Formal Integrated Care System (ICS) Board
3 November 2021, 10.00 am - 12.30 pm
Via MS Teams Videoconference

Agenda

Item	Description	Owner	Action	Format
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Declarations of Interest/Conflicts of Interest relating to the items on the agenda	Chair	Note	Verbal
3.	Minutes of previous formal ICS Board meeting held on 1 September 2021, Matters Arising and Actions	Chair	Approve	Attached
4.	Key Messages	Andrew Bennett	Note	Verbal
Managing 2021/2022				
5.	Preparations for Winter 2021/22	Andrew Bennett	Discuss	Attached
6.	Supporting General Practice to Improve Access for Patients	Dr Peter Gregory/ Dr Lindsey Dickinson/ Peter Tinson	Discuss	Attached
7.	Emerging shape for L&SC H2 Planning Submission	Gary Raphael/ Carl Ashworth	Discuss	Attached
8.	System Financial Recovery Update	Gary Raphael/ Sam Proffitt	Discuss	Attached
9.	ICS Finance Report	Gary Raphael	Discuss/ Note	Attached
Building the system for 2021/22 and beyond				
10.	a) System Reform Programme – General Update b) Place-Based Partnerships: Proposed Governance and Leadership Arrangements for 2022/23	Andrew Bennett Geoff Jolliffe	Discuss Approve	Attached Attached
11.	New Hospitals Programme Update	Jerry Hawker	Discuss	Attached
Items for information only				
12.	Lancashire and South Cumbria System Development Programme – Highlight 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: Formal meeting - Wednesday, 12 January 2022, 10 am to 12.30 pm, MS Teams videoconference				

Development of the Integrated Care System
Glossary of key terminology and visual attached

Glossary of integrated care language

Integrated Care System (ICS): Refers to the health and care system across Lancashire and South Cumbria. There are 42 ICSs across the country. Within each ICS there is an Integrated Care Partnership and an Integrated Care Board.

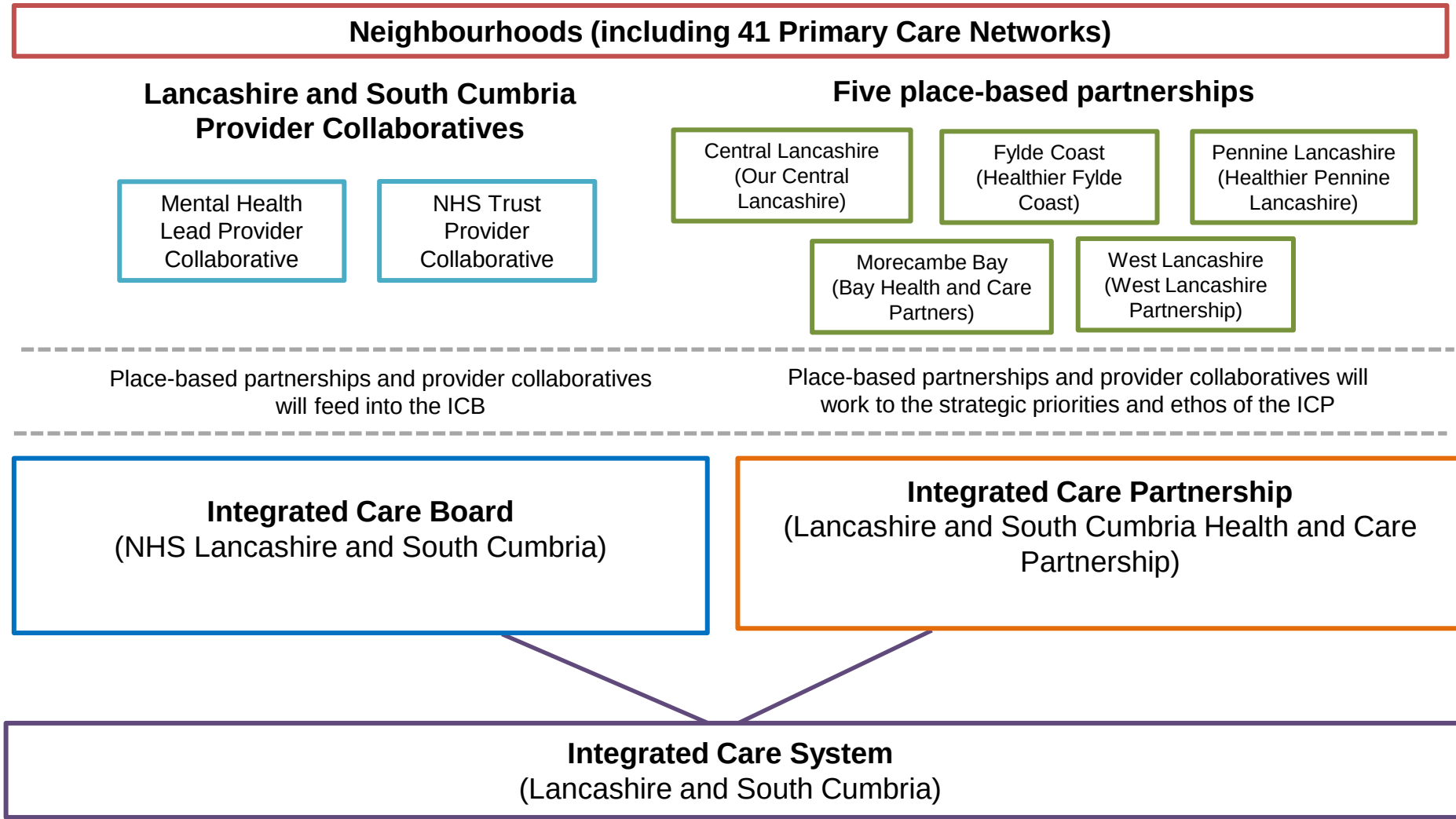
Integrated Care Partnership: A partnership of NHS, local authority, VCFSE and academic institutions working together on a joint health and care agenda to coordinate services and to plan in a way that will deliver improvements in population health and reduces inequalities between different groups. This is our partnership at system level called Lancashire and South Cumbria Health and Care Partnership. This term has now started to be used in the most recent national guidance. However this is different to how we have used this term previously. It was previously used to describe our five place-based partnerships.

NHS Integrated Care Board: This is the new NHS organisation that will be established on 1 April 2022, subject to legislation. We expect this is likely to be known publicly as “NHS Lancashire and South Cumbria”, but this is subject to the legislation being agreed through Parliamentary processes.

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. We have five place-based partnerships in Fylde Coast, Central Lancashire, Morecambe Bay, Pennine Lancashire and West Lancashire. It’s important to note that 'Integrated Care Partnership' is now being used to describe the partnership at Lancashire and South Cumbria level.

Neighbourhoods: Based on local populations of between 30,000 and 50,000. Neighbourhoods, in some instances, may align with Primary Care Networks and Integrated Care Communities.

Primary Care Networks (PCNs): GP practices working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices. Find out more on PCNs on the NHS England website.


Neighbourhoods (including 41 Primary Care Networks)
Lancashire and South Cumbria Provider Collaboratives
Mental Health Lead Provider Collaborative
NHS Trust Provider Collaborative
Five place-based partnerships
Central Lancashire (Our Central Lancashire)
Fylde Coast (Healthier Fylde Coast)
Pennine Lancashire (Healthier Pennine Lancashire)
Morecambe Bay (Bay Health and Care Partners)
West Lancashire (West Lancashire Partnership)
Place-based partnerships and provider collaboratives will feed into the ICB
Place-based partnerships and provider collaboratives will work to the strategic priorities and ethos of the ICP
Integrated Care Board (NHS Lancashire and South Cumbria)
Integrated Care Partnership (Lancashire and South Cumbria Health and Care Partnership)
Integrated Care System (Lancashire and South Cumbria)

Find out more

- A more detailed glossary for Lancashire and South Cumbria is available on our website:
  Lancashire and South Cumbria glossary of language

- Read about national integrated care developments on the NHS England website:
  NHS England – national guidance

- Read about how we are developing integrated care locally:
  Lancashire and South Cumbria: Integrated Care

Subject to ratification at the next meeting

Formal Meeting of the ICS Board

Minutes of Meeting	
Date	Wednesday, 1 September 2021
Venue	Microsoft Teams Videoconference
Chair	David Flory

Present		
David Flory	Independent Chair	Lancashire and South Cumbria ICS
Andrew Bennett	Executive Director for Commissioning	Lancashire and South Cumbria ICS
Jane Cass	Director of Strategic Transformation / Locality Director	NHS England and NHS Improvement NW
Elaine Collier (representing Gary Raphael)	Head of Finance	Lancashire and South Cumbria ICS
Talib Yaseen	Director of Transformation	Lancashire and South Cumbria ICS
Andy Curran	Executive Medical Director	Lancashire and South Cumbria ICS
Caroline Donovan	Chief Executive Officer	Lancashire and South Cumbria NHS Foundation Trust
Chris Adcock (representing Aaron Cummins)	Finance Director	University Hospitals of Morecambe Bay NHS Foundation Trust
Kevin McGee	Chief Executive Officer	Lancashire Teaching Hospitals NHS Trust and Blackpool Teaching Hospitals NHS Foundation Trust
Martin Hodgson	Chief Executive Officer	Lancashire Teaching 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 (and representing Claire Heneghan)	Director of Strategy and Operations	NHS West Lancashire CCG
Geoff Jolliffe	Chair	Morecambe Bay CCG
Denis Gizzi	Chief Officer	Central Lancashire CCGs
Cllr Graham Gooch	Cabinet Member for Adult Services/County Councillor	Lancashire County Council
Mike Wedgeworth	Non-Executive Director	Lancashire and South Cumbria ICS
Ian Cherry	Non-Executive Director	Lancashire and South Cumbria ICS
Isla Wilson	Non-Executive Director	Lancashire and South Cumbria ICS
Eileen Fairhurst	Chair	East Lancashire Hospitals NHS Trust
David Blacklock	Chief Executive Officer	Healthwatch Cumbria and Lancashire
Peter Armer	VCFSE Independent Chair	Voluntary Care and Faith Sector
In Attendance		
Tracy Murray	Programme Director for Elective Care Recovery	Lancashire and South Cumbria ICS
Paul Havey	Executive Financial Advisor	Lancashire and South Cumbria ICS
Sam Proffitt	Director of Provider Sustainability	Lancashire and South Cumbria ICS
Sarah Sheppard	Interim Executive Director of HR & OD	Lancashire and South Cumbria ICS

Jerry Hawker	Senior Responsible Officer, New Hospitals Programme	Lancashire and South Cumbria ICS
Nicki Latham	Deputy Chief Executive/Director of Strategic Partnerships	Blackpool Teaching Hospitals NHS Foundation Trust
Seamus McGirr	Director of Nursing and Urgent Care	NHS Midlands and Lancashire Commissioning Support Unit
Louise Taylor	Executive Director Adult Services and Health & Wellbeing / Chair Adult Social Care and Health Partnership	Lancashire County Council
Dr Arif Rajpura	Director of Public Health	Blackpool Council
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Pam Bowling	Corporate Office Team Leader	Lancashire and South Cumbria ICS
Rebecca Higgs	Business Manager	Lancashire and South Cumbria ICS
Sandra Lishman	Corporate Office Co-Ordinator (Minute Taker)	Lancashire and South Cumbria ICS
Public Attendees		
9 public attendees		

Routine Items of Business

1. Welcome, Introductions and apologies
- **System Development and Legislative Change**

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 in advance of the meeting. Members were informed that with immediate effect all meetings of the ICS Board held in public would be recorded and added to the ICS website after the event.

