating to creation of the ICB has caused additional uncertainties for staff affected in CCGs, the CSU and current ICS team. The frequency of colleague briefings to keep staff informed, updated and engaged have been increased to monthly in order to provide a regular opportunity for staff to ask questions and raise concerns. Staff FAQs are being updated monthly following the briefings and key messages for senior leaders are updated regularly to ensure consistent messaging within local briefings. Stakeholder briefings are also being prepared to ensure all partners and stakeholders understand the delay in the ICB establishment and our local ambitions to continue our progress as much as possible and not lose momentum.

A strategic narrative for NHS provider collaboration has been approved by the ICS Development Oversight Group and the Provider Collaboration Board to support the NHS Trusts in describing their vision, ambitions and priorities for working together. This is now being used to keep leaders, staff, partners and members of the public informed about the development of NHS provider collaboration in Lancashire and South Cumbria. The narrative was developed involving a wide range of leaders and incorporating feedback from a Communications and Engagement Review Group with representatives from a number of partners, sectors and lay members.

An illustrated video to describe place-based partnerships has been produced to describe how our five places have worked together to think about their common purpose, including what a place-based partnership aims to do, how they plan to work as partnerships and the benefits of working in this way. The video explains what a place-based partnership is and describes some of the detail behind the collaborative approach that is being taken across Lancashire and South Cumbria. A final segment will be added to the video to give a view from the Chair of the Place-Based Partnership Development Advisory Group: https://youtu.be/JmgupnDPmys

8. Recommendations

The ICS Board is asked to

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

Health and Social Care Integration White Paper

Summary of policy proposals and key messages

February 2022

NHS England and NHS Improvement

Background and context

In September 2021, the Government published *Building Back Better: Our Plan for Health and social Care,* which (amongst other things) committed to **a comprehensive national plan for supporting and enabling integration between health and social care, with a renewed focus on outcomes, empowering local leaders and wider system reforms.**

It argues partnership working has been demonstrated and strengthened during the pandemic. Further change is required to go 'further and faster' with a particular focus on empowering integration at 'place' through the development of shared outcomes across health and social care

In this context, the Integration White Paper, ***Joining Up Care for People, Places and Populations,*** is a **statement of policy intent.** It was published on 9 February 2022 and is subject to a period of engagement and Government response. This briefing summarises the key proposals, next steps and consultation questions contained in the paper.

Summary of proposals in the White Paper

- A **framework for local outcome prioritisation** focused on individual health and wellbeing and on improving population health in addition to nationally set priorities (e.g. the mandate). There will be a further consultation on the detail in due course, with implementation from April 2023.
- Health and care services in local communities ('Places') to be strengthened. By Spring 2023 **all 'Places' should adopt a leadership and governance model with a single person** (e.g. an individual with a dual role across health and care or an individual lead for a 'place board'), **accountable for the delivery of the shared plan and outcomes for the place**, working with local partners. The single person will be agreed by the relevant local authority or authorities and ICB. The plan will be underpinned by pooled or aligned resources, including an extensive proportion of services and spend held by the Place-based arrangement by 2026.
- Further **progress on the key enablers of integration** (financial alignment; workforce, digital and data)
  - Review of legislation underpinning pooled budgets to simplify and update to better facilitate aligned financial arrangements.
  - Every health and care provider within an ICS to reach a minimum level of digital maturity by March 2025
  - Review of regulations that prevent the flexible deployment of health and social care staff across sectors
  - Local leaders to consider what workforce integration looks like in their area and the conditions and practical steps required
  - Guidance for ICPs to produce integrated workforce plans across the whole of systems, including more collective promotion of careers across health and social care and making it simpler for people to move between sectors.
- **Robust regulatory mechanisms,** including CQC to assess outcomes and delivery of integrated care at Place level. The detailed methodology for inspections will be subject to future consultation. This work will be supportive of and complementary to existing oversight and support processes (including those used by NHS England and NHS Improvement to support integrated care systems, and sector led improvement in local government).

Key messages from the White Paper

- There is **continued commitment to the current draft legislation**, this paper seeks to build on rather than undo those proposals
- Building on Thriving Places, the expectation is that all areas will have plans for their Places agreed by April 2023, with the delegation of services and finances to Places by 2026. This will include a single point of accountability across HSC for each Place.
- While the White Paper will set out an illustrative example of Place-based governance, the precise governance model is **to be agreed locally**. Where strong partnerships already exist, DHSC does **not** want to unwind these.
- Where systems and places are effectively the same geography, there will be no need for both place-based and ICS arrangements.
- ICSs should **not** pause the process of setting up Place based partnerships and/or recruitment to wait for the White Paper.
- There are no national plans for further changes to ICS boundaries.
- The Accountable Officer role of the ICB and Chief Executive will **not** change. Any local arrangements will still need to be mutually agreed, including any aligning and/or pooling of budgets.
- There will be a subsequent consultation on a new local outcomes framework that will allow for variation in priorities between Places (for example to reflect different demographies) that will sit **alongside national priorities**. These national priorities will continue to be set, for example, in the mandate and planning guidance.

Next steps as outlined in the White Paper (1/2)

- On shared outcomes, consult stakeholders and set out a framework with a concise number of national priorities and approach for developing additional local shared outcomes, by Spring 2023
- Government will review alignment with other priority setting exercises and outcomes frameworks across health and social care system and those related to local government delivery
- Ensure implementation of shared outcomes will begin from April 2023
- On leadership, accountability and oversight, set an expectation that by Spring 2023, all places should adopt a model of accountability and provide clear responsibilities for decision making including over how services should be shaped to best meet the needs of people in their local area
- Review section 75 of the 2006 Act which underpins pooled budgets, to simplify and update the regulations
- Government will work with partners to develop guidance for local authorities and the NHS to support going further and faster on financial alignment and pooling.
- Publish guidance on the scope of pooled budgets Spring 2023
- Work with the CQC and others to ensure the inspection and regulation regime supports and promotes the new shared outcomes and accountability arrangements at Place
- Develop a national leadership programme, addressing the skills required to deliver effective system transformation and place-based partnerships, subject to the outcomes of the upcoming leadership review

Next steps as outlined in the White Paper (2/2)

- Publish a final version of the Data Strategy for Health and Care will be published (Winter 2021/22)•Ensure every health and adult social care provider within an ICS reaches a minimum level of digital maturity
- Ensure all professionals have access to a functionally single health and adult social care record for each citizen (by 2024) with work underway to put these in the hands of citizens to view and contribute to
- Ensure each ICS will implement a population health platform with care coordination functionality, that uses joined up data to support planning, proactive population health management and precision public health (by 2025)
- Develop a standards roadmap (2022) and co-designed suite of standards for adult social care (Autumn 2023)
- Ensure 1 million people to be supported by digitally enabled care at home (by 2022)
- On workforce, strengthen the role of workforce planning at ICS and place levels
- Review barriers (including regulatory and statutory) to flexible movement and deployment of health and care staff at place level
- Develop a national delegation framework of appropriate clinical interventions to be used in care settings
- Increase the number of clinical practice placements in social care during training for other health professionals
- improve opportunities for cross-sector training and joint roles for ASC and NHS staff in both regulated and unregulated roles
- Appoint a set of front-runner areas in Spring 2023. These will trial the outcomes, accountability, regulatory and financial reforms discussed in this document

Consultation questions

Outcomes

(i) What role can outcomes play in forging common purpose between partners within a place or system – and can you point to examples of this?

(ii) How can we get the balance right between local and national in setting outcomes and priorities?

(iii) How can we most effectively balance the need for information about progress (often addressed through process indicators) with a resolute focus on achieving outcomes (where data can lag)?

(iv) How should outcomes be best articulated to encourage closer working between the NHS and local government?

(v) How can partners most effectively balance shared goals / outcomes with those that are specific to one or the other partner – are there examples, and how can those who are setting national and local goals be most helpful?

Financial

(vi) How can we improve sharing of best practice regarding pooled or aligned budgets?

(vii) What guidance would be helpful in enabling local partners to develop simplified and proportionate pooled or aligned budgets?

(viii) What examples are there of effective pooling or alignment of resources to integrate care / work to improve outcomes? What were the critical success factors?

(ix) What features of the current pooling regime (section 75) could be improved and how? Are there any barriers, regulatory or bureaucratic that would need to be addressed?

Consultation questions

Accountability

(x) How can the approach to accountability set out in this paper be most effectively implemented? Are there current models in use that meet the criteria set out that could be helpfully shared?

(xi) What will be the key challenges in implementing the approach to accountability set out in the paper? How can they be most effectively met?

Workforce

(xii) What are the key opportunities and challenges for ensuring that we maximise the role of the health and care workforce in providing integrated care?

(xiii) How can we ensure the health and social care workforces are able to work together in different settings and as effectively as possible?

(xiv) Are there particular roles in the health or adult social care workforce that you feel would most benefit from increased knowledge of multi-agency working and the roles of other professionals?

(xv) What models of joint continuous professional development across health and social care have you seen work well? What are the barriers you have faced to increasing opportunities for joint training?

(xvi) What types of role do you feel would most benefit from being more interchangeable across health/social care? What models do you feel already work well?

Consultation questions

Digital and data

(xvii) What are the key challenges and opportunities in taking forward the policies set out in this paper, and what examples of advanced / good practice are there that could help?

(xviii) How do we best ensure that all individuals and groups can take advantage of improvements in technology and how do we support this?

The consultation period is open for 8 weeks (from February 10th 2022)

Responses need to be sent to DHSC at the following mailbox: iwpimplementationquestions@dhsc.gov.uk.

Integrated Care System Board

Date of meeting	**2nd March 2022**
Title of paper	**Mental Health, Learning Disability and Autism System Transition Board**
Presented by	**Steve Christian, Chief Integration Officer, LSCFT**
Author	**Chief Integration Officer, LSCFT**
Agenda item	**10**
Confidential	**No**

Purpose of the paper

For discussion.

Executive summary

The purpose of this paper is to provide an update to the ICS Board on progress of the Mental health, learning disability and autism System Transition Board

Mental health, learning disability and autism services are to be transformed to improve the support available for people across Lancashire and South Cumbria. This important agenda is a key element to the work of Lancashire and South Cumbria Integrated Care System (ICS) whose overarching vision is to improve health and reduce health inequality.

The ICS engaged an independent consultancy in summer 2021, Moorhouse, to work with system partners to help facilitate the co-production of a roadmap to guide the system's transformation for mental health, and learning disability and autism services. Moorhouse completed 40 structured interviews with senior representatives from the ICS, NHSE/I, NHS providers, local authorities, CCGs and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. The report outlined a number of key priority actions for implementation.

To drive this work, the ICS set up a System Transition Board for mental health, learning disability and autism services in June 2021. Chaired by ICS non-executive director Isla Wilson, the System Transition Board includes representatives from the NHS, local authorities, the voluntary, community, faith and social enterprise (VCFSE) sector, primary care, and service users/carers. The System Transition Board programme of work forms part the ICS System Reform Plan.

This paper provides an overview of the programme and key updates.

Recommendations

The Board is asked to **note** the report.

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

Meeting	Date	Outcomes
Provider Collaborative Board	17.02.2022	Noted progress

Conflicts of interest identified

None

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	

Mental Health, Learning Disability and Autism Collaboration Update

1. Overview

- Mental health, learning disability and autism services are to be transformed to improve the support available for people across Lancashire and South Cumbria. This important agenda is a key element to the work of Lancashire and South Cumbria Integrated Care System (ICS) whose overarching vision is to improve health and reduce health inequality.

- The ICS engaged an independent consultancy in early 2021, Moorhouse, to work with system partners to help facilitate the co-production of a roadmap to guide the system's transformation for mental health, and learning disability and autism services. Moorhouse completed 40 structured interviews with senior representatives from the ICS, NHSE/I, NHS providers, local authorities, CCGs and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. The report outlined a number of key priority actions for implementation.

- To drive this work, the ICS set up a System Transition Board for mental health, learning disability and autism services in June 2021. Chaired by ICS non-executive director Isla Wilson, the System Transition Board includes representatives from the NHS, local authorities, the voluntary, community, faith and social enterprise (VCFSE) sector, primary care, and service users/carers. The System Transition Board programme of work forms part the ICS System Reform Plan.

- The System Transition Board oversees two key strands of work:
    - a change in the way mental health, learning disability and autism services are commissioned; and
    - the creation of a Mental Health, Learning Disability and Autism Provider Alliance to bring all health and care providers together to lead the improvement of mental health, learning disability and autism services. This includes the development of new strategies to improve health outcomes relating to mental health, learning disability and autism services.

- These developments are supported by changing legislation which will make it easier for health and care organisations to work effectively together to join-up services.

2. Changing commissioning arrangements for mental health, learning disability and autism services

- The way mental health, learning disability and autism services are commissioned is changing. National policy in England means that NHS trusts have recently taken on the commissioning responsibility from NHS England/Improvement for some specialist mental health, learning disability and autism services. These include:
    - Mental health inpatient services for children and young people
    - Low and medium secure services for adults
    - Eating disorder services for adults.

- Locally, Lancashire and South Cumbria NHS Foundation Trust (LSCFT) is now buying and planning these specialist services, contracting with other providers as appropriate. LSCFT, as the 'lead provider', is accountable to NHS England and NHS Improvement for service quality and health outcomes.

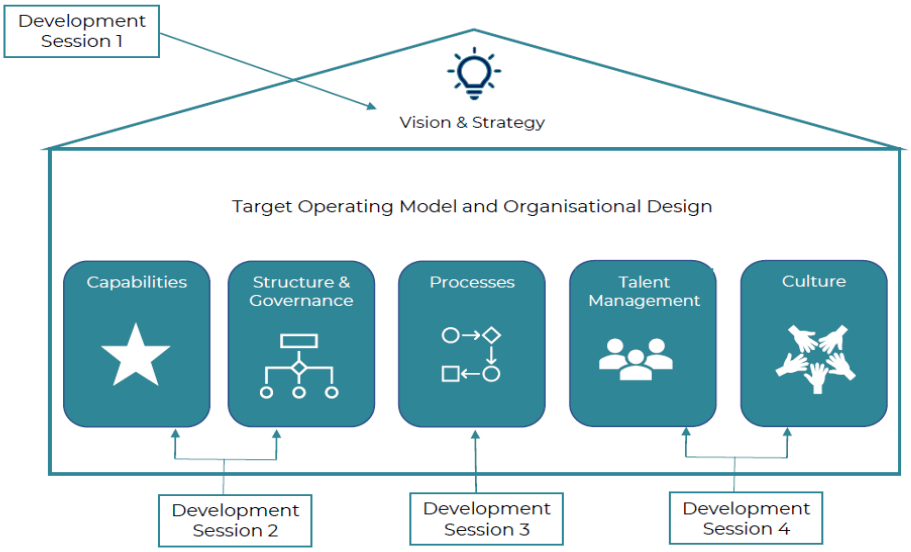
- In addition, there are plans to extend the lead provider model further to include mental health, autism and learning disability services currently commissioned by the area's clinical commissioning groups (CCGs). LSCFT would be contracted by NHS Lancashire and South Cumbria Integrated Care Board to do this. The plan is for local commissioning arrangements to move to LSCFT in shadow form, in partnership with the Integrated Care Board (ICB), during 2022/23. Go-live is expected from April 2023.

- In its dual role as a commissioner and a provider, LSCFT will undertake activities such as planning, transforming and delivering services, monitoring quality and performance, and allocating resources to deliver collectively agreed outcomes. This will be done in partnership through the Mental Health, Learning Disability and Autism Provider Alliance.

- LSCFT, as the 'lead provider', will work closely with place based leaders and the PCB. There will be advantages of the LSCFT working at scale with access and influence at 'system level' - whilst being able to operate flexibly at 'place level' to support local planning and integration of services involving those local communities and partners.

- A 'Commissioning for the future' project group has been established. This group reports through to the System Transition Board and involves ICS colleagues and CCG commissioning managers. This group is responsible for developing the future MHLDA commissioning cycle and lead provider target operating model (TOM) which will be piloted through a shadow form arrangement / agreement with the ICB during 2022/23.

- The System Transition Board has commissioned the Values Circle to work with the 'commissioning for the future' group to support development of the Lead Provider TOM. The Values Circle will be conducting a series of facilitative and independent workshops which will include members and key stakeholders to support design.



- Benefits of these new arrangements include:

    - A more proactive approach to support health and wellbeing which **better meets people's needs**. This is because clinicians who are best placed to interpret the needs of service users will be leading commission and service development.

- Ensuring services are **accessible, joined-up** and of **consistently good quality** no matter where people live. Mental health, learning disability and autism services across Lancashire and South Cumbria have until now been commissioned by a number of different organisations which has led to variation in investment and access for service users.
- Improving **population health and reducing health inequalities**. This is because the 'lead provider' will be able to work with the wider health and care system through the Mental Health, Learning Disability and Autism Provider Alliance to plan and join-up services, 'levelling up' quality across the area.
- **Reduced waste and bureaucracy** where services can be developed through collaboration rather than competition. Long-term contracting between providers will allow planning and recruitment over more useful timescales. Incentives within the system will be aligned to common goals of high-quality evidence-based care delivered close to home.

3. Creation of a Mental Health, Learning Disability and Autism Provider Alliance

- Our physical and mental health is affected by many social, economic and environmental factors. These 'wider determinants of health' include housing, education, employment and social isolation. Moreover, evidence shows that good mental health leads to better physical health and reduced health inequalities. It's therefore vital that all relevant agencies work together effectively to support better mental health.

- The Lancashire and South Cumbria Integrated Care System (ICS) is bringing these agencies together through a new Mental Health, Learning Disability and Autism Provider Alliance. Partners – including local authorities, VCFSE, service users and the NHS – will be able to make joint decisions about how to organise mental health, learning disability and autism services to benefit the 1.8million people living across the area. The Alliance will be the mechanism for the Lead Provider model (for MHLDA commissioning) to work with the wider health and care system on commissioning intentions and system wide transformation.