Apologies had been received from Gary Raphael, Carl Ashworth, Jackie Hanson, Jane Scattergood, Claire Heneghan and Aaron Cummins.

It was acknowledged that Kevin McGee had today started in his new role of Chief Executive Officer of Lancashire Teaching Hospitals NHS Foundation Trust (LTHFT) and would continue his role as Chief Executive Officer for Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT) for a short period of time.

David Flory was pleased to announce that he had been appointed as Designate Chair of the new NHS Lancashire and South Cumbria Integrated Care Board. The nationally co-ordinated process to recruit a Chief Executive Officer would begin imminently, following which, a full Board would be appointed, operating initially in shadow form. Whilst there were fixed points in the regulations and guidance there was also discretion in considering the right structure to represent the system in a way that would be collectively agreed. Over the coming months further thought would be given to the plans and priorities from April 2022 working with the five Placed Based Partnerships and connecting with the different parts of the system. It was important to continue to do business in this Board with due diligence and care in order to support the new arrangements when agreed.

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 7 July 2021, matters arising and actions

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

RESOLVED: The minutes of the meeting held on 7 July 2021 were approved as a correct record.

Action Log – The action log was acknowledged with open actions to be reviewed at future meetings.

4. Key Messages

Andrew Bennett (AB) provided the following update:

Local Government Re-organisation. On 21 July 2021, the Secretary of State for Housing, Communities and Local Government published a decision for local government re-organisation in Cumbria, proposing two unitary councils. The ICS would be working closely with Cumbria County Council during this process. It was noted that the re-organisation would not alter the boundary for the Lancashire and South Cumbria ICS.

The Care Quality Commission recently published an inspection into Morecambe Bay Hospitals NHS Foundation Trust (MBHFT) and the Trust had now received a report that required a series of actions to be undertaken. To support the process and monitor improvements, a System Improvement Board was meeting, chaired by the Regional Medical Director. In addition, the Provider Collaborative was looking at how partners in the system could provide support.

Changing Futures Programme. Work with homeless people during COVID, co-ordinated via the Housing/Homeless cell, led to local government and NHS partners across Lancashire submitting a bid for funding from the Local Government Changing Futures Programme which aims to improve outcomes for people experiencing multiple disadvantage. The bid was successful and £6.5 million has been awarded over the next few years to build a model of support. Dr Arif Rajpura, Director of Public Health, chaired the Homeless cell during COVID and is the Senior Responsible Officer for this programme.

Managing 2021/2022

5. Operational Recovery and Performance – Status reports on sector by sector recovery and performance

Andrew Bennett (AB) presented the paper which provided a sector by sector 'situation report' offering an insight on current system performance, the challenges being faced and actions being taken. The reports were received by the Senior Leadership Executive (SLE) group on 18 August alongside a presentation setting out the financial context for the imminent operational planning round for the second half (H2) of this financial year. System leaders had noted the situation reports; endorsed proposed actions for H2; confirmed common themes and risks that required collective action in advance of H2 and supported the presentation of the reports to the ICS Board.

The following sector situation report were presented to the Board, highlighting the key challenges and issues, key actions for H2 and associated risks.

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

There were a number of common themes highlighted through the reports including capacity, demand and other factors including the requirement for cost improvements. Workforce availability was an issue and staff had limited time for recovery from the effects of the pandemic. The level of demand upon services was

significantly higher than pre-pandemic and the imbalance between capacity and demand was leading to backlogs of people waiting to access services. Evidence of this included poor flow through the system with lower hospital discharge into constrained out of hospital support. The possible impact of new Covid-19 variants together with the usual or increased winter pressures could make this imbalance grow further. There was also recognition of the hard work of everyone across the whole pathway.

The Chair thanked colleagues for their presentation and invited comments and questions.

Peter Armer reflected on the challenges faced by the VCFSE including increase in activity during the pandemic in areas such as debt counselling, mental health and domestic abuse. This had been exacerbated by loss of income by organisations dependent upon self-generating funding. However, the VCFSE were part of the recovery programme albeit members needed to be mindful that some organisations would not survive following the pandemic.

In response to the presentation by Louise Taylor (LT) on the Care Sector, Ian Cherry commented that he had recently had discussions around intermediate care and it was felt that the system was being pulled between supporting hospital discharge and trying to help admission avoidance. Primary care colleagues had reported the system to be difficult to access due to multiple entry routes. Mr Cherry asked how the ICS Board could take an overarching systemic view to ensure a fair application across all parts of the system that need support. Louise Taylor responded that there was a need for good population health, admission avoidance community services and a robust multi agency system within hospitals which allows people to be discharged expeditiously where appropriate.

Isla Wilson commented on the need for clear actions from the Board in response to the risks identified and that in terms of workforce there was need for better collaboration between health and social care, to listen out for the 'asks' from the social care sector.

Kevin McGee (KM) thanked LT for her leadership in this area, with a consistent approach across local authority partners due to the discipline and leadership shown. Reference was made to the pressure in terms of flow of patients through the system and the need for the ICS Board to be supportive of the long-term work described by LT but also to work together as a system to alleviate the immediate issues over the next 6 to 8 weeks. KM expressed confidence that this was being dealt with as a system more so than had been done so previously.

Peter Gregory (PG) added that focussing on avoiding admissions and improving discharges, increased pressure on the care system. However, there were opportunities available as a system to maximise independence and affect avoidable deterioration in people and primary care could consider additional roles to support an integrated multidisciplinary team. Reference was also made to how performance is measured in the system and that patient-based feedback and listening to communities needed to be included moving forward. Peter Tinson asked for support from the Board in terms of flexibility from NHSE in the use of the underspend on primary care workforce due to recruitment issues, particularly the additional roles scheme, to target it at other roles. Geoff Jolliffe commented on the future of general practice and offered thoughts around the Board sponsoring a piece of work on a new vision for primary care to be able to continue to respond in a sustainable way.

The Chair invited further thoughts and suggestions from members on opportunities to ensure the system was working as efficiently and effectively as possible. The following comments were made:

- There was increasing evidence of clinical teams willing to move patients, particularly long waiting patients, and this must continue
- A view expressed at a recent national visit was that there was over caution with elective pathways and there could be more efficiency on patient activity by relaxation on swabbing and isolation times.
- Some diagnostics were doing over 100% activity, generally resulting in a reduction of backlogs
- Solid communication was required with members of the public to understand the position and the challenges being faced which could help patients to make different choices

AB thanked the sector leaders for their presentations and the work they are undertaking. It was recognised that the system was performing well considering the circumstances. Teams were working well together and there had been a massive effort from all staff. There were opportunities to think differently about how services are organised in the future and for clinical teams to work differently, supported by the forthcoming structural changes.

The Chair stressed the importance of giving consideration to the priorities and opportunities highlighted in the discussion. There was to be further discussion on finance at today's meeting and a deeper look at workforce issues via the People's Board was required. The new system architecture, ways of working and financial regime would provide opportunities to improve some parts of the system going forward and acknowledged the points made regarding the need for capturing patient experience in designing new ways of working.

RESOLVED: The ICS Board:

- **Received the situation reports**
- **Endorsed SLE's proposed actions in advance of the H2 operational planning process.**

6. System Financial Recovery Update

Sam Proffitt (SP) provided an update from the System Financial Recovery Board meeting held on 23 August 2021. The system remained on track to meet its H1 (half year to 30 September 2021) position. Pace and focus was required to ensure reduction of recurrent costs and to support continued delivery in to the second part of the year. It was anticipated that the cost savings within the programmes were likely to start to impact during H2 (second half of the financial year).

The System Recovery Board held good challenge and debate at their recent meeting. The system financial diagnostic support had been launched and made a successful start. Aligned to this was a review of corporate benchmarking to identify further savings opportunities in year. The HR, Procurement and Finance workstreams were supporting the H1 with schemes such as agency rates, contract reviews and asset reviews. Other programmes included medicines management and CHC schemes.

RESOLVED: The ICS Board noted the contents of the report.

7. ICS Finance Report

Elaine Collier (EC) reported on the month 4 financial performance for the Lancashire and South Cumbria system, confirming the system was on track to deliver a break-even position for H1, after applying the benefit of Elective Recovery Funding (ERF) income. Efficiencies were being monitored, being a little behind year to date, however, organisations were expected to recover. There was concern that this may impact on H2 where the ask is even more ambitious.

RESOLVED: That the ICS Board note the ICS Finance report.

8. Financial Context for 2021/22 H2 Operational Plans

Elaine Collier (EC) explained that the system was under continuing scrutiny from the national and regional team for H1 delivery. The system was currently in a good position being on track to deliver, but focus would need to continue. Members noted the significant challenge expected for H2. The planning guidance and financial envelope for H2 was due to be published on 16 September 2021 and was expected to be more challenging, with potentially a 3% reduction in the financial envelope compared to H1, circa £50m. ERF income had been used to balance plans in H1 but this was not expected in H2. New national priorities and emerging pressures would need to be considered in planning for H2.

As a consequence of the issues and constraints described, there was a need to work on the basis of planning for contingencies in developing plans for H2. A pragmatic approach to this was supported by the

Senior Leadership Executive Team at their meeting on 18 August and in order to deliver on system priorities it was agreed that a task and finish group be established to review and confirm the most impactful changes across sectors that are affordable within the constrained H2 envelope. The ICS Board was asked to endorse the creation of a task and finish group.

Ian Cherry expressed congratulations to all those involved on the expected achievement of financial balance in H1 and asked how the system was ensuring that clinical ownership was embedded into the workstreams and delivery programmes. Sam Proffitt responded that governance around the programmes of work was being considered and would lead into the next stage of the plans and across the system. Where relevant, every programme would have proper clinical engagement and clinical leadership within it. Discussions on the work around diagnostics was being fed into the Clinical Collaboration Group, chaired by Professor Thomas. Dr Curran confirmed that when each workstream is identified, clinical leadership is embedded and existing Clinical Leadership Groups are utilised to make improvements along with improving quality and outcomes using medicines management as an example. If clinical challenge considers that quality would be hampered, an alternative way forward is requested. Peter Gregory welcomed the establishment of the Clinical Collaboration Group and this collaborative approach.

In response to a question from Roy Fisher, EC confirmed that efficiencies were expected to roll into H2. As part of the efficiency planning, 3% influenceable spend for CCGs had been agreed in H1, rising to 5% by end of H2. The financial envelope for H2 may bring additional efficiencies. RF referred to an agreement that no contingency reserves would be held by CCGs and EC confirmed that this decision was taken around affordability within the H1 envelope and would be looked at again when information was received on the H2 envelope.

In response to a comment from Eileen Fairhurst about the prioritisation work including a perspective from individuals in the population, SP confirmed that data was being used to inform potential savings and the diagnostic work included clinical benchmarks relating to population data. Once this information was available communication with patients and the public, including the voluntary sector, was imperative.

David Flory summarised that the financial envelope for H2 was awaited, pressures and priorities in the system would have to fit into the resource allocated and recognising a large deficit there would be a significant challenge to balance. The ICS Board had a responsibility to ensure the best fit was made between financial pressures, workforce constraints, service pressures and priorities of service development to take forward.

RESOLVED: The ICS Board endorsed the approach as described in section 7 of the report to ensure that the overall shape of the plans for H2 was agreed to consider alongside national guidance.

9. 2021-22 Capital Update

Paul Havey (PH) presented the report on the 2020/21 provider capital position in the context of an envelope of £112m and identified the priorities that would need to be considered for funding, should any slippage on capital occur later in the financial year.

PH advised that the current position was an over commitment of £1.3m against the capital envelope, which needed to be managed in-year. All organisations had indicated they would spend any slippage by the end of the year but would be asked to confirm their year-end forecast and final level of slippage at a review meeting with DoFs on 27 September 201.

A number of further priorities and developments had been identified, including the year 1 capital costs of implementing the approved stroke business case and the potential for the four acute Trusts having to fund the cost of developing the Pathology Collaboration FBC. At this stage the additional costs were unaffordable within the £112m envelope as the £1.3m over commitment excluded them. As and when slippage on the existing plan was confirmed the schemes would need to be prioritised and be ready to proceed in order that

the resource could be spent in year. To facilitate this, a set of prioritisation criteria had been agreed and shared with the system. PH proposed that following the review of expenditure on 27 September, the SLE (or other ICS Board preference) meet to prioritise the use of any slippage identified in excess of what is required to balance the programme and consider a first call on capital for 2021/22.

The Chair urged expedition of this process of prioritisation and robust challenge on the level of slippage in the system for the second half of the year.

It was agreed that Andrew Bennett, Gary Raphael and Paul Havey meet outside of this meeting to decide who should be involved in the work on setting priorities.

ACTION: Andrew Bennett

RESOLVED: The ICS Board:

- **Noted the current position and the process going forward.**
- **Agreed that Andrew Bennett, Gary Raphael and Paul Havey meet to decide on who should be involved in the setting of priorities.**

Building the system for 2021/22 and beyond

10. System Reform Update

(a) System Reform Programme - General Update

Andrew Bennett provided an overview of actions taken in last two to three months and highlighted key points in the report. The Health and Care Bill (2021) was proceeding through the parliamentary process having received its first and second readings. A range of guidance had been published in the last few weeks, which was detailed within the report, with further guidance to follow. New terminology was being used and the statutory NHS body was referred to as 'Integrated Care Board' (ICB).

Attention was drawn to the NHS Operational Planning Guidance for 2021/22 and the intention to delegate some of NHS England and NHS Improvement's direct commissioning functions to ICBs as soon as operationally feasible from April 2022 ie, primary medical services, dental, general ophthalmic services and pharmaceutical services. The HR framework for developing Integrated Care Boards had been published outlining the national policy ambition and practical support for dealing with the change processes required to affect the transfer and the transition. Good progress was being made in the development of a provider collaborative and the ICS development Oversight Group approved a mandate for a task and finish group relating to the development of a clinical and professional leadership model.

RESOLVED: That the Board noted the update within the report.

(b) System Reform - Integrated Care Partnerships (Place Based Partnerships) Development Programme and Delivery Update

Geoff Jolliffe (GJ) presented the report and advised that overall good progress was being made with ICP development. The report provided an overview on progress to date in Quarter 1, the expected ICP development deliverables for Quarter 2, an overview of progress against the broader ICP development programmes and an update on delivery of integrated working within the five place-based partnerships. Good progress had been made on the actions at the end of quarter 1.

The ICP Development Advisory Group had developed a paper following publication of guidance in June and July 2021. The guidance sets out five place-based governance arrangements that could be established by the NHS ICS body in partnership with local authorities and other partners to jointly drive and oversee local integration. Programme Directors had developed and internally measured the options against an option appraisal which would be circulated to ICPs. ICPs would be asked to consider options, for collation in September, with a view to presentation of the final version to the ICS Board in October or November, being mindful that the chosen option could not be signed off until the new Chief Executive Officer was in post. Other parts of the ICP development programme, ie, the financial framework and workforce, would be dependent on guidance still due.

Outlined in appendix 3 were a number of case studies across the five place-based partnerships which showcased what has been delivered across Lancashire and South Cumbria in 2021.

RESOLVED: The ICS Board:

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

Mike Wedgeworth referred to the need to engage with people and communities, including staff, and was pleased to see an action on the creation of a local communication and engagement plan for delivery in quarter 1. Neil Greaves confirmed that plans were underway for consistent and co-ordinated communication and engagement across the NHS and other partners.

Cllr Graham Gooch (GG) spoke around the nationally mandated five range of options for ICPs documented within the ICS Design Framework commenting that the options looked very NHS focussed and not reflective of it being a partnership of equals with a broader spectrum of involvement from other public sector organisations and community and voluntary groups. He suggested building into existing partnerships and referred to the West Yorkshire model where delivery occurs at place and each partner at place was accountable to one and other. GC asked that his comments be taken into account in the further deliberations.

In response it was stated that no decisions on the model had yet been taken and comments were to be fed in via each individual ICP. The guidance is issued by the NHS and does not seek to exclude the wider partnership but seeks assurance that the architecture is in place to run a new system from 1 April 2022. The guidance reflects the different approaches being taken in different parts of the county. 'Place' is where most of the delivery will take place with delegated resource to enable the NHS to work with its partners with a place-based leader. It was noted that there was a need to move away from using the term 'ICP' to describe place to 'Place Based Partnerships'.

David Flory (DF) summarised, confirming that the ICS was fully committed to working as a system, following the direction and guidance set. At place level there was a need to ensure collective ownership and responsibility working with all partners to do the best for people in Lancashire and South Cumbria in an open and transparent way in addressing the issues already discussed in this meeting today.

11. The Role of the VCFSE sector in the Health and Care Partnership

Peter Armer (PA) presented the report and briefed the Board on work completed to date in shaping the Lancashire and South Cumbria VCFSE sector, the VCFSE strategy and 'next level' planning. He reported the experience of the VCSFE sector with statutory partners was working well and expressed his thanks to all who had provided advice and guidance, including the Development Advisory Group (DAG) and programme directors.

The Lancashire and South Cumbria VCFSE Alliance had been developing toward a position and structure that would allow VCFSE organisations to take part in, and make valuable contribution to, emerging health and social care structures. To take this forward, the VCFSE Alliance had developed a 'Four Pillars' model, with each pillar describing an area of responsibility to the sector and responsibility to the health and social care system: (1) Voice, (2) Influence, (3) Engagement and (4) Representation. In addition to responsibility, each pillar represented opportunities for the VCFSE sector to make an enormous contribution, particularly with its knowledge of communities and the issues that would affect communities, especially those groups of citizens that are seldom heard or hard to reach. This would be an important contribution to addressing the wider determinants of health and health inequalities.

PA went on to describe the sector's 'next-level' planning process and how the sector would develop specific plans to meet the needs on the respective ICPs and how the plans would adapt to the characteristics of places. Capacity was highlighted as an issue and whilst some funding had been secured, the sector was operating largely on good will.

PA concluded by saying that he saw lots of opportunities in working with partners in ICPs and sought the endorsement of the ICS Board to the VCFSE planning process.

Isla Wilson acknowledged and welcomed the amount of work undertaken to reach this stage and referred to the significant piece of work to be done to join this up with the 'ask' from the system in advance of the statutory responsibilities coming into effect from April 2022 and the funding that would bring. PA responded that in his view the 'ask' would be developed in the ICPs as it would be different dependent upon the characteristics of the population. Geoff Joliffe agreed there was a funding issue which would be looked at in the future. Many of the projects ongoing across the system depended on the involvement of the VCFSE and funding for VCFSE was a worthwhile option.

The Chair thanked Peter for his presentation and confirmed that the ICS endorsed the process and next stage and would look at how the system developed the ask and how this would shape work going forward.

RESOLVED: The ICS endorsed the VCFSE planning process.

12. New Hospitals Programme Quarter 1 Report

Jerry Hawker provided an update on the New Hospitals Programme for the period April to June 2021. It included progress on the revised governance, progress against plan including the key products to support business case development along with the public, patient and workforce communications and engagement activities underway. The level of communications and engagement within the Case for Change was emphasised. The 'Big Chat' had been supported by radio interviews and engagement with MPs and Healthwatch. The framework model had been approved by the Strategic Oversight Group and was working closely with the Clinical Collaboration Board to take forward the work as part of the wider provider collaborative. The long list of options would be published in September for consideration and feedback.

RESOLVED: That the ICS Board:

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

13. Items to forward for the next ICS Board meeting

- H2 Submission Plans

14. Any Other Business

There was no other business.

Date and time of the next formal ICS Board meeting:
Wednesday, 3 November 2021, 10 am – 12.30 pm, MS Teams Videoconference

ICS Board – Action/Decision Log (Updated 18 October 2021)

Item Code	Title/Action	Responsible Lead	Status	Due Date	Progress Update
ICSB - 20210707- 07	**Anchor Collaboratives** To receive detail on the next steps at the next ICS Board meeting.	Andrew Bennett	**Closed**	1 September 2021	Closed. Update report to be brought to ICS Board in Q4
ICSB - 20210602-06	**Revenue Financial Plans** **Health Inequalities –** Isla Wilson asked for urgent assurance as to the plan for health inequalities	ICS Execs	**Closed**	July 2021	Closed. ICS Execs to ensure link to H2 planning process and longer-term strategy.
ICSB- 20210602-05	**Elective Recovery Accelerator Programme** Key data on numbers, focussing on P1 and P2, number of cancellations, etc. to be provided at a future meeting.	Kevin McGee	**Closed**	August 2021	Closed. Operational Recovery and Performance presented to ICS Board on 1/9/21
ICSB - 20210901 - 09	**2021-22 Capital Update** Andrew Bennett, Gary Raphael and Paul Havey to meet outside of the meeting to decide who should be involved in the work on setting priorities.	Andrew Bennett	**Closed**	3 November 2021	Closed. Specific action has been completed. Further discussions to be held with finance colleagues to monitor progress of 2021/22 capital programme.

ICS Board

Date of meeting	**3 November 2021**
Title of paper	**Preparations for Winter 2021/2022**
Presented by	**Andrew Bennett**
Authors	**Rebecca Higgs**
Agenda item	**5**
Confidential	**No**

Purpose of the paper		
Executive summary		
A paper was presented to the ICS Board in September 2021 providing a sector by sector situation report which offered insight into system performance, the challenges being faced and the mitigations that had been established as we move into the winter period. This paper is intended to provide ICS Board with an update on the situation for core sectors, given the ongoing community transmission of COVID-19 and associated workforce pressures that are being experienced across the health and care system. Information regarding Primary Care and the approach to planning for the second half (H2) of this financial year is provided in the papers associated with subsequent agenda items for this meeting.		
Recommendations		
The ICS Board is asked to receive and review the situation reports and note the mitigations that are currently in place.		
Governance and reporting (list other forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
N/A		
Conflicts of interest identified		
None		

Lancashire and South Cumbria Health and Care Partnership

OPERATIONAL RECOVERY AND PERFORMANCE 2021/22

SITUATION REPORT for H1 & PROPOSED ACTIONS FOR H2

1. Background

As we enter the second half of the year we continue to operate in a system that is experiencing pressures associated the requirement for the ongoing management of COVID-19, alongside the restoration agenda. In September the ICS Board received an overview of the key issues, risks and mitigations that key sectors within the health and care system expected to manage as we go into Autumn/Winter.