- The Mental Health, Learning Disability and Autism Provider Alliance will work closely with the PCB in order that NHS services can deliver integration of physical and mental health services – when it makes sense. The PCB has established a Clinical Integration Group (CIG) which will act as a key group to ensure interdependencies are agreed. The Mental Health, Learning Disability and Autism Provider Alliance will Go Live in spring 2022. The governance will be shared with the PCB and the ICS Development Oversight Group for sign-off following System Transition Board endorsement.

- The Mental Health, Learning Disability and Autism Provider Alliance will be a key part of the ICS. As part of the Alliance development, partners will need to agree how it links with the system as well as the five local place-based partnerships in the area.

- The Mental Health, Learning Disability and Autism Provider Alliance will have three sub-groups, one each to oversee the improvement of mental health, learning disability and autism services for people of all ages. Each sub-group will be jointly led by both a director of social care and an NHS provider executive, supported by representation from primary care and the VCFSE sector.

- The strategy for each sub-group is being developed through an engagement programme with partners and experts with experience, and will be available in late Spring 2022. The strategy workshops have involved over 80 health and care providers and a range of service user groups. The process has been truly collaborative and based on co-design.

- Benefits of developing alliance across health and care partners will lead to the development of mental health, learning disability and autism services which:

    - …are more **joined-up**, **and so are easier for people to access and navigate**. All providers will be engaged to look at pathways for the benefit of the whole population. In the past providers have focused on their part of the pathway, and so services are not always joined-up.

    - … better **meets the community's needs**. By working together across the Alliance, partners will have more opportunities to co-design services with individuals and communities.

    - … are **more local**. By considering the whole pathway together, organisations involved will be able to make sure any current service gaps are addressed. This includes bringing more specialist provision into Lancashire and South Cumbria which people often have to travel out of the area for.

    - … are **based in people's communities**. By service providers working together to boost provision within community settings, people should have more services tailored to the needs of their area. VCSFE organisations often have the capacity and links to local communities that can complement NHS services.

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    - … are a **consistently high-quality**. By working as a group of providers across the whole of Lancashire and South Cumbria, the aim is to 'level up' quality across Lancashire and South Cumbria so that people have a consistently good experience no matter where they live.

    - …are more **innovative**. This is because VCFSE organisations, working in partnership with other providers, will be able to undertake small-scale pilots to test new services and ways of working. In addition, having a such a diverse group of providers with different experiences working more closely should result in problems being looked at from different viewpoints. This will drive better decision-making and innovation.

    - … continue to be provided by **highly skilled colleagues**. By working more collaboratively across the system, colleagues will have greater peer support and will be able to share best practice, skills and experience. In addition, the whole region can be presented as an attractive place to work to ensure a great workforce for the future.

    - … **are more sustainable**. Joined-up working will reduce duplication and waste to free-up precious resources for frontline services.

4. Transformation at scale – partners working in collaboration

- The partnership working of Mental Health, Learning Disability and Autism health and care providers across Lancashire and South Cumbria is gaining huge momentum with a number of system wide transformations underway. One example is the work underway in transforming Community Mental Health services. This programme is overseeing the single biggest NHS investment in mental health services that we have seen in recent times.

- The programme sets out a model of care that enhances community based support for people living with moderate to severe mental illness and complex needs. The funding provides mental health NHS Trusts the opportunity to focus on population health and reduce inequalities. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) is delivering on this transformation programme through the strengthening of local partnerships with other NHS partners, local authority-funded services and the Voluntary, Community, Social, Faith and Enterprise (VCFSE) sector. The ambition is that people moderately to severely affected by mental illness can expect to receive the right treatment at the right time within 4 weeks from 2023/24.

- The following principles are fundamental to the new community models:
    - Removing the idea of thresholds and multiple assessments – if someone is unwell and in need of support, they should receive it, as they would in acute care. If that service turns out to not be quite right then the system should be flexible enough to offer other options and step up and step down care as
    - A 'no wrong door' policy, or even a 'no door' policy
    - People should be able to tell their story and experience just once
    - A focus on specific, tailored and inclusive support needed for underrepresented groups – including the black, Asian and minority ethnic (BAME) population and people from lesbian, gay, bisexual, transgender, questioning and intersex (LGBTQI) communities.
    - Personalised health and social care support – including entitlements under the Care Act and personal health budgets.
    - Joint commissioning of services for people and communities

- The access into the community model will be at a neighbourhood level within Primary Care Networks (PCNs); which are groups of GP practices that specifically focus on the needs of local populations. The plan is to create Community Hubs with aligned services and teams wrapped around a number of PCNs with close connections to a local network of community groups and VCFSE organisations.

- The intention is that people will be able to access a multidisciplinary team (MDT) comprising:
    - Mental health practitioners/consultants/support workers
    - Social care staff
    - VCFSE staff
    - Primary care staff
    - Substance misuse providers
    - Housing/finance/employment support
    - Peer support workers

- The programme will introduce a new trusted assessment and formulation model that is strengths based, and goal/solutions focussed. Assessment and formulation (with input from the full MDT) will be delivered by both statutory staff, voluntary sector staff and peer workers trained to the same standard. Where appropriate, the same staff will coproduce a personalised care and support plan and provide a range of short-term clinical, social and community interventions designed to promote recovery and reduce risk of crisis. The first wave of community hubs will Go Live in late Spring.

Conclusion

- This is the start of the journey for the transformation of Mental Health, Learning Disability and Autism services. The System Transition Board will continue to update the Board as the roadmap makes progress. What's important is that partners from all relevant agencies and experts with experience are engaged in transforming services and codesigning future models of care.

Item 11

L&SC ICS System Reform Programme

Monthly ROS Highlight Report

Lancashire and South Cumbria Health and Care Partnership

High Level Summary

ROS Ref	Description	LSC Exec Lead	FEB - Current RAG Rating (target date 01/07/22)	FEB - Projected RAG Rating (target date 01/07/22)
1	**Integrated care partnership (ICP): Initial ICP arrangements and principles agreed**	Andrew Bennett	Progress made - Minor concerns	On target for delivery by July 2022
2	**Integrated care board (ICB): Designate appointments to the Board of the ICB made and Board quorate in line with relevant guidance**	Sarah Sheppard	On target - No concerns	On target for delivery by July 2022
3	**System development plan, ICB constitution and governance arrangements: System Development Plan, ICB constitution and governance arrangements in place**	Andrew Bennett	On target - No concerns	On target for delivery by July 2022
4	**Provider partnerships: Provider partnership arrangements agreed**	Caroline Donovan, Kevin McGee, Peter Tinson	On target - No concerns	On target for delivery by July 2022
5	**People and culture: People function ready for operation**	Sarah Sheppard	Progress made - Minor concerns	On target for delivery by July 2022
6	**Quality, safety and EPRR: Quality, safety and EPRR systems and functions ready for operation**	Andrew Bennett, Jane Scattergood	On target - No concerns	On target for delivery by July 2022
7	**Clinical and care professional leadership: Model / arrangements prepared**	Andy Curran, Jane Scattergood	Progress made - Minor concerns	On target for delivery by July 2022
8	**Working with people and communities: Public involvement and engagement strategy / policy**	Andrew Bennett	Progress made - Minor concerns	On target for delivery by July 2022
9	**System oversight: System oversight arrangements between NHS England and NHS Improvement regional team and ICB**	Andrew Bennett	Progress made - Minor concerns	On target for delivery by July 2022
10	**Finance and planning: Planning for 2022/23 developed in line with national requirements and finance function and systems ready for operation**	Sam Proffitt	On target - No concerns	On target for delivery by July 2022
11	**Data, digital and information governance: Systems ready to operate and information governance activities on target**	Gary Raphael	Progress made - Minor concerns	Delivery by July 2022 is at risk but mitigation plan in place
12	**Transition from CCGs to ICBs: Equalities duties complied with, due diligence of people and property complete, consultation completed in line with TUPE requirements / COSoP guidance, staffing and property lists prepared and first day arrangements confirmed**	Andrew Bennett, Denis Gizzi, Sarah Sheppard	On target - No concerns	On target for delivery by July 2022

ROS 2 - National Requirements by Exception

ROS Ref	Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Projected RAG Rating (target date 01/07/22)
2.5	ROS	Other designate appointments made and postholders ready to take up post on 1 July 2022 (minimum additional Executive roles: finance; medical; nursing) to ensure quoracy of the ICB Board, according to its Constitution	31/01/22	Recruitment window extended to accomodate interviews with Designate ICB CEO. Some risk associated with Executives being in post for 1 July 2022, depending upon notice period or successful candidates. Impact on quoracy for ICB Board relates to Medical Director / Director of Nursing posts. Provision in draft constitution for this to be addressed.	Adam Burgess Evans	Delivery by July 2022 is at risk but mitigation plan in place

ROS 3 - National Requirements by Exception

ROS Ref	Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Projected RAG Rating (target date 01/07/22)
3.1	ROS	System development plan (SDP) in place indicating how the ICB will work with its partners in the ICP from July 2022 to meet the needs of the population, with a focus on reducing health inequalities	18/03/22	Needs greater focus on integrated plan for delivery, linked to Integrated care strategy of the ICP. Need greater attention on PHM/health inequalities, system priorities - this will be addressed via the preparatory work and findings of the Health Equity Commission, and the development of population health plans in each place-based partnership. Risk associated with capacity and completion of required inputs not scheduled for completion until Q4.	Vicki Ellarby	Delivery by July 2022 is at risk but mitigation plan in place