The ICS Executive is keen to provide the ICS Board with an update on current system performance, giving a strong sense of the challenges being faced and what we are doing about them. These are tactical updates in the main but are intended to provide an all-round view of our performance and pressures.

2. Links between this paper and other agenda items

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

- Item 6 on supporting Primary Care to improve access for Patients and
- Item 7 on the emerging shape of the H2 planning submission

3. Summary of common risks

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

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

4. Summary of key capacity and demand themes from sector situation reports

The Appendix to this paper contains updated sector by sector “situation report” on

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

Sectors covered include:

- Urgent and Emergency Care
- Elective Care Recovery
- Care Sector
- Mental Health

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

Capacity

- Embedding of C19 processes into business as usual continues to constrain available capacity
- Workforce availability continues to remain fragile due to ongoing levels of sickness that are higher than has historically been experienced, the impact of compulsory vaccination in the care sector and competition from the wider external workforce market, such as hospitality and retail.
- It should however be recognised that the impact of compulsory vaccination in the care sector has been minimised via the provision of significant multi-agency support to enable informed decision making by staff, including myth busting sessions, additional evergreen vaccination offers and community champion engagement.

Demand

- Levels of demand being made upon services remains significantly higher than pre pandemic across all sectors.
- Patients are also presenting with increased acuity of patients, increasing both treatment and care requirements.
- The imbalance between capacity and demand is resulting in poor flow through the system, with lower hospital discharges into constrained out of hospital support, high numbers of patients medically fit for discharge staying in beds and lower bed availability for admissions leading to crowded EDs with long waits.

5. Summary of mitigating actions being taken

System colleagues continue to work collectively to ensure that workforce planning and modelling is undertaken across sectors. Recruitment and retention efforts are being undertaken in an open, transparent and collaborative manner to reduce the risk of de-stabilising the market.

Health and care colleagues are also working jointly to ensure any additional financial resources that have been made available are used effectively.

Recommendations

The ICS Board is asked to receive and review the situation reports and to note the ongoing mitigations that are in place.

Lancashire and South Cumbria
Health and Care Partnership

L&SC ICS Board

3rd November 2021

Preparations for Winter

Sector Situation Reports

Situation reports follow on the following sectors:

Lancashire & South Cumbria ICS – Situation Report

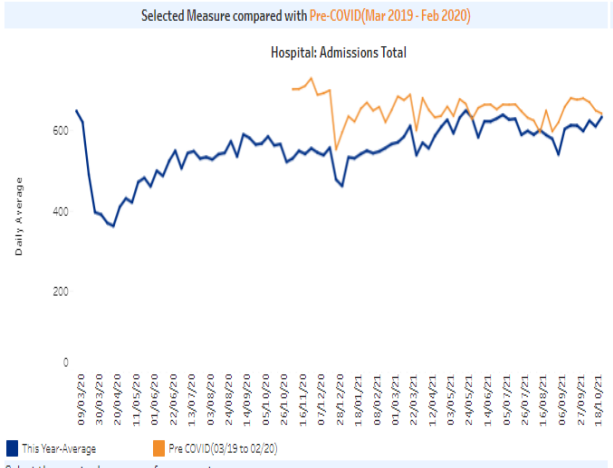
Name of Sector	Urgent & Emergency Care

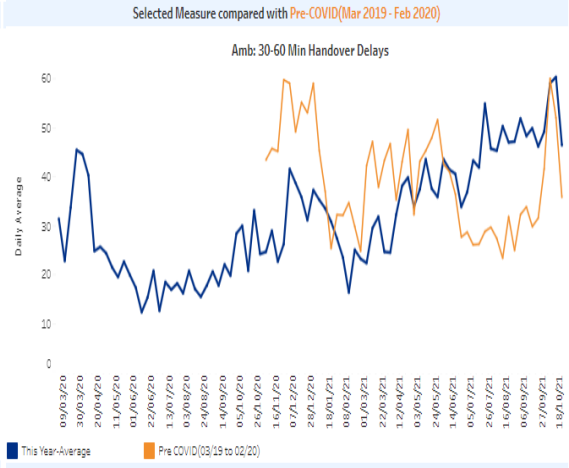
Performance – current headlines

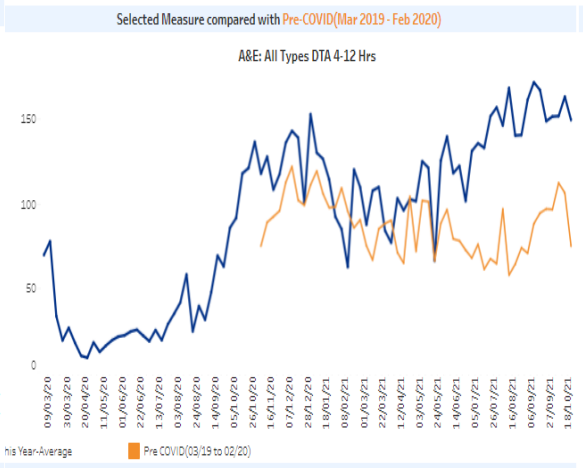
LSC ED 4 hour performance continues to be slightly higher than both the NW and national position although the following challenges are evident :

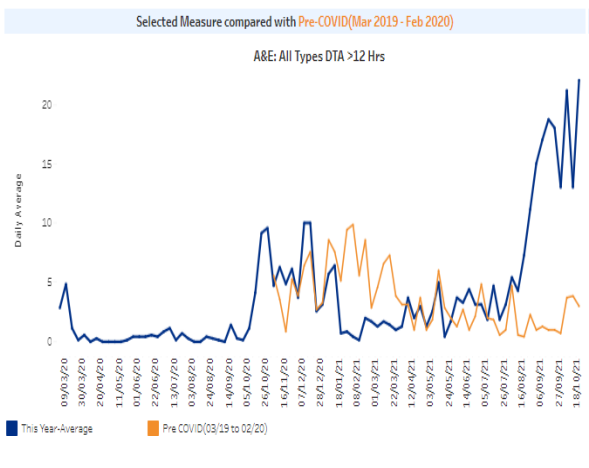
1) Pressures, particularly staffing in community health settings and in the care sector have led to the highest rate of patient delays in hospital recorded in the "post wave 3 pandemic phase" for patients waiting for community and residential and nursing home step down. Close to 20% of all hospital beds are affected at two Trusts Blackpool and Central Lancashire. The impact of the delays creates admission delays from ED and has a knock on effect on ambulance turnaround times which are an NHS E priority for winter.
2) Hence ED 4 hour performance shows a continued trend deterioration with 4-12 hour and 12 hour plus delays for admission particularly affected at respectively 1.6 and 3 times the usual seasonal rate normally seen. Circa 150 patients per 24hours at present are experiencing a 4-12 hour delay of which typically 20 per day experience a 12 hour plus delay.
3) Whilst total ED activity (type 1, 2 & 3) has risen slightly (circa 5%) compared with seasonal expectation, because of challenges with GP access and the need to protect inpatient units from undiagnosed COVID admissions, a much higher proportion of total ED activity is now via our main EDs (type1) which are about 20% busier than expected in activity terms before taking account of the additional pressures brought by exit block.

Summary :EDs across LSC are crowded much earlier this year than usual through a combination of a higher proportion of total activity accessing hospital through ED, bottlenecks for admission driven in large part by discharge delays and with the impact of a circa 100% increase in Ambulance delays at EDs in the last 12 monthsm circa 25% greater than pre Pandemic.









Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Elective Care Recovery

Performance – current headlines

Restoration %
Rolling 4 week average w/e 17th October:

IP	88%	MRI	118%	Colonosc	124%
DC	84%	CT	112%	Gastrosc	98%
OPF	97%	US	108%	Flex Sig	59%*
OPFU	98%				

All POD system restoration %: 99% **

52 week+ waiters
Acute - 10,175 (has stabilised at this level since end Jun '21)
ISP CCG - 946 Aug (consistently reducing since Mar '21)

104 weeks 350 (ahead of trajectory

P2s waiting >1 month for treatment
PAS systems currently unable to capture the wait from the point a patient became a P2, a process is being developed to capture. In the meantime trusts are validating P2 patients and P2s will not be cancelled without Exec approval, any cancelations will be rescheduled within 28 days.

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

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

Priorities going into second half of 2021/22

Restoration: Continue to improve restoration rates; returning to or exceeding pre-pandemic levels.

Reduce Long Waits:
- 52 wk+ equal to or less than Sept '21
- 104 wk+ reduce to 0 (excluding P5/6) by Mar '22

Waiting list size
Equal or less than Sept '21

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

Outpatient Priorities:
- A&G; 12% of 1st OP attendances
- PIFU; 1.5% of all OP attendances by Dec '21 and 2% by Mar '22
- Virtual Consultation; 25% of all OP by Mar '22

RTT Completed Pathways:
89% or beyond of 19/20 baseline to secure access to ERF funding

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

Risks

Our ability to hold or reduce waiting list size, hold or reduce the number of patients waiting over 52 weeks, eradicate 104 week waiters and achieve the 62 day cancer standard will be adversely impacted if:

- UEC and/or COVID demand increase beyond expected levels
- Insufficient funding is available for additional activity
- There is insufficient capacity to discharge into community and social care
- Patients are unwilling to transfer to a different clinician/site
- Insufficient workforce available for increased levels of activity to clear the backlog due to higher than expected levels of sickness and/or an inability to recruit and retain staff
- There is continued reduced capacity/productivity due to social distancing/isolation/swabbing IPC guidance
- Primary Care cannot increase A&G referrals and/or there's insufficient capacity within the acute trusts to deal with an increased number of referrals

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Care sector

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
1. Increased demand, especially upon domiciliary care – around 20% up on last year's levels 2. Immediate & growing risk arising from lack of staff capacity to meet demand, leading to delayed packages of care at highest known levels across all L&SC Councils 3. This risk likely to be exacerbated over coming months as care sector staff leave due to mandatory vaccination requirements – between 3 and 5% 4. Longer term approach is to attract more staff through higher pay and revised immigration controls 5. In the meantime, crisis management is underway to meet priority demand within constrained capacity 6. Extra funding has been made available from govt to support additional workforce recruitment costs	1. We will continue with the development of an ICS strategy for all care sector services, including intermediate care, to ensure we understand modelled demand, required capacity and market availability 2. We will create a system wider set of criteria to manage consistent immediate allocation of services and support across ICPs 3. We will establish a set of principles to how we will apply these criteria i.e. NHS not separately commission, apply mutual aid where this is available etc. 4. We will be clear on what are the key priorities against national expectations across all service sectors and be clear on resource commitments 5. We will identify what other immediate options we might be able to activate to augment the volume/capacity issues 6. We will work to understand how the additional govt funding for workforce can assist in increasing capacity for the short term	• Further loss of care sector staff due to mandatory vaccination regulations • Potential care sector provider failure due to staff shortages • Blocking of flow of discharges from the acute sector • CQC expectations of providers re staff vaccination mandate • Many sectors 'fishing in same pond' for workforce • Additional govt funding may not increase workforce capacity