ROS 11 - National Requirements by Exception

ROS Ref	Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Projected RAG Rating (target date 01/07/22)
11.1	ROS	Activities outlined in the Organisation Data Service (ODS) reconfiguration toolkit as due by 1 July 2022 have been delivered	18/03/22	ICB has received ODS code (QE1) and can begin operation when required	Andrew Thomson	Delivery by July 2022 is at risk but mitigation plan in place

ROS 1 - LSC System Development by Exception

Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)
SDP	Confirm boundaries and partners of the LSC Health and Care Partnership	12/11/21	Boundaries confirmed - no changes planned in relation to Cumbria County Council unitary outcome (which will come into effect from April 2023) Partners to be confirmed as part of work on Health and Care Partnership.	Vicki Ellarby	Progress made - Minor concerns
SDP	Proposals on success measures for the ICS Health and Care Partnership	18/03/22	Initial system priorities agreed. Work underway on common components of PBP balanced scorecards, linked to system-wide and local PBP priorities. Further T&F group meetings scheduled, although these have been delayed due to operational challenges. Risk remains re capacity across senior leaders during Q4 of 2021/22.	Vicki Ellarby	Progress made - Minor concerns

ROS 3 - LSC System Development by Exception

Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)
SDP	CCG teams only operating at sub-system level where LSC plans to establish a significant place-based function at that footprint (as described in 1.b.)	31/12/21	Some teams have moved to a system/place model of working, but there are a number if functions/teams still operating within CCGs. This is linked to local requirements within CCGs, delays in the completion of Data Sharing Agreements and therefore delays in reviewing current resources available across the system, and operational demands linked to the ongoing pandemic response. The ICB Design Group (meeting fortnightly) is now reviewing proposals for new ways of working, especially during the transitional period from now to 1st July 2022.	Gary Raphael	Not on Target - Significant concerns
SDP	Implementation of local communications and engagement plan re development of place-based partnerships		Communications and engagement plan in development for place-based partnerships. Illustrated video to describe the common narrative document has been produced and each PBP will add a localised segment. Main focus for Q4 for comms and engagement is to support the appointment of place-based leaders and then supporting those place-based leaders to communicate ambitions and priorities - which has been slightly delayed due to the appointment process delays and now the timeline extensions.	PBP PDs	Progress made - Minor concerns

ROS 5 - LSC System Development by Exception

Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)
SDP	Scope requirements of organisational development programme (system and place)	31/03/22	Scoping work underway. Minor delays anticipated due to availability of senior leaders, however, E05 has been extended to end of Q2 so now in progress with no delays.	Danielle Coupe	Progress made - Minor concerns

ROS 6 - LSC System Development by Exception

Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)
SDP	Shadow Nursing and Quality Structure in place	01/04/22	Proposed structure developed, business case near final - cannot be progressed further without CEO sign off, Exec support and HR support for structure and recruitment implications	Jane Scattergood	Progress made - Minor concerns
SDP	Describe vision for ICS 3-5 year plan for Quality and Nursing	01/04/22	Not commenced in isolation - needs broad ICS ambition to be articulated and Quality & Nursing vision to be described to support the achievement of ICS ambition. Needs to tie in with Clinical and Care professional Leadership development. Some ambitions written into business case to support new structure and can be developed.	Jane Scattergood	Progress made - Minor concerns

ROS 11 - ICB Establishment by Exception

Source	Description	Finish Date	Update	LSC Workstream Lead	FEB - Current RAG Rating (target date 01/07/22)
ICB Est Timeline	Commence ODS Reconfiguration Toolkit activities - ie take action in accordance with instructions from NHS Digital once new ODS codes and ODS Reconfiguration Toolkit received (precise timing dependent on NHS Digital work programme but the date is due to be confirmed by 31.10.21 and an indicative release date is mid-November for the ODS Reconfiguration Toolkit)	15/11/21	ICB has received ODS code (QE1) and can begin operation when required.	Andrew Thomson	Progress made - Minor concerns
ICB Est Timeline	Confirm ready for operational closure of legacy CCG ODS codes	TBC	National systems changes need to be implemented, local system challenges need to be understood.	Andrew Thomson	Progress made - Minor concerns
ICB Est Timeline	Confirm ODS Reconfiguration toolkit activities on target	31/01/22	ICB has received ODS code (QE1) and can begin operation when required	Andrew Thomson	Progress made - Minor concerns

Risk & Issues - Residual Score 15 and over

Risk / Issues No.	Risk or Issue	Risk Oversight	Risk / Issue Description	Issue / Risk Actionee	Agreed Mitigating Actions	Residual Risk Score
R0032	Risk	ICS Dev Oversight Gp	Risk that the transition of key systems and services e.g. ESR/Payroll, OH provider, NHS Jobs, will be unsuccessful or significantly affected due to the timescales associated with the transition.	Elaine Collier	System arrangements for key transactional processes need to be well planned and timely. Each of these may require a procurement exercise by the new ICS organisation unless nationally mandates services/solutions are proposed. Once a supplier identified, detailed and timely technical project and transiton plans are established to manage these process and transition. It is expected that VPD/ESR would need between 3 and 6 months to transact successfully. Work is ongoing nationally with IBM (provider of ESR) - assurance required on progress. Leadership identified within ICS as a 'receiver' to take forward ESR/payroll discussions with current providers. ICS exec advised of actions required to select/procure, a provider Potential conflict of interest so propose that this is done independent to workforce lead as CSU provide some of these services . Propose that this action is move to finance workstream with input from HR to manage this. Elaine Collier now progressing ESR and Payroll discussions with legacy CCGs in order to identify single provider Single provider not yet identified - finance leads considering options. Requirement to identify single provider urgently.	16
R0055	Risk	CCG Transition Board	There is a RISK that due to the uncertainty of the staffing structure in the new NHS LSC system, that current CCG staff leave to secure alternative employment, leaving insufficient staff to manage CCG closedown and transition, and to undertake the new responsibilities of the new system, and resulting in a loss of system knowledge and expertise.	Helen Curtis	Further to discussion at the Exec Meeting on 14 Dec and despite work undertaken to reduce the risk, this risk is being maintained at 16 due to escalation to level 4 and the impact of implementation on vaccination booster programme. Further discussions took place at the Exec Mtg in January - highlighting the impact of the delay of policy implementation on staff resilience and capacity. work to be undertaken as part of reconciliation to programme plan for closedown that is now impacted due to delay.	16

Lancashire and South Cumbria Health and Care Partnership Programme Summary Report

February 2022

1. Service Transformation

Significant programmes aimed to deliver transformational change across Lancashire & South Cumbria, progressing through the ICS decision flow (see appendix 1.) to complete the business case and subsequent implementation process

Programme & Executive Sponsor	Stage / Gateway	Key Highlights
Adult Community Mental Health – *Caroline Donovan*	**3b.Plan**	During the last month the Adult Community Mental Health Programme has reviewed all applications for the procurement framework, and the successful applicant was informed on 2nd February. The programme held several PCN workshops ready for the go live date in year 1, and the remaining PCN workshops are booked in readiness for the same. The programme has finalised the handbook for the Mental Health Practitioner Additional Roles Reimbursement Scheme (ARRS), some of which have already commenced in post and the remainder will be in post over the next few months. The ICS funding for the year 2 application has been completed and submitted to NHSE. The start dates for Personality Disorder Practitioners (PDP) has been confirmed. The asset map visualisation has been completed, and further providers are being added as they are identified. The eating disorder model for hubs has been confirmed with the BI and finance data now completed to align staff to hubs and so the business case has been submitted to the LSCFT Executive Team. The priorities for the following month are for the Lancashire MIND starting service user and carer engagement to take place and plans to confirm the physical health, and rehab pathways.
CAMHS Redesign – *Hilary Fordham*	**4. Implement**	Recruitment for Year 1 and 2 fast track is still underway and initial discussions have taken place for remaining Year 2 transformation recruitment. The Lancashire and South Cumbria Children and Young Peoples Mental Health Strategic Transformation Plan 2021-2024 has now been approved by the All-Age Mental Health Board and the programme outcomes will now be developed. The inaugural Operational Group meeting will take place on the 22nd of February 2022 to support this work. The provider presentations are in development for Northwest Strategic Clinical Commissioning Network ICS / provider service data and quality reviews. The project initiation document and scope for the programme has been completed to support the development of a system-wide escalation policy to support Children and Young People to be discharged from unsuitable settings, and discussions with Local Authority Children's Services are due to take place. A soft launch of Pennine Initial Response Service (IRS) Phase 1 commenced with adults only, and a workshop has been scheduled for the 17th of February to map the (IRS) Pennine children & young people pathway. The perfect week will take place using the CYP calls received since the soft launch. In addition, the THRIVE redesign model and transformation programme socialisation plan across services and teams is to be rolled out from February.