Lancashire & South Cumbria ICS – Situation Report

Name of Sector	Adult Mental Health

Performance – current headlines	**Priorities going into second half of 2021/22**	**Risks**
Adult mental health demand through Emergency departments (July – September) has increased by 25% when compared to our pre-covid demand. Increased ED demand will reduce capacity from liaison team and from the ability to in-reach to the acute wards. Mental Health Liaison team 1 hour responsiveness continue to be circa 90%. Significant increase in demand for Health Based Places of Safety. Almost 100% increase in demand compared to pre-covid activity. All community Mental Health services have seen an increase in demand compared to pre-Covid levels, but increases have been particularly notable in key areas: CAMHS - **23%** increase Eating Disorders – **September** was the highest number of referrals recorded Adult acute pathways: Home Treatment - **21%** increase Crisis Line demand was **187%** higher in July 2021 than in July 2020	Implement phased approach to IRS and street triage model Continue with current inpatient bed expansion Confirm system capital slippage to bring forward timeframe of inpatient bed expansion plan Continue to deliver against the investments schemes approved for 21/22 Continue with Trust wide improvement programme Building on LoS reductions to see a stepped reduction in stranded patients Implement winter planning schemes to support flow across the system Continue to implement efficiency improvement schemes and develop schemes for 22/23	Recruitment of workforce continues to be a high risk. The Trust has engaged with a workforce attraction agency to support the Trusts new and ongoing recruitment campaigns Demand continuing at current unprecedented levels in both number and acuity In patient bed demand continues to rely on OAP provision about forecast levels Increased acuity across the wards, making utilisation of the OAP capacity challenging Capital delays to bed expansion due to supplies / workforce

Integrated Care System (ICS) Board

Date of meeting	**3rd November 2021**
Title of paper	**Supporting General Practice to Improve Access for Patients**
Presented by	**Peter Tinson, Director of Collaborative Commissioning Dr Lindsey Dickinson and Dr Peter Gregory – Associate Medical Director Primary Care**
Author	**Peter Tinson**
Agenda item	**6**
Confidential	**No**

Purpose of the paper

The paper provides an update on work to support general practice to improve access for patients

Executive summary

General practice teams continue to be under significant workload pressure alongside their community, hospital and ambulance colleagues.

Many of the challenges facing general practice are not new, especially those relating to workforce. There is therefore a wider debate about what a sustainable operating model looks like for general practice which both provides the best possible patient care within the available resource and the best working experiences for staff.

A new £250m (£7.6m for Lancashire and South Cumbria) Winter Access Fund scheme was announced on 14 October 2021 to help patients with urgent care needs to get seen when they need to, on the same day. The Lancashire and South Cumbria ICS plan was submitted on 28 October 2021. A thematic overview of the ICS and PBP schemes submitted is presented for information. Feedback is currently awaited from NHS England and Improvement.

Recommendations

The ICS Board is asked to receive this report for information

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

Meeting	**Date**	**Outcomes**

Conflicts of interest identified

Implications

If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**

Quality impact assessment completed			N/A	
Equality impact assessment completed			N/A	
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	

Report authorised by:	Peter Tinson

Lancashire and South Cumbria
Health and Care Partnership

Supporting General Practice to Improve Access for Patients

1. Introduction

General practice teams continue to be under significant workload pressure alongside their community, hospital and ambulance colleagues.

Across Lancashire and South Cumbria Primary Care Networks (PCNs) have delivered the majority of our vaccination programme, 1,391,854 vaccinations to date (54% of the total), in addition to their existing workload.

Practices are also delivering more appointments for patients when compared to the same period before the pandemic (total appointments increased +12.2% (76,159) between August 2019 and August 2021).

The care they provide and the way in which it is provided has been subject to national standard operating procedures, including infection, prevention and control requirements.

Like other health and care partners, practices are experiencing significant pent-up demand and delayed routine care. For example, weekly calls to a sample practice requiring a same day response have increased by 23% from July and August 2019 to 2021.

Patient satisfaction with general practice continues to be high (with 83% of respondents across Lancashire and South Cumbria, describing their experience of their GP practice as good or very good) which reflects the dedication and hard work of general practice teams.

Teams also recognise that at times access is not as good as they would like it to be. They have also increasingly been subject to unacceptable abuse from patients which will not be tolerated.

2. Improving Access

Access to general practice must be considered in the wider context of:

- Changes to population health, for example increasing complexity
- Changes to the ways in which people choose to access services, e.g. remotely

There is therefore a wider debate about what a sustainable operating model looks like for general practice which both provides the best possible patient care within the available resource and the best working experiences for staff.

Many of the challenges facing general practice are not new, especially workforce. Across Lancashire and South Cumbria there is currently an average of 65.25 GPs per 100,000 population which compares to 79.18 per 100,000 in Cheshire & Merseyside and 77.22 per 100,000 in Greater Manchester. Also, workforce shortages are not equally distributed, areas with higher levels of deprivation also have fewer GPs relative to the patient population, despite a greater burden of chronic disease. A national long term workforce growth strategy is required coupled with local supporting and enabling actions. Whilst some of these challenges require national support to address, there are however actions that are being progressed locally. The remainder of this paper focuses on the actions that specifically relate to the recent NHS publication *Our plan for improving*

access for patients and supporting general practice and the proposed Winter Access Fund schemes.

3. Winter Access Fund

A new £250m (£7.6m for Lancashire and South Cumbria) Winter Access Fund scheme was announced on 14 October 2021 to help patients with urgent care needs to get seen when they need to, on the same day.

The fund can be used in two ways:

a. To drive improved access to urgent, same day primary care, ideally from patients' own general practice and/or PCN
b. To increase the resilience of the NHS urgent care system during winter by expanding same day urgent care capacity, through other services in any primary and community settings

Integrated Care Systems (ICS') were asked to determine the optimum use of the funding in line with local issues and solutions and national expectations.

The ICS plan was submitted on 28 October 2021 following a system co-ordinated rapid development process which involved Place Based Partnership (PBP) discussions with practice, PCN, Local Medical Committee (LMC) and urgent care partners. The ICS Primary Care Sub-cell recommended the plan to the ICS Chair and ICS Interim Chief Officer and received agreement to submit.

The following table provides a thematic overview of the ICS and PBP schemes submitted.

PBP/System	Scheme name	Number of practices to be supported	Cost
System-wide	GP CPCS 'button'	201	£98,892
System-wide	Communication	201	£100,000
System-wide	Enabling - Workforce planning & leadership support	201	£150,000
System-wide	Demand and capacity leadership and support	201	£80,000
System-wide	General Practice Improvement Week	201	£100,000
System-wide	Care Navigation Active signposting	201	£231,000
System-wide TOTAL		201	**£759,892**
Morecambe Bay	Bronze/Silver Appointments* (*part of Winter package)	32	£526,750
Morecambe Bay	Additional Late Blood Collections*	25	£29,000
Morecambe Bay	Winter Wellness*	32	£227,500
Morecambe Bay	Additional Administrative and Nursing Resource (using staffing pool) *	32	£174,720
Morecambe Bay TOTAL			**£957,970**
Fylde Coast	Additional Pop-Up WIC in South area/Expand the extended access provision to include same day urgent requests rather than just routine clinics	36	£522,273
Fylde Coast	Deflection of A&E attendances	36	£300,000
Fylde Coast	Relief Admin team	36	£266,000
Fylde Coast	Reduce the burden on GP to undertake secondary care requests for blood tests	36	£50,000
Fylde Coast	CPCS bolt-on	36	£60,000
Fylde Coast	Voluntary Sector can provide some admin duties to support patients and reduce demand on GP appts	36	£55,000
Fylde Coast	Prescribing Hub	36	£12,000

Fylde Coast TOTAL			**£1,265,273**
Central	Hubs	48	£1,544,559
Central	Covid Vulnerable Project - Population Health approach	48	£270,000
Central TOTAL			**£1,814,559**
Pennine	Workforce Locum Bank/Pool	70	£260,000
Pennine	Enhanced Primary and Community Care Hubs (Primary Care led).	70	£1,000,000
Pennine	Primary Care Frequent Attenders LES	70	£531,137
Pennine	Pilot understanding access in an area of cultural diversity and high deprivation	70	£50,000
Pennine	At scale clinical functions	70	£194,000
Pennine	At scale back-office functions	70	£292,000
Pennine	Enabler squad	70	£30,000
Pennine	Research/Pilot to understand nature of work being shifted into primary care	70	£10,000
Pennine	Pennine Lancashire Acute Visiting Service (AVS)	70	£200,000
Pennine TOTAL			**£2,567,137**
West Lancs	Same Day Access Service	15	£200,000
West Lancs	Workforce Locum Bank/Pool	15	£50,000
West Lancs	At scale back-office functions	15	£110,000
West Lancs TOTAL			**£360,000**
TOTAL			**£7,724,831**

Feedback is currently awaited from NHS England and Improvement (NHSE&I).

4. Recommendation

The ICS Board is asked to receive this report for information.

Integrated Care System (ICS) Board

Date of meeting	3rd November 2021
Title of paper	Emerging shape for L&SC planning submission
Presented by	Gary Raphael, ICS Executive Director of Finance and Investment
Author	Gary Raphael
Agenda item	**7**
Confidential	No

Purpose of the paper				
To apprise the Board on the emerging shape of H2 plans.				
Executive summary				
The report presents an early view of the way in which our H2 plans are shaping up, so that as a system we can ensure that the key issues are addressed and resolved as we move towards submission on 16th November.				
Recommendations				
The Board is asked to **note** the report.				
Governance and reporting (list other forums that have discussed this paper)				
Meeting	**Date**			**Outcomes**
Planning team considered an early draft of the report.	25th October 2021			General support for the thrust of the report and comments made which have been incorporated into this draft.
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	At this stage
Equality impact assessment completed			X	At this stage
Privacy impact assessment completed			X	
Financial impact assessment completed			X	At this stage
Associated risks	X			
Are associated risks detailed on the ICS Risk Register?		X		
Report authorised by:	Gary Raphael, ICS Executive Director of Finance and Investment			

Emerging shape for L&SC planning submission

Introduction

1. This paper identifies the emerging shape of the L&SC plan for H2, having regards to the early information and related issues across our system.

Elective Recovery

2. Overall the system's NHS trusts are planning to meet the national requirements:

	Baseline		Mar '22 Plan
Eliminate 104 wks (except P5/6)	Sept '21	561 (P2-4)	0
Hold/Reduce 52wks @ Sept levels	Sept '21	10,168	7,677
Stabilise WL @ Sept levels	Sept '21	139,526	131,218
62day waits to Feb '20 levels	Feb '21	417	407

Meeting these requirements assumes that we will maintain current elective capacity and achieve approximately 95% of 2019/20 activity levels for the same period, albeit that our ability to earn ERF is not clear and may be minimal. However, the System is currently spending £4.7m per month on elective capacity that has no income cover and early estimates for H2 are that around £30m extra capacity will be required for which funding is as yet uncertain.

3. The options for covering the extra costs being incurred by NHS trusts on the elective recovery programme are:
    - Achieving activity levels at an average of 9 percentage points above the 89% threshold (we could earn roughly £0.5m for every percentage point above the threshold).
    - Reducing the costs of the elective recovery programme by achieving a higher level of efficiency or reducing capacity in some specialisms.
    - Achieving a high level of reduction to waiting lists through validation procedures and thus contributing to meeting and surpassing the threshold for ERF income.
    - Focus more activity on high volume low complexity, recognising that this may impact on clinical priorities

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4. Our elective recovery plans comply with national guidance on activity assumptions, but do not estimate the impact of an increase in non-elective/Covid activity above September levels. This may not be a reasonable assumption to make and will be tested as part of the scenario development phase of planning mentioned in the conclusion to this paper.

5. **Risks** are as follows:
    - Potential for rising waiting times/lists, but cancer/high priority surgery would continue to be a priority

- A rising and significant level of deficit, if activity falls below the point at which ERF ceases to cover the costs of extra elective capacity
- Adverse impact on activity levels from an increase in NEL activity/Covid
- The complexity of the ERF leads to an inability to forecast income accurately and quickly as a system – ERF can only be earned on a system basis even if individual trust figures suggest success at that level
- Inability to adjust elective capacity and costs in line with changes in income

6. **Areas being developed as part of our H2 plans for elective recovery:**
    - Reducing elective recovery costs in any scenario.
    - Contingency plan development should non-elective activity rise significantly above September levels and adversely impact on elective capacity.
    - Maximisation of activity through the I.S, because if we are able to exceed 2019/20 baseline levels, external funding will be earned.
    - Improving our ability to reduce costs (= capacity) quickly in the event that our forecasts for the following month indicate that we will not meet the break-even point for elective recovery programme.

NEL pathways/winter plans

7. Winter plans have been developed by the A&E delivery boards to comply with national requirements. We have not yet clarified the additional, unfunded schemes in each place that have already been implemented in response to pressures experienced prior to H2.

8. Each A&E DB has identified a prioritised list of additional, unfunded schemes, including their top three.

9. Winter plans include proposals for extra capacity, but the availability of workforce and finance have yet to be clarified.

10. It is also clear that there are substantial staffing shortages in the social care sector and initial suggestions from L&SC DASSs is that discharge rates are unlikely to be capable of being increased much above current levels.

11. Given the workforce and financial constraints in the system and also the major issues being experienced in the social/regulated care sector, our efforts this autumn and winter ought to focus on admission avoidance.

12. Data from Gold Control indicates that the biggest challenge we will face this autumn and winter will be from all forms of respiratory illness, including Covid 19. Older people with mild to moderate frailty score could account for a substantial proportion of all bed days, but it appears that only 9% of those potential patients have care plans. This is the patient cohort for which solutions must be found this autumn and winter.

13. There is also increased complexity of cases, from patients presenting later in the progression of their disease and from trauma, which is also impacting on the delivery of non-elective care.

14. **Risks** are:

- The usual rise in non-elective admissions in the second half of the year (above the levels experienced in September).
- A major increase in respiratory illnesses and a consequential use of hospital capacity.
- Control of flow into and out of hospital.
- A consequential impact on ambulance turnaround times and NWAS's ability to meet demand on emergency calls.
- Extreme pressure on urgent care services in primary, acute, MH and social care services.
- Pressure on staff.

15. **Areas being developed as part of our H2 plans for urgent care services**:

- A focus on admission avoidance, primarily aimed at respiratory illness, where care plans need urgently to be put in place by PCNs (supported by the rest of the system) and rapid response mechanisms, including in social care, scaled up. Funding for this must be prioritised.
- An urgent assessment on demand for 2-hour community rapid response crisis service and our ability to flex staffing to meet peak demand when it arises.
- Approval and funding for high impact A&E DB schemes.
- Contingency plans for various levels of escalation, including a worst-case scenario of indeterminate duration (hope for the best, plan for the worst).
- Commissioning and funding of voluntary sector support on admission avoidance and return to home support, linked to admissions avoidance and 2-hour rapid response service.
- A public communications campaign to inform the public of the best way to access services and encourage self/family support for a range of conditions likely to exacerbate this winter.
- Stepping up Gold Command to seven days per week to cover the whole system and ensure key metrics are monitored and forecasted.
- Improved joint hospital and out of hospital cell working.

Mental Health

16. In H1 plans were developed for the whole year. It is not intended to revise them. However, given developing pressures in this sector there is a need to respond with some new schemes in H2.

17. Some additional national funding has been made available for winter pressures and this will need to be applied in a way that helps to meet patients' urgent care needs, with the consequential beneficial impacts on acute services also identified. Focus should be on additional community and/or ED support to divert patients away from front door

Status of workforce plans

18. Workforce plans have focused on workforce needs, having regards to demand for elective and urgent care services. For the remainder of the planning process the focus will be on workforce supply estimates.

Finance

19. Apart from a range of winter pressures identified by all partners which need to be validated but are nevertheless substantial, the other key financial pressures can be summarised as follows:
    - £20m ERF contribution, which helped us to balance the books in H1 and most likely will not be available in H2.
    - £6m QIPP/CIPs schemes not delivered in H1 which may impact on H2.
    - Extra efficiency requirement in H2 of circa £38.4m, of which system-wide plans of £30m were already being developed.
    - A reduction in Covid funding of £6m, which may be possible of being mitigated by cost reductions applied to changes in the application of IPC guidelines.
    - Funding to cover the cost of pay awards in H2 and backdated pay for H1.
    - Growth funding in H2 of £10m.
    - Other flexibility being generated from existing budgets.

20. Clearly, the financial picture does not support our system being able to introduce significant extra capacity, except where we can earn ERF and it also points to us needing to ensure that we focus on cost effective admission avoidance solutions in health **and** social care services.

21. **Areas of focus for financial decision making are**:
    - To set a budget for high impact admission avoidance schemes.
    - To set a budget on high impact A&E BDs recommended schemes.
    - Determine local policy for any reductions that may be possible from the application of new IPC guidelines.
    - To set a budget for a communications campaign.
    - To set a budget for commissioning voluntary sector support.
    - Taking the above into account – to set the level of QIPP/CIP for each part of the NHS system.

Conclusion

22. The system is likely to face a difficult autumn and winter period, which follows on from the raising of lockdown and an intense period of elective recovery. Our staff are weary.

23. Overall, the planning team believes that we must as a system plan for at least three scenarios, best case = current planning guidance on a September baseline for NEL activity levels; most likely case = an autumn and winter period with a substantial increase in non-elective activity; and a scenario which assumes a larger surge in respiratory illnesses.

Recommendation

24. The ICS Board is asked to **note** this update on H2 plans.

Lancashire and South Cumbria Health and Care Partnership

Gary Raphael

H2 planning lead
26th October 2022

Integrated Care System (ICS) Board

Date of meeting	3rd November 2021
Title of paper	System Financial Recovery
Presented by	Gary Raphael, ICS Executive Director of Finance and Investment
Author	Gary Raphael
Agenda item	**8**
Confidential	No

Purpose of the paper				
To apprise the Board of the major issues in system financial recovery.				
Executive summary				
See the attached short report.				
Recommendations				
The Board is asked to **note** the report.				
Governance and reporting (list other forums that have discussed this paper)				
Meeting	**Date**		**Outcomes**	
.				
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		
Report authorised by:	Gary Raphael, ICS Executive Director of Finance and Investment			

System Financial Recovery Programme

Introduction

1. The System Financial Recovery Board met on Monday 25th October to consider progress on the financial recovery programme. This is to report on the main issues at the current time.

System Performance

2. The system has delivered financial balance in H1, which is a major achievement. The System Financial Recovery Board (SFRB) were informed that the majority (75%) of the £50m savings achieved were non-recurring and that this would mean that they would need to be found again in 2022/23. A shortfall of £6m in H1 will impact in H2.

3. The SFRB also learned that a shortfall of £9m on the ERF was covered partly by underspending on I.S contracts and also other budgets where underspending had occurred compared to the original plans.

4. The SFRB has been monitoring run rates for the NHS trusts in L&SC and noted that the trend was a marginally down over H1.

System Diagnostic

5. The SFRB received a final report from 'The PSC', a company that had been appointed to provide an objective assessment of the drivers of our System's deficit and to make recommendations for recovery. The PSC have reached the end of their 13 week assignment.

6. The good news is that a substantial proportion of the opportunities available to resolve our deficit are operational, meaning that we should be able to deliver substantial savings in the following areas:
    - End-to-end performance of **clinical services**, relative to peers, as indicated by
      NHS RightCare, Model Hospital, and Getting it Right First Time.
    - **Workforce**: vacancy rates that are worse than peers, and hence use of agency/
      locums that is higher than peers
    - Cost of **corporate support services and functions**

7. The SFRB was asked to consider and approve the recommendations in the PSC report covering the strengthening of system-wide governance that is required to ensure that progress is maintained on financial recovery.

8. The Board acknowledged that at present our governance arrangements are not sufficient to enable some key decisions and delivery of system-wide recovery to be implemented quickly. However, the Board was mindful that it has a leadership role to play in ensuring progress is maintained, especially considering the requirement to enter 2022/23 with a coherent financial recovery plan. Therefore, the Board charged senior management with delivery on the recommendations that can be progressed through existing channels, with any additional, early management proposals made for progressing the recommendations that may require adaptations to governance.

Savings tracker

9. The Board reviewed the savings tracker and noted that areas where 'system-wide' savings were planned were overlapping some organisational plans and therefore were not additional savings. Delivery risk was also considered.

10. ICS and PCB programme teams agreed to clarify any duplication in estimates and identify further savings to mitigate delivery risk.

Conclusion

11. Overall L&SC has made substantial progress in being able to plan and monitor on a system-wide basis:
    - our CIP and QIPP programmes
    - organisational run rates
    - financial performance for both revenue and capital programmes

    We have also developed the capability to ensure that financial flows are managed across the system to enable variances from plan to be rectified where system working has given rise to issues that have impacted disproportionately across organisations.

Recommendation

12. The ICS board is asked to **note** this report.

Gary Raphael
ICS Executive Director of Finance and Investment
26th October 2021

Integrated Care System (ICS) Board

Date of meeting	November 2021
Title of paper	ICS Financial Report
Presented by	Gary Raphael, ICS Executive Director of Finance and Investment
Author	Elaine Collier, ICS Head of Finance
Agenda item	**9**
Confidential	No

Purpose of the paper				
For noting.				
Executive summary				
This paper reports on the month 6 (H1) financial performance for the L&SC system. It covers the revenue and capital positions of all L&SC NHS partners and the position on ICS central functions. It also starts to consider the H2 planning process and H2 financial envelope information.				
Recommendations				
The Board is asked to **note** the report.				
Governance and reporting (list other forums that have discussed this paper)				
Meeting	**Date**		**Outcomes**	
None				
Conflicts of interest identified				
Not applicable				
Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			X	
Equality impact assessment completed			X	
Privacy impact assessment completed			X	
Financial impact assessment completed	X			
Associated risks	X			
Are associated risks detailed on the ICS Risk Register?		X		
Report authorised by:	Gary Raphael, ICS Executive Director of Finance and Investment			

Lancashire and South Cumbria Health and Care Partnership

ICS Financial Report

1. Introduction

1.1 This paper reports on the month 6 financial performance for L&SC partners and ICS central functions. It also looks forward to the H2 financial planning process.

2. Financial Performance

2.1 At month 6, we are pleased to report that we have delivered the H1 plan, ending the first half of the year with a small surplus. This is a considerable achievement for the L&SC system and has been a real challenge to deliver. It has only been made possible by deploying a range of non-recurrent measures (underspends on certain budgets) to cover shortfalls on areas such as: a £5.9m shortfall on our H1 efficiency plan and a £10m gap on our elective recovery plan.