Programme & Executive Sponsor	Stage / Gateway	Key Highlights
Corporate Collaborative Services – *Sam Proffitt*	**2. Scope**	Terms of Reference (ToR) are being drafted at a project team level for all workstreams which sit under the Corporate Collaborative Services Programme. This aims to build the accountability, structure and organisation of the individual projects and encourage the engagement of the appropriate stakeholders in order to see projects through to delivery. The current workstreams include Procurement, IM&T, Estates and Facilities, Finance, Human Resources, and Legal and Governance. More detailed plans and timescales will be developed with each of the project groups including; risks, and benefits to monitor progress and delivery.
Diagnostics – *Kevin McGee*		**Diagnostic Imaging:** has submitted the Imaging Network maturity matrix baseline to the Northwest Region. The provision of CT scanners has now been reviewed in light of the 2022/2023 operational planning guidance and the draft outputs of capacity and demand modelling for CT was presented to the Data Group and plans are now to start the modelling for CT, MRI and NOUS capacity. Bids have been successful for HEE funding to increase radiography training capacity and for recruitment to new Imaging Navigator role at Lancashire Teaching Hospitals. The outcome of another bid for radiology training capacity is still awaited. The workforce paper on 'recruiting at risk/in readiness' approach has been developed and drafted for discussion/endorsement by Diagnostics Programme Board on the 24th of February 2022. The programme now aims to finalise the workstream priorities and complete the development of the programme and operational plan by March 2022, and in line with the Northwest Imaging Strategy Implementation plan, which is currently awaited. Work is still ongoing in relation to the recruitment of staff into programme roles. **Community Diagnostic Centres:** Over 21,500 diagnostic tests across 4 sites in Lancashire and South Cumbria have been delivered since launching in July 2021. There is agreement from local acute Trusts that imaging assets in the Year 1 CDC sites (Rossendale and Preston) will be extended into the new financial year. This includes the unit which is shared between East Lancashire Hospital Trust and Lancashire Teaching Hospitals Foundation Trust. Capital funding of £43.269 million has been allocated to the L&SC system to support Year 2+ implementation of the estate modifications and procurement of equipment in community settings, along with some acute hospital sites. The demand and capacity model for Year 2+ and CDC will be completed early February to inform the Year 2+ business case development. The CDC national revenue allocation is expected to be in the region of £410 million in 2022/23. A high-level proposal will be developed outlining a summary of the L&SCs 5 place-based schemes, including the indication capital and revenues costs, and will be submitted to Northwest NHS Regional Assurance by 4th March. The temporary Echothon network delivery model for L&SC has been agreed which will provide an additional 800 echocardiograms throughout February and March 2022, utilising a fixed sessional rate, existing NHS staff and cross site working utilising digital passports.
Clinical Systems		The Electronic Patient Record (EPR) programme is making good progress with the development of the ICS Strategic Outline Case (SOC) modelling work due by mid-February 2022. In relation to the procurement process this has been

Programme & Executive Sponsor	Stage / Gateway	Key Highlights
Road Map – *Gary Raphael*		paused until the SOC is complete/signed off by NHSEI. There were two expressions of interest for the SRO role for the ICS EPR and the successful candidate has now been appointed. The EPR Programme Board is expected to be set-up during February/March 2022. Further discussions are currently taking place with NHSEI to get clarity on the position of funding before moving to the next phase of this work, and in particular to support the clinical risks Blackpool are facing due to its expiring PAS.
Funded Care Services – *Talib Yaseen*	**3c. Design**	The workstream has reviewed and RAG rated the outstanding actions and deliverables, to enable priority setting in preparation for moving the services of Funded Care into the ICB. Leads will be providing position statements for any deliverables due for completion between 1st April 2022 and the ICB start date 1st July 2022.
Intermediate Care - *Louise Taylor*	**3b. Plan**	Intermediate Care is integrating the requirements for the development of both 2-hour Urgent Community response and a range of Virtual ward models within the planning guidance as part of overall future plans. It is intended that the development of plans against the planning guidance will be a first step to informing the broader strategic plan (across all sectors – it is fully recognised that this needs to be a full health and social care plan) that will come back to SCC later this year (April/May) following that initial work. Proposals for a revised structure, for both governance and management, of the Intermediate projects was taken to the joint cell on 7th February 2022 and plans to deliver on this are underway following further discussion at the February Adult Social Care and Health Partnership.
New Hospitals – *Jerry Hawker*	**3b. Plan**	The team has made significant progress on the development of key products to build the business case(s); the longlist of proposals, estate/site solutions, the identification and quantification of benefits, and the preparation for the workshop to assess the options are all underway. The longlist of options was approved in Q3, since then the programme has held several workshops with clinical, operational, estates/site, finance and infrastructure colleagues to focus on developing the required detail of the estates options, socio-economic value, aligning the NHP and the ICS Clinical Strategy. Work has commenced on the identification and quantification of benefits with clinical and estates colleagues, supported by external advisors, to create a log of benefits and associated risks. On 17th February, the programme is expected to agree the shortlist of options. This workshop will use the Critical Success Factors to appraise the longlist. The output of this will inform the final shortlist of options, which the programme looks forward to announcing in Q4.
Regulated Care – *Jane Scattergood*	**4. Implement**	**Booster vaccination programme:** there is regional and national oversight on progress. 100% of homes have had an initial booster vaccination visit, but there is regional and national concern on the low uptake within staff groups. **Contingency planning in the event of provider failure:** Contingency plans have been drawn up and agreed by joint cell. There is a need for Director level decision-making on the enactment of these plans. **IPC/PPE compliance monitoring:** all outbreaks are monitored with support is provided by LCC IPC teams and free PPE continues.

Programme & Executive Sponsor	Stage / Gateway	Key Highlights
		Support for workforce capacity: there are significant challenges with available workforce due to requirement to isolate for a minimum of 7 days post positive C-19 PCR results. This is impacting on ability of care providers to accept new admissions for residential care or to take on new packages of care.
Stroke Services – *Aaron Cummins*	**4. Implement**	The Stroke Programme for the acute has received confirmation for 2022/23 revenue from the Finance Director. The ISNDN request for resources for 22/23 and 23/24 has yet to be confirmed. The programme presented at the Lancashire County Council Health Scrutiny Committee in relation to the Acute Stroke Business Case and regular assurance is to be provided around the recruitment of workforce as per phased implementation plan, the plans to mitigate the increased travel for some stroke patients, and the engagement of staff side representatives. The Population Health Board Chair and Clinical Lead support the development of a proposal for a L&SC ICS wide CVD Prevention and Detection Group and will be presented to the Board in February. The programme is also collaborating with the Cardiac Network to confirm the prevention workstream priorities for the next 18 months and a proposal will be presented to the Population Health Board in February. For psychology, the Design Oversight Forum is developing the Model of Care for delivering psychology support following a stroke. Neurorehabilitation: The programme has collected insights on neuro and stroke rehabilitation criteria and drafted a position paper for the ISNDN, which has identified a range of patient complexity measures which have been shared with clinical teams for review and the preferred metrics will be shared with the ISNDN. The case for change will also be redrafted with input from the steering group ready for sign-off.
Vascular – *Kevin McGee*	**3c. Design**	The Vascular programme continues to collaborate, and a vascular multi-disciplinary team (MDT) meeting is in development which will support the work on the business case and the Network clinical pathway documentation. The programme aims to describe the right vascular service provision in the future model of care on all L&SC hospital sites and how these will be delivered in the most effective way in terms of outcomes and minimal travel for patients and clinicians. A workshop is being arranged in March 2022 to achieve this. The outcomes will inform the developing business case

2. Continuous Improvement

Programmes aimed to improve the effectiveness and/or the equity and consistency services/areas across Lancashire & South Cumbria and positively impact upon key performance indicator targets (quality/ financial / performance).

Programme & Executive Sponsor	**Performance:** Key highlights to narrate performance against KPIs (+/-) and against the previous months actual.
Palliative and End of Life Care – *Talib Yaseen*	The L&SC Getting to Outstanding EOLC patient journey early adopter project has now launched. The Early Identification project with Primary Care, which has been paused due to the covid response, is to be re-established, together with a staff training programme for advance care planning. A priority is to baseline both the actual and expected number of patients (by place-based partnerships) on GP palliative care registers, aiming to have these by June 2022.
Population Health & Reducing Inequalities – *Julie Higgins*	Recruitment to the Central Population Health Team and Place Based Team Directors and continues with interviews scheduled for February. Likewise, and further posts will to be recruited thereafter. Plans are also in progress to recruit to the Clinical Director and PCN Clinical Leads posts. **Health Equity Commission:** The Institute for Health Equity (IHE) has produced draft recommendations; based on evidence gathering with stakeholders across the region, which aim to improve health equity across Lancashire and Cumbria. An action plan has been developed and is being considered by the HEC Panel and the HEC Steering Group before the consultation widens to include all stakeholders. The final report and recommendations will be shared at the Health Equity Summit on the 21st of April at Lancaster University.
Primary Care – *Peter Tinson*	During January the team have been working on draft options appraisal for spirometry, an update against the Winter Access Fund which includes details of the related Regional Assurance Report and initial proposals regarding future analysis and reporting of primary care data to support demand and capacity management. Alongside this, work is continuing to develop the future operating model and resourcing proposals for the Primary & Community Care programme. The continuing pressures created by the covid response and potential staff absence remain a significant risk to the progression of the wider collaborative work programme.
Urgent & Emergency Care – *David Bonson*	The programme delivery plan will be updated during the course of February/March 2022 in line with the Operational Plan and the ten-point UEC recovery plan. Risks have been updated in line with the current programme position. Milestones/benefits/risks and products will be further updated once the milestone plan has been developed so that monitoring can commence from April 2022.