2.2 Table 1 below shows a summary of the month 6 position by sector. The year-to-date and H1 outturn show achievement of a small surplus of £0.4m which is £2.4m better than our plan, due to the resolution of £2m of NWAS 111First funding which was outstanding during planning.

Table 1 – L&SC summary financial position as at the end of month 6, September 2021:

Financial Position Overview - M06						
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	0.1	0.1	0.0	0.1	0.1
NHS Providers	(2.0)	0.3	2.3	(2.0)	0.3	2.3
System Financial Performance	**(2.0)**	**0.4**	**2.4**	**(2.0)**	**0.4**	**2.4**

2.3 Appendix 1 shows a more detailed overview of the financial performance by CCG and provider sector, showing income and expenditure by sector.

2.4 Table 2 below reports on the ICP performance against the plan.

Table 2 – L&SC ICP summary financial position at the end of month 6, September 2021:

System performance Surplus / (Deficit) - M06						
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	0.0	(0.0)	0.0	0.0
Fylde Coast ICP	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Pennine Lancashire ICP	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
Morecambe Bay ICP	0.0	0.0	0.0	0.0	0.0	0.0
West Lancashire MCP	(0.0)	0.1	0.1	(0.0)	0.1	0.1
North West Ambulance Service NHS Trust	(2.0)	0.3	2.3	(2.0)	0.3	2.3
Lancashire and South Cumbria NHS FT	0.0	0.0	0.0	0.0	0.0	0.0
ICP Financial Performance	**(2.0)**	**0.4**	**2.4**	**(2.0)**	**0.4**	**2.4**

3. Efficiencies

3.1 L&SC set an ambitious £56.6m target for efficiencies in H1. This comprised 3% for all trusts and 3% of influenceable spend for CCGs.

3.2 At month 6, we can report that we delivered £50.7m efficiencies, which is £5.9m short of our plan. The actuals also show that 75% of this achievement was non-recurrent in nature. Whilst this H1 shortfall has been offset through other non-recurrent means, the gap and non-recurrent nature of schemes will have a real impact on future delivery.

3.3 The efficiency plan for H2 is even more ambitious than H1. The plan is for organisations to deliver a further £56.6m, supplemented by £30m of system-wide schemes. The efficiency programme is reported in detail to the System Finance Recovery Board, but table 3 below shows a summary of the H1 position by ICP.

Table 3 – L&SC ICP efficiency delivery as at the end of month 6, September 2021:

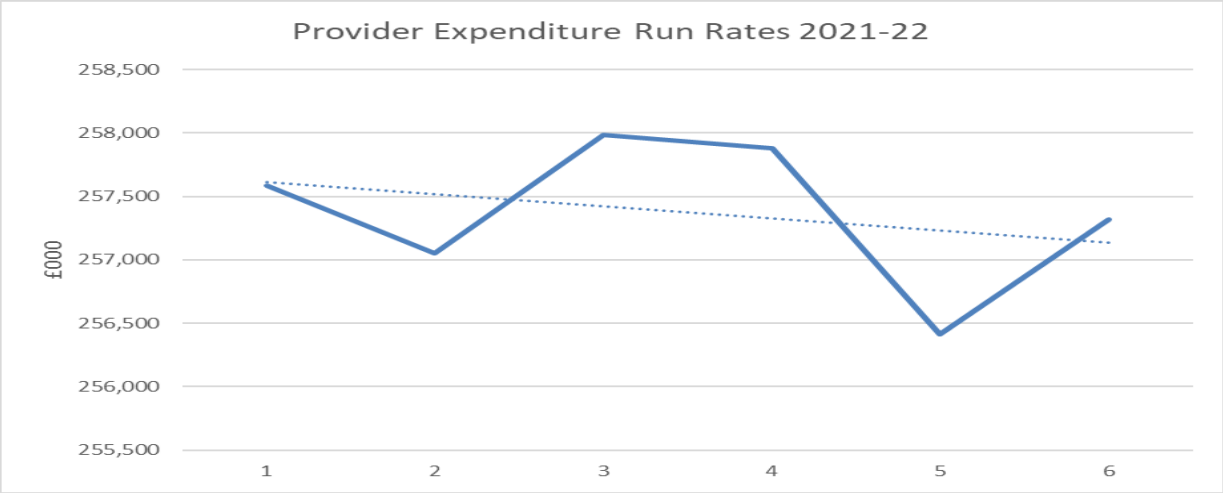
Efficiencies : CIPS / QIPPS - M06						
ICP	YTD	Forecast Outturn				
	Actual £m	Forecast Recurrent £m	Forecast Non-Rec £m	TOTAL Forecast £m	Plan £m	Variance to Plan £m
Central Lancashire ICP	9.3	*1.5*	*7.8*	9.3	13.0	(3.7)
Fylde Coast ICP	12.6	*0.9*	*11.7*	12.6	12.6	0.0
Pennine Lancashire ICP	13.1	*2.4*	*10.7*	13.1	13.1	0.0
Morecambe Bay ICP	8.1	*4.9*	*3.2*	8.1	10.2	(2.1)
West Lancashire MCP	1.9	*0.7*	*1.3*	1.9	2.1	(0.1)
North West Ambulance Service NHS Trust	3.6	*1.2*	*2.4*	3.6	3.6	0.0
Lancashire and South Cumbria NHS FT	2.1	*1.0*	*1.2*	2.1	2.1	0.1
ICP Performance	**50.7**	***12.5***	***38.2***	**50.7**	**56.5**	**(5.9)**
		25%	*75%*			

4. Run-Rate Monitoring

4.1 The ICS has recently introduced a monthly collection of run-rate data to help understand the monthly financial performance of each of our organisations and to enable us to demonstrate the impact of the efficiency programme or other actions taken. This is reported in detail to the System Finance Recovery Board, but Table 4 below shows the provider data received to date in both graphical and table form. The overall trend is downwards and the expenditure trends of most providers are starting to fall. We hope to develop this work over the coming months as we further diagnose the data collected.

4.2 We are also working on a similar collection for CCG data but need to consider that most of their spend is nationally mandated.

Table 4 – Provider run-rate information collected for months 1-6:



By Organisation	Monthly Run-rate Data						
	M01 £m	M02 £m	M03 £m	M04 £m	M05 £m	M06 £m	H1 TOTAL £m
Blackpool Teaching Hospitals NHS FT	46.7	46.6	47.9	47.3	47.1	47.2	282.8
East Lancashire Hospitals NHS Trust	52.7	52.2	52.2	52.2	51.9	52.1	313.3
Lancashire and South Cumbria NHS FT	35.2	35.0	35.5	34.9	34.8	34.8	210.2
Lancashire Teaching Hospitals NHS FT	53.8	53.7	54.2	55.1	55.3	54.5	326.6
North West Ambulance Service NHS Trust	32.1	32.7	32.1	32.5	31.7	32.3	193.2
University Hospitals of Morecambe Bay NHS FT	37.1	36.9	36.1	35.9	35.7	36.4	218.1
NHS Provider Total	257.6	257.0	258.0	257.9	256.4	257.4	1,544.3

5. H2 Planning

5.1 At the time of writing this report, we are working through the H2 planning process. We have now received the financial envelope for H2 and the planning guidance, with the final system submission being due on 16 November 2021. The financial envelope for H2 is shown in table 5 below.

Table 5 – H2 financial envelope compared to H1:

L&SC - Financial envelope	H1 £m	H2 £m
CCG allocations	1,510.2	1,546.5
Top up funding	117.7	99.3
Covid funding	94.4	90.6
Growth funding	68.1	80.5
FINANCIAL ENVELOPE	**1,790.4**	**1,816.9**

5.2 At first glance, the H2 envelope funding looks favourable when compared to H1. However, the H2 envelope includes £24.6m of funding to cover H1 backpay for the recent NHS pay award. The envelope also needs to fund the inflationary and pay award pressures for H2.

5.3 The system top-up funding has been reduced significantly in H2. This is mainly due to an additional targeted efficiency. The maximum targeted efficiency applied nationally is 1.50%, which relates to the scale of excess resource that systems are consuming relative to their adjusted FIT position (Financial Improvement Trajectory). For L&SC, this equates to 1.49% (a £24.8m reduction), the highest in the North West (the adjusted FITs are made up of CCG published allocations and other previously notified funding like FRF, MRET). In addition to this amount is a 0.82% efficiency deduction made to inflation funding = £13.6m, making a total efficiency requirement in H2 above H1 levels of £38.4m. As mentioned above, as a system we were already planning for a £30m efficiency increase in H2, meaning that the national requirements represent an £8.4m increase on our existing plans.

5.4 Covid funding has also been reduced for all systems (£6m for L&SC) to reflect the change in IPC guidelines.

5.5 Growth funding includes £10.3m new and additional capacity funding to reflect increased levels of non-elective activity. It could be argued that the system is already incurring additional spend in this area, so to spend this new money will only increase the level of efficiencies that we must deliver.

6. Capital Performance

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

6.2 At month 6, we are reporting that we are significantly below the plan by £27.5m. Although the ICS cannot change the plan reported to Region, discussions are underway to re-profile plans internally in line with the latest forecasts from trusts, which indicate the allocation will be fully utilised by the year end. Nevertheless, given the uncertainties around supply lines and labour availability, on-going scrutiny of plans is essential, and should expenditure on current schemes be delayed, the expectation is that substitute schemes will be implemented.

6.3 The ICS has a duty to ensure that the envelope is spent in full as any underspend represents lost resource. The ICS is committed to achieving this at year end. Table 6 below summarises the current position.

Table 6 – L&SC summary capital position as at the end of month 6, September 2021:

Capital Overview - M06						
Capital	Year-to-date			Forecast Outturn		
	Plan	Actual	Variance to Plan	Plan	FOT	Variance to Plan
	£m	£m	£m	£m	£m	£m
Charge against Capital Envelope	**55.5**	**37.1**	**18.4**	**112.0**	**112.9**	**(0.9)**
National allocations plus other items charged to CDEL	25.5	16.4	9.1	44.9	44.9	0.0
Capital DEL	**81.0**	**53.5**	**27.5**	**156.9**	**157.8**	**(0.9)**

7. ICS Central Functions

7.1 Table 7 below provides an update on the financial position for ICS central functions. Nationally funded budgets are currently showing a significant year-to-date underspend, but we anticipate that these funds will be spent as they relate to key deliverables set by regional and national teams. There are several purchase orders working through the system for these funds and we are also working to identify if there is likely to be any slippage on these areas.

Table 7 – ICS central functions summary financial position at month 6, September 2021:

ICS Central Functions - M06							
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	157	125	32	313	313	0
	Enabling Functions	907	839	68	6,440	6,440	0
	Executive Functions	1,261	1,095	166	2,459	2,459	0
	Other Support Functions	185	224	(40)	369	369	0
		2,509	2,283	226	9,581	9,581	0
Nationally Funded Budgets		5,463	1,946	3,517	10,890	10,890	0
System Funded Budgets		412	154	258	823	823	0
TOTAL		**8,383**	**4,383**	**4,000**	**21,294**	**21,294**	**0**

8. Recommendation

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

Gary Raphael
ICS Executive Director of Finance and Investment
25 October 2021

Lancashire and South Cumbria
Health and Care Partnership

Appendix 1

Detailed overview of financial performance by CCG and provider sector.