3. National Policy

Policy work with specified delivery plans, including nationally required performance targets and deadlines

Programme & Executive Sponsor	**Performance:** Key highlights to narrate performance against KPIs (+/-) and against the previous months actual.
Cancer Alliance - ***Talib Yaseen***	The Cancer Alliance has completed the assurance submission for quarter 3 and await any feedback from the national team. The assurance covers all planning priorities. Diagnostics, particularly CT and endoscopy remain challenged and colorectal now accounts for half of the overall backlog. The programme has supported external consultants to review endoscopy booking practices across all trusts, and currently awaiting the final reports. Delays are continuing to be experienced in Endoscopic Ultrasound (EUS) and the programme is working with ELHT to develop short, medium, and long-term plans to address capacity issues. Mutual aid continues to enable the cancer programme to work across the Cancer Alliance governance framework and with system leaders, clinical leads and cancer managers weekly. The programme has been successful in several external capital bids to support endoscopy and have received funding for trans-nasal endoscopy for each trust. Funding has also been received to support the implementation of FIT as a risk stratification tool to support demand management across our system in Q4. KPMG have started working on the second phase of the oncology review and will be with the system for eight weeks. The focus over the next month is to support cancer across the system as it recovers from COVID. The pathway improvement work continues and is utilising the IST pathway analyser tool to support this key piece of work. The programme is also working with partners to develop and complete the 2022/2023 planning requirements.
Diabetes – ***Sakthi Karunanithi***	**Prevention:** the referral conversion rates are being closely monitored (currently 44.8% as opposed to 60%) and the feasibility of the CSU providing conversion rates improvement support is being investigated. Next month, the programme will continue work to increase referrals and participation, undertake mailing activity with CSU support and progress the 'Wave 7' provider re-procurement process. **Recovery:** Funding has been received for recovery of diabetes care processes affected by the pandemic to support the 8 PCN's. Action plans in relation to this work will be developed from February. **Inequalities:** has identified 5 funded projects to improve inequalities and diabetes care and the funding transfers completed. A programme management and assurance process are now in place. **Structured Education:** has decided to disengage with MyWay Diabetes (MWD) due to onboarding issues, efficacy and certainty of future funding to support platform. An alternative platform has been identified; 'Healthy Living' and a changeover plan is being implemented. Over next month, the MWD contract will be terminated, the changeover deployed, and associated comms plan implemented.

Maternity & Newborn Alliance – *Jane Scattergood*	In recent months, some maternity transformation deliverables were reported to be at risk, however all maternity targets are currently paused, pending national review of the deliverables, which mainly relate to the Continuity of Carer (CoC) workstream. In the meantime, NHSE have put national and regional team support visits in place for each individual trust to discuss their challenges and support needs, to help them to develop robust local CoC plans which will then be submitted to regional team. In the Digital workstream, the East Lancs Hospital Trust is now live for antenatal bookings and intrapartum care. For Safe & Effective Care, a draft screening pathway has been developed which is expected to be ratified on 4th February and for Perinatal Mental Health, the Parent & Infant Pathway has been completed.
Children & Young People's Health (CYPH) – *Jane Scattergood*	The national programme of work is due to commence for the 'Epilepsy for Children & Young People' workstreams. Implementation of the pilot 'Complications Relating to Excess Weight' programme continues with recruitment to specialist posts and is expected to go live at LTHTR in January / February 2022.
Mental Health (All Ages / LD&A / SEND) – *Andrew Bennett*	**IAPT:** IAPT Access and prevalence remain a concern within IAPT which are performing 30% below Q2 trajectory at end of Q2, and partial Q3 showing further reduction in performance. Development of a digital comms campaign is underway, with all providers to support increased awareness and understanding of IAPT and encourage greater access. A number of initiatives are also underway with providers which include workshops across Blackpool for 'Sleep and relaxation', 'Resilience and me', 'Anxiety and worry' and 'Low mood', working with the Lancashire Constabulary to promote IAPT across their workforce, developing further pathways with physical health services, enhanced 'Mindsmatter' website and new HiT Trainees due to commence in Service January. Progress with Individual Placement and Support has been made to enable activity to flow to the mental health data set, with support from the NHS digital team. Training is being set up for the teams to use the system and work is also planned to look at the potential for self-referrals for individuals currently under the care of Community Mental Health Teams. The caseload in the community team is being reviewed along with the IPS service to accommodate the additional number of referrals and considering employment retention within these services. **Maternal Mental Health Service:** A plan has been agreed for the delivery of trauma Informed Care training across maternity providers/specialist MH teams/VCFSE orgs/Neonatal/Prevention which will commence in April and conclude October 2022. Key deliverables include expanding Peer Support Co-ordinator capacity, development of service specification and safeguarding policy in line with national guidance. A formal launch event is planned for the 8th of June 2022. **Learning Disabilities & Autism:** Work is underway with IPA to develop a complex case framework and service specifications for 4 key areas. **SEND:** The second ICS SEND maturity return for NHSE/I has been completed indicating that Lancashire and South Cumbria are achieving a **green rating** across the whole ICS and the four local area partnerships. The next return is due in April 2022 and requires some ICS positioning in relation to succession planning and consideration of the new governance structure for SEND within the ICB and at place for consistency. The Blackburn with Darwen partnership undertook the SEND Inspection Methodology Testing in

<table>
<tr><td></td><td>November 2021, from which there was learning about the move towards provider focused inspections in the future and will be shared across the system to ensure that all providers can develop an appropriate level of maturity. Preparation for the SEND inspection at Blackpool is anticipated early in 2022 and includes the continued development of a new strategy, an improved Self Evaluation Framework, and building the partnership arrangements. South Cumbria are awaiting an inspection revisit in early 2022. Accelerated progress plans have been developed for some areas of significant concern to ensure delivery of improvements.</td></tr>
<tr><td>Elective Recovery – Gemma Stanion</td><td>
<table>
<tr><th>Restoration %</th><th>Actual</th></tr>
<tr><td>EL DC OP (23.01.22 Flex)</td><td>89%</td></tr>
<tr><td>EL DC OP + Diagnostics (23.01.22 Flex)</td><td>92%</td></tr>
<tr><td>System ERF H1 Estimate</td><td>96% £34.3m</td></tr>
</table>
<table>
<tr><th>52 week waits</th><th>Actual</th><th>Plan</th></tr>
<tr><td>Total (23.01.22)</td><td>10,027</td><td>10,210</td></tr>
</table>
<table>
<tr><th>104 week waits</th><th>Actual</th><th>Forecast (Mar22)</th></tr>
<tr><td>Total p2-p4 (as at 23.01.22)</td><td>1,132</td><td>0</td></tr>
<tr><td>Total P5/6 (Pts who have chosen to defer)</td><td>30</td><td>319</td></tr>
</table>
* Target = equal to or less than Sept ’21 (139,526)

Waiting list size
<table>
<tr><th>Actual Oct 21</th><th>Actual Nov 21 (28/11)</th><th>Actual Dec 21 (02/01/22)</th><th>Actual Jan 22 (23/01)</th></tr>
<tr><td>140,451</td><td>140,319</td><td>141,641</td><td>145,229</td></tr>
</table>
Restoration rates in January dipped due to Omicron pressures, rates are beginning to increase again over the last couple of weeks. The over 52 weeks wait patient list has remained fairly static since June 2021 however the over 104 week wait patients rose to 1,132 ad was higher than January plan of 871. Mutual aid discussions with Chief Operating Officer’s and Medical Directors to support LTH due to take place on 4th February. The number of patients overall on the waiting list has been consistently increasing since April 2021 and January 2022 has seen a sharper increase than normal due to the impact of Omicron.
</td></tr>
</table>

4. Enabling Functions

Central ICS functions delivering development activity in a subject matter area to underpin and enable change and delivery of the ICS objectives and programmes

Function & Executive Sponsor	**Highlights:** Key highlights to update on any enabling developments or challenges affecting the system from the last or upcoming month
Digital – *Gary Raphael*	Procurement of ‘Online and Video Consultation’ and ‘Digital Front Door Triage’ for Primary Care has been paused due to the delay in the establishment of the ICB which would have given the opportunity to procure a single contract for the System. A request has been made to extend the current contracts for 3 months and this will be presented to the Primary Care Programme Board for consideration. The Centralised Viewer within the Shared Care record (LPRES) is now live in the 4 Acute Trusts and LSCFT which will allow healthcare professionals to diagnose and collaborate while viewing and sharing 2D/3D medical images. A Digital Review paper will be presented