Financial Position Overview - M06						
Surplus / (Deficit)	Year-to-date			Forecast Outturn		
	Plan £m	Actual £m	Variance to Plan £m	Plan £m	FOT £m	Variance to Plan £m
Acute Services	(1,043.1)	(1,041.8)	1.3	(1,043.1)	(1,041.8)	1.3
Mental Health Services	(198.7)	(198.5)	0.2	(198.7)	(198.5)	0.2
Community Health Services	(151.0)	(152.0)	(1.0)	(151.0)	(152.0)	(1.0)
Continuing Care Services	(89.1)	(99.7)	(10.6)	(89.1)	(99.7)	(10.6)
Primary Care Services	(199.2)	(198.7)	0.5	(199.2)	(198.7)	0.5
Primary Care Co-Commissioning	(136.9)	(135.9)	1.0	(136.9)	(135.9)	1.0
Other Programme Services	(56.8)	(56.3)	0.5	(56.8)	(56.3)	0.5
Running Costs	(16.0)	(15.7)	0.3	(16.0)	(15.7)	0.3
Hosted Services	0.0	0.0	0.0	0.0	0.0	0.0
COVID Outside Env & ERF Unvalidated	(8.0)	0.0	8.0	(8.0)	0.0	8.0
Total CCG Net Expenditure	(1,898.9)	(1,898.8)	0.1	(1,898.9)	(1,898.8)	0.1
In-Year Allocation	1,898.9	1,898.9	0.0	1,898.9	1,898.9	0.0
CCG Total	**0.0**	**0.1**	**0.1**	**0.0**	**0.1**	**0.1**
Income Excl Reimbursements	1,634.1	1,645.3	11.2	1,634.1	1,645.3	11.2
COVID-19 Reimbursements	5.1	22.0	16.9	5.1	22.0	16.9
Total Income	1,639.2	1,667.3	28.1	1,639.2	1,667.3	28.1
Pay	(1,091.2)	(1,116.4)	(25.2)	(1,091.2)	(1,116.4)	(25.2)
Non Pay	(529.1)	(529.8)	(0.8)	(529.1)	(529.9)	(0.8)
Non Operating Items (exc gains on disposal)	(21.0)	(20.8)	0.2	(21.0)	(20.8)	0.2
Total Expenditure	(1,641.2)	(1,667.0)	(25.8)	(1,641.2)	(1,667.0)	(25.9)
NHS Provider Total	**(2.0)**	**0.3**	**2.3**	**(2.0)**	**0.3**	**2.3**
System Financial Performance	**(2.0)**	**0.4**	**2.4**	**(2.0)**	**0.4**	**2.4**

Integrated Care System (ICS) Board

Date of meeting	3rd November 2021
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, Neil Greaves, Head of Communications & Engagement, Debra Atkinson, Head of Corporate Business, Sam Proffitt, Director of Provider Sustainability, Steve Christian, Chief Integration Officer (LSCFT) Andrew Bennett, Interim Chief Officer
Agenda item	10(a)
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:

- National guidance
- Readiness to Operate Statement and System Development Plan
- ICB Governance
- Provider Collaboration
- Communications & Engagement

Specific recommendations in relation to naming conventions and the use of the Lancashire and South Cumbria Health and Care Partnership identity are included for approval.

Recommendations

The ICS Board is asked to

- Discuss the report which updates on the current system development programme
- Endorse the naming protocols for submission to NHSEI
- Endorse the recommendations for use of Lancashire and South Cumbria Health and Care Partnership identity.

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. National Guidance

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

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

A range of guidance has been published since the previous ICS Board meeting, with limited further guidance anticipated:

Published 23rd September 2021:

- ICB Establishment Timeline

Published 27th September 2021:

- Introduction to Population-based Payment

Published 28th September 2021:

- HMRC VAT & PAYE Guidance for ICB Establishment & CCG Abolition
- ESR Guidance for ICB Establishment & CCG Abolition

Published 4th October 2021:

- FAQs ICB Functions & Governance

Published 6th October 2021:

- Example role profiled ICB executive roles

Published 13th October 2021:

- Menu of Support Offers

Published 21st October 2021:

- Management of NHS resources by Integrated Care Board
- Integrated Care Board Model Terms of Reference

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

3. Readiness to Operate Statement and System Development Plan

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 1st April 2022. 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 requirement. These RAG ratings are required for both the current position and for the projected position as at March 2022.

The first formal submission of the ROS checklist together with the updated SDP has been made to Region. We have also participated in the second peer review session and are awaiting feedback.

4. ICB Governance

The ICB Establishment Timeline published on 23rd September requires that systems should start to engage with appropriate stakeholders to develop a draft constitution (including standing orders) for the new ICB in line with the already published Model Constitution. In Lancashire and South Cumbria, this engagement will take place in two parts:

1) The **Board Size and Composition**. The first part of the engagement exercise will commence from 4th October, with this being completed by 17th November.

2) Part two will include **all other aspects** of the constitution, including any local supplementary criteria to the appointments and/or nomination process for Members of the Board, and the ICBs committee arrangements. This second stage of the exercise will close on 30th November

The draft constitution is required to be submitted to regional teams by 3rd December 2021. Following feedback from the regional team by 21st December, there is a requirement that by 18th March 2022 the following are also prepared:

- ICB Constitution, including standing orders
- ICB Scheme of Reservation and Delegation (SoRD)
- ICB Standing Financial Instructions (SFIs)

- ICB Governance Handbook (setting out the governance arrangements)
- ICB Functions and Decision Map
- Standards of Business Conduct Policy
- Conflicts of Interest Policy
- Any essential polices identified through risk assessment (e.g. commissioning, safeguarding, HR)

Consideration of the ICBs Committee or sub-committee structure (stage two of engagement) must align to and support the ICS strategic narrative and emerging delegation and delivery model for ICB functions at all levels of the system and place to ensure the Board can effectively discharge its full range of duties and functions.

Drawing from the legal and policy requirements in the Design Framework and other recently published guidance, work has begun on a draft committee structure of the ICB and key areas for consideration. This will assist in mapping any delegation of commissioning functions and statutory duties as the operating model is agreed and inform the committee and delegation structure for the ICB and its constitution. This will be taken forward under stage two of the engagement exercise.

5. Provider Collaboration

The Provider Collaborative Board have set out a clear direction and priorities, which are to:

i. Develop a joint **Clinical Vision to** improve quality within financial resources
ii. Develop a clear **Financial Strategy** to underpin the Clinical Vision
iii. Develop a joint **vision for Corporate, Clinical Support and Estates Services**
iv. **Recovery and Restoration** of elective care and other operational services
v. **Improvement in the Emergency and Urgent Care** performance of the system
vi. Develop our **Leadership** and ensure a great place to work with a **Resilient Workforce**

Outputs from the event facilitated with all Board members by NHSE/I on 23rd September have been drafted and sent to all Trust Boards. This was a well-attended event with great contribution from 88 attendees and good feedback has been captured across the agreed 6 priority areas.

To support the work a system diagnostic has been undertake over a 13 week period and has shown that there are a number of opportunities to improve quality and outcomes whilst reducing inefficiency and strengthening our workforce. These have been grouped into three main areas:

a) End-to-end performance of **clinical services**, relative to peers, as indicated by NHS RightCare, Model Hospital, and Getting it Right First Time.
b) **Workforce:** reducing vacancy and hence use of agency/ locums especially for: (i) Medical staffing within providers; (iii) Nursing within providers
c) Cost of **corporate support services** and functions. Analysis of the national benchmarking model hospital data has been undertaken to understand these costs.

The work will be taken forward with oversight from three key groups. The Clinical Integration Group, the Corporate Collaboration Board and the People Board.

A communications plan is being developed and will start to be delivered from November.

MHLDA Provider Collaboration Arrangements
The System Transition Board (STB) for Mental Health, Learning Disabilities and Autism (MHLDA) has been established since June 2021. The Group comprises of board members from the ICS, NHS providers, Local Authority and VSFSE across the Lancashire & South Cumbria health and care system. The MHLDA STB is chaired by Isla Wilson (ICS NED) and members work collaboratively to plan and deliver against a number of priority areas set out in the externally commissioned Moorhouse review. A high-level update on key and emerging programmes is summarised below:

MHLDA Lead Provider (LP) Model: The LP model is when a single NHS provider trust takes commissioning responsibility for an agreed set of NHS services. LP models have been established as part of the NHS Long Term Plan in order that NHSE can delegate its commissioning responsibility for MHLDA specialist services. As part of the delegation arrangement the LSCFT LP model is now responsible for CAHMS Tier 4 and Adult Secure programmes for the Lancashire and South Cumbria population. There is a direction of travel to include the local NHS commissioning of MHLDA services into the LSCFT LP model for Lancashire and South Cumbria. A group is in place reporting to the MHLDA STB to consider the target operating model with an intention to shadow run the arrangement proposed by 1st April in line with the wider ICS commissioning reforms.

MHLDA Provider Collaborative Arrangements: Partners of the MHLDA STB are planning a programme of work to support system wide transformation at scale for MHLDA services. The partners of the Group include VCFSE, LA, NHS partners. Our aim is to establish a collaborative function to act as the future vehicle, through partnership working, for the delivery of local joint work with appropriate governance, methods of working and a resource plan. The next step is to reach agreement on how the collaborative will deliver on our key programmes of work linked to LP model responsibilities and local health and care transformation programmes. The proposals will be presented to the MHLDA STB in December for initial review.

Development of all age strategies for Lancashire and South Cumbria: Workshops have been completed to engage partners from across health and care in the development of three all age strategies: Mental Health, Learning Disabilities and Autism. The work has confirmed its design framework through workshops with multiple partners working together and agreed a set of shared principles. The work now moves into the production stage with an ambition to finalise the three strategies by 31 March 2022.

6. Communications and Engagement

Each ICS has been asked to complete a return to NHSEI by 18 November detailing their naming conventions for their system and partnership. Building on the language and glossary materials presented to ICS Board members, the table below outlines our proposed submission to NHSEI:

Current ICS geographical descriptor	Integrated Care Board (ICB) legal name	Proposed public name of ICB	Proposed name of integrated care System (ICS)	Proposed description/name of Integrated Care Partnership (ICP)
Lancashire and South Cumbria	NHS Lancashire and South Cumbria Integrated Care Board	NHS Lancashire and South Cumbria	Lancashire and South Cumbria Integrated Care System	Lancashire and South Cumbria Health and Care Partnership

The national nomenclature clearly recognises an Integrated Care Partnership (ICP) as a system level component of an Integrated Care System. The board is asked to endorse the use of Place-based Partnerships as place level terminology to help reduce confusion as the legislation progresses.

ICS Board members are asked to endorse these proposals prior to submission to NHSEI.

Use of partnership branding

Since June, the use of Lancashire and South Cumbria Health and Care Partnership branding has been established in preparation for the developments of integrated care.

This branding is for use in relation to any project, programme or initiative which is being delivered as a partnership in Lancashire and South Cumbria.

To demonstrate partner commitment to Lancashire and South Cumbria Health and Care Partnership, we have developed a version of the logo which we are requesting all partners to adopt secondary to their organisational identity. This will help to demonstrate commitment to partnership working within individual organisation identity

Proud to be part of
Lancashire and South Cumbria Health and Care Partnership

7. Recommendations

The ICS Board is asked to

- discuss the report which updates on the current system development programme
- endorse the naming protocols for submission to NHSEI
- endorse to recommendations for