Function & Executive Sponsor	**Highlights:** Key highlights to update on any enabling developments or challenges affecting the system from the last or upcoming month
	by the Chair of the Digital Portfolio Board to Provider Collaborative and SLE to provide an update on the work being progressed. Work will also commence on the three-Year Digital Transformation Investment Plan that has been commissioned from MLCSU.
Estates – ***Gary Raphael***	**Our Ways of Working:** Internal reconfiguration plans to develop Chorley House as an interim headquarters for the ICB have been drawn up and is due to be completed by mid-February 2022. A phased go-live for the booking system is planned from early March, noting that staff are expected to continue working from home until otherwise advised by senior leadership. Canon PrintAnywhere is being tested site by site and switch on dates are being aligned with Ubook go-live. Ubook administrators were trained on 31 January 2022 and communications for training of other staff will be arranged during February. An interim common door access system is being investigated in advance of a more permanent solution covering all buildings. Over the course of the next month Identify and action any shortages of furniture or IT kit at Chorley House and ensuring that all desks are ready to use/clear desk policy operational. **Sustainability:** Trust Green Plans were received from all 5 Provider Trusts by the 14 January 2022 deadline. Two of these are currently awaiting Board approval. The data submission for the quarterly review was submitted by 31 January 2022 deadline by all Trusts and the ICS. (Quarter 3 Greener NHS data returns). The ICS Infrastructure Strategy 2022 – 2040 was presented at the Board on the 2 February 2022, which included a significant carbon reduction element. An app for use in Primary Care is being developed and Rambol have been commissioned to carry out a Net Zero Carbon Review across all Trust sites in Lancashire and South Cumbria. During February the priorities are to progress the ICS Green Plan and recruit to ICS sustainability lead. **Lloyd George Digitisation:** The programme is progressing as scheduled, which is also building a national reputation and responding to requests for help and advice from CCGs in other parts of the country as the digitisation programme opens up again. Around 60% of practices are now actively involved with the process, and over 750,000 records have been scanned to date, with the final practices scheduled to begin the process in June 22. **Secondary Care Records Digitisation:** Xerox have been commissioned to carry out a Discovery exercise, looking at paper medical records held by Acute and Mental Health Trusts across L&SC. This work started in mid-January 2022 and is due to complete by the end of February 2022. This piece of work will form the basis of a business case which will be developed further to digitise all secondary records across L&SC. A short-term proof of concept is being developed to digitise 360,000 records housed in a basement at Blackpool Victoria Hospital, to provide a theatre area required for clinical use. This is in response to an urgent request for help at BVH and will use end of year capital funding. A “mini” procurement exercise has been undertaken and BTH Board approval to appoint the preferred supplier is being sought w/c 31 January 2022, to enable the work to start as soon as possible before the 31 March 2022 deadline for removal of records and starting the scanning.

Function & Executive Sponsor	**Highlights:** Key highlights to update on any enabling developments or challenges affecting the system from the last or upcoming month
Leadership & Organisation Development- *Sarah Sheppard*	Work has continued on the establishment and development of the ICB function with agile working support and guidance developed for CCG and ICS staff and agile working OD, engagement and comms plan developed and mobilised. The OD plan for Place Based Partnership's (PBP) is progressing and the National Leadership Leading for Systems change pilot is being commissioned to support relationship building and board development at Place Base level. OD planning is linked to ICB development and design work has been started and a plan being drafted which is linked to a system development working group.
Personalised Care – *Talib Yaseen*	The Omicron surge has disrupted a number of the Personalised Care projects which will result in work slipping into 2022/23. NHSE is concerned that L&SC will fail to deliver on targets and accrue a delegated funding underspend, so, they are looking at how outstanding commitments can be incorporated into future agreements. To date, NHSE has confirmed that L&SC will receive a letter of variation to the MOU for some elements of the agreed programme to convert these into a 2-year agreement and funding with the output delivery dates extended accordingly. NHSE has also requested a reprofiling of other priority projects to provide a phased delivery over a 15-month period from January 2022. A meeting has been arranged for late February to sign off these changes and for proposals to be submitted for sign-off at the ICS Executive Board or by a delegated representative.
Workforce – *Sarah Sheppard*	The Digital Staff Passport (DSP) implementation now has arrangements in place for ICS wide use for the 'Echothon' work, which is designed to address large recruitment backlogs across the system. This will run for 2 months from February 2022. Discussions with other clinical networks are underway, i.e., to use the DSP to support the movement of chemo nurses. Challenges have arisen outside the scope of the DSP, regarding rostering and payments systems for the different organisations, but potential solutions are being explored to address this. The Careers Platform delivered 21 programmes over the past month; including workshops, virtual work experience, open days and days which highlight different professional roles. The first cohort of the Step into Social Care programme was successfully completed, with a second cohort underway and a third to commence at the end of February. RESTORE2 training for care professionals continues until the end of February, when an evaluation will determine whether additional training is required. The first Functional Skills programme was positively received, and the team are now working with the Prince's Trust to enrol their learners onto the 5-week employability programme. The Strategic Apprenticeship Group has been working on both system-wide action plans and individual action plans for the apprenticeship pipeline and these were presented in early February, alongside the refresh of the Apprenticeship Strategy. Discussions on Levy sharing, and joint cohorts continue, and the team are also working on the first system-wide Apprenticeship Awards event, planned for June 2022. For college placements; a consistent approach to working and a system-wide Service Level Agreement is in place with future planned discussions to focus on creating longer term funding plans to allow placements to develop as part of the workforce pipeline. For student nursing placements in social care, additional funding has been secured to increase support to providers and students, allowing the programme to continue into 2022-23.

5. Risks & Issues

5.1 Risks: *All open **risks,** rated 'Very High' for individual programmes are provided in the table below:*

Programme Name	Risk No.	Risk Description	Initial Level	Current Level	Agreed Mitigation Actions	Action Taken
Diagnostic Imaging	RI/Diagimag03	Risk to patient safety in relation to delivery of thrombectomy and neuro interventions for emergency patients Due to lack of available capital funding for replacement of ageing CT biplanar at LTH. If bi-planar becomes non-operational, patients will not have access to emergency neuro-interventional radiology procedures within LSC	**Very High**	**Very High**	Mitigations being explored through NW Region, LTH and NHS Specialised Commissioning	Raised with NW Regional and NHSEI Specialised Commissioning colleagues

5.2 Issues: *All open **issues**, rated 'Very High' for individual programmes are provided in the table below:*

Programme Name	Issue No.	Issue Description	Initial Level	Current Level	Agreed Mitigation Actions	Action Taken
Maternity & Newborn Alliance	RI/M&Nb85	Unsafe service provision to women and babies due to reduced, unsafe maternity (midwifery) staffing levels within maternity services increased SIs	**Very High**	**Very High**	Recruitment (Ockenden monies) ongoing recruitment Retention and Pastoral Care incentive Agreed at last Board that Heads of Midwifery (HoMs) will discuss other short-term options	Nov 21 - Ongoing recruitment at Trusts and BR+ either completed or being completed, plus commencing Retention and Pastoral care work. Reporting better staffing at last SitRep but still unstable. Score to remain the same until robust reporting in place to support staffing levels that are safe and being sustained

	RI/M&Nb86	Unsafe service provision for NICU babies due to reduced, unsafe neonatal staffing levels within maternity services increased Serious Incidents	**Very High**	**Very High**	Staffing and service levels being monitored daily through national submission of status Implementing acuity monitoring tool to monitor daily system pressures	All staffing issues have been escalated to the MNBA Board and further discussions have been requested across the LMS about other potential short-term interventions
	RI/M&Nb87	Significantly impaired capacity to lead on the current key projects and the new requirements for workforce and education, due to having no LMS Learning and Development Lead in post and awaiting the handover of key project documentation from previous Lead: this may result in the non-delivery of projects and the 2021-22 deliverables and a non-compliance with Ockenden.	**Very High**	**Very High**	Urgent solution required to identify a resource to: Lead the Workforce & Education Transformation steering group (workstream) - with revised ToR, ensure delivery of current projects, enable compliance reporting to QAP, Work with ICS and Regional colleagues to agree strategy and short/ medium/ long term plans for LMS workforce and education. Secure support from the ICS Workforce Team and Regional Workforce Team	Nov 21 - request to BTH HoM and LTHTr HoM for 1 day a week of PD midwife to support continuation of key pieces of work until 31st March 2022.

6. Planned Key Benefits

A summary of the KEY planned benefits for each programme and their associated KPI measures, where identified.

Work is ongoing to establish the KPI measures and this will be included once agreed. When the benefits for a programme start to be realised, the progress will be reported through actuals, detailed as part of the relevant individual programme update, in Sections 1-4.

Programme	Key Benefit Description	Benefit Measure / KPI
CAMHS Redesign	An additional 17,886 children and young people across LSC will be able to access NHS funded services by 2029 based on a local prevalence of 1:10	The number of Children & Young People up to their 19th birthday supported through NHS funded mental health services with at least 2 contacts
	An additional 17,886 children and young people across L&SC will be able to access NHS funded services by 2029 based on a local prevalence of 1:10	Number of CYP up to their 19th birthday supported through NHS funded mental health with at least two contacts

Programme	Key Benefit Description	Benefit Measure / KPI
	We will be providing for specific extra capacity for early intervention and ongoing help by providing Mental Health Support Teams which will cover at least 25% of Lancashire & South Cumbria's education population by the end of March 2024	Long Term Plan
	Waiting time standard will be sustained for children and young people's eating disorder services. 95% of those in need of urgent NICE concordant treatment will receive it within 1 week	CYP receiving treatment within 1 week
	Waiting time standards will be met and sustained for children and young people's eating disorder services. 95% for those in need of routine NICE concordant treatment will receive it within 4 weeks	CYP receiving treatment within 4 weeks
	Waiting time standards of 2 weeks from referral to assessment will be met and sustained in the delivery of Early Intervention is Psychosis services (EIP).	Number of CYP receiving an assessment within 2 weeks of receipt of referral
	The C&YP 4-week Referral to Assessment target 100% will be reached by end of 2023 across all place-based locations and within all teams.	Number of CYP receiving an assessment within 4 weeks of receipt of referral
	The C&YP 18-week Referral to treatment target 100% will be reached by end of 2022 across all place-based locations and within all teams.	Number of CYP receiving a treatment within 18 weeks of receipt of referral
	There will be an expansion of 24/7 urgent and emergency mental health response for children and young people to meet 57% coverage by 2021/22.	Number of CYP with access 24/7 urgent and emergency mental health response
	There will be an expansion of 24/7 urgent and emergency mental health response for children and young people to meet 100% coverage by 2023/24.	Number of CYP with access 24/7 urgent and emergency mental health response
Collaborative Services	Ensuring all Trusts procure medical agency staff via framework approved by NHSE/I	Financial savings – to be quantified
	Ensure all Trusts procure agency nurses via framework approved by NHSE/I	Financial savings – to be quantified
	To design/procure a payroll system that will blend cultural change and new technology	Financial savings – to be quantified
Collaborative Services	Savings made in National Insurance contributions	Financial savings – to be quantified
	The procurement workstream is highly interdepartmental - currently working closely with other workstreams such as Estates & Facilities supporting Trust collaboration to ensure financial savings through economies of scale	Financial savings – to be quantified
	Merging procurement management functions and operations allow for common ground and will enhance the synergies cross the wider system	Financial savings – to be quantified
Diagnostics – Imaging	Reduce the system's % of 6WW breaches below the constitutional standard of 1%.	% Of patients waiting more than 6 weeks for a diagnostic imaging test
	Restoring activity to pre-covid levels (comparison to 2019/20 activity)	2021/22 CT, MRI and non-obstetric ultrasound activity compared to 2019/20 actual activity

Programme	Key Benefit Description	Benefit Measure / KPI
Funded Care	Funded Care transformation via a new integrated collaborative model - via the development of a new business transformation model for delivering CHC/IPA across Lancashire & South Cumbria (LSC) and the operationalisation of this as BAU. This involves the setting up of a collaborative central business unit with 4 Placed Based Partnerships around a "hub and spoke" model. This integrates the Blackpool model, within the system and has been progressed collaboratively with local authority input.	Increase in activity and reduction in cost KPIs
	Efficiency Savings via improved System Management and governance of the >£180-£200m expenditure within the programme (£5m)	
	Performance Improvement - reduction in health inequalities and better outcomes through improved access and standardised approaches with a workforce that can meet future needs	National KPI
	System-wide integrated working - no incomplete/open referrals or overdue reviews	Focus Groups/ Workshops
	Personalisation - a Golden Thread throughout to shape services going forward.	Comms & Engagement KPI
	Joined-up, integrated, system wide policies that have been agreed and implemented by all parties (e.g., Disputes Policy for CHC and Non-CHC, CHC Practitioner Guidance [SOP], Enhanced Observations and 1:1 Request Form), with a view to achieving a consistent service delivery and patient experience across LSC.	Focus Groups/working practice, making services leaner and reducing Risk
Intermediate Care	Reduced cost of Short-Term Social Bed Care	for Cohort of £1.5m p.a. versus 2019 cost
	Reduced cost of Non-Elective Acute Bed Care	for Cohort of £37.9m p.a. versus 2019 cost
	Increase Funding for Intermediate Care Services	of £35.5m versus 2019 cost
	Reduced HLSC ICP Average Cost Per Episode	for cohort by £177 versus 2019 cost
	Released Acute Bed Capacity	from Cohort of 16,905 Episodes of Care p.a. versus 2019
Intermediate Care	Reduced Staff Training & Recruitment Costs as a Result of Turnover	
	Improved Service Availability of an Additional 32,742 Episodes of Care versus 2019 Activity	Episodes of care
	Improved Outcome Setting, Tracking & Attainment	
	Improved Service Quality	
Regulated Care	NHSmail uptake for medicine optimisation (proxy ordering); transfer of information and contribute to reducing delayed transfers of care	
	Workforce – Stabilise the current Workforce; accelerate Workforce development; support the Sector development to become an employer of choice	
	Reduce the resources involved in crisis management as quality improves	

Programme	Key Benefit Description	Benefit Measure / KPI
Children & Young People's Health	Improved system efficiency where local priorities are based on population health approach and issues arising from Covid-19	
	Co-production with children, young people, carers and their families regarding CYP health services	Co-production with voluntary sector Representation on workstreams
	Improved care coordination and partnership working across children's and adult services for CYP who are preparing for adulthood (transition)	National transition framework
	Improved joint decision making between commissioners and providers about financial planning and prioritisation that will support system delivery of CYP health services	
	Improved diagnosis and quality of care for CYP with long term conditions	
Palliative & End of Life Care	Reduced variation across key indicators for Lancashire & South Cumbria that promotes equity of access and supports a consistent approach system-wide	
	Increased early identification and advance care planning to enable patient choice and avoid hospital conveyance.	
	Improved understanding of population needs to support service planning for bereavement service capacity and access to meet those needs	
	Future working models will be evidence-based - underpinned by a gap analysis and the development of an end-to-end model	
Population Health & Reducing Inequalities	Improved health outcomes and reduced inequalities across an entire population, using data to mobilise the workforce to shift care further upstream to improve efficiency	
	Reduced health inequalities and the NHSE/I Covid-19 KLOEs (key lines of enquiry) being met, in terms of its uneven societal impact	
	Improved health, enhanced experiences, and outcomes for patients, producing a demand reduction and cost improvement (per capita cost of care in the public sector)	
Urgent & Emergency Care	Transforming Access to Urgent & Emergency Care Services	
	999 Ambulance Services (optimising performance and reducing wider service pressures	
	Developing Capacity in Community Settings	
	Improving flow through hospitals (emergency Departments and Same Day Emergency Care)	
	Managing Hospital Occupancy	
	Measuring Performance in a Transformed Way	
	Faster Diagnosis Standard	

Programme	Key Benefit Description	Benefit Measure / KPI
Cancer	62-day referral to treatment	Target 975 with the Actual at 1,015 = 104% (as of December 2021). Backlog for January estimated at 1,040
	Restoration of referrals	Target currently 125% with the Actual at 100%
	Restoration of first treatments	
	Patients waiting over 62 days	
Diabetes	Expansion of the NHS Diabetes Prevention Programme & expanding digital access	Referrals / IAs / Completions / Demographic variations
	All hospitals provide access to multi-disciplinary footcare teams	Reduction in foot ulcers, amputations, and death from diabetes related foot problems
	All hospitals provide access to diabetes inpatient specialist nurses	Reduced hospital stays and medication errors
Maternity & Newborn Alliance	Women, Birthing People and families access a safe, equitable and personalised experience	% Of women with Personalised Care and Support Plans (PCSPs) in place - Antenatal, Intrapartum and Post Natal
	Improve the health of the population through preventive initiatives to smoking, obesity and improve lifestyle choices	Baby Friendly Initiative at all four Trusts 40% of smokers to be offered inhouse long term pathway
	Sustainable and competent workforce	% Turnover for each workforce group Current vacancies as % of establishment % MDT training
	There is an equitable service across the LMS that is safe and compliant	Reduction in Still Births, Neonatal deaths maternal deaths and inter-uterine ABIs Maternity Incentive Scheme compliance Ockenden compliance
	Optimising health and well-being outcomes and experiences	% Of women placed onto CoC pathway % of Black, Asian, mixed ethnicity women placed onto CoC pathway % of women from lowest decile of deprivation placed onto CoC pathway
Mental Health (National)	IAPT Access Rate	IAPT Access Rate
	IAPT 1st to 2nd Treatment >90 days	IAPT 1st to 2nd Treatment >90 days
	OAP Bed days (inapp)	OAP Bed days (inapp)
	PH SMI % Achievement	PH SMI % Achievement
	Perinatal Access Rate	Perinatal Access Rate

Personalised Care	Increased Strategic Coproduction input into Pathway Redesign	Increased and earlier access to services from vulnerable groups who do not traditionally engage or present late Increased customer satisfaction Reduction in healthy lifespan gap
	Patient segmentation and health coaching embedded in Pathway design and delivery to provide more tailored and effective care	Increased System capacity with associated successful patient outcomes
	Embedding behaviour change into patient care plans as an alternative/support to clinical intervention and medication	Reduction in unnecessary clinical interventions and over prescribing of medication
	Increased Patient Choice with personalised care approaches and behaviour change becoming a key component in delivering integrated care	Patient expectation of service to shift from a silo model with hand-offs to a continuum of integrated care delivered on a multi-agency basis

Appendices.

1. ICS Decision Flow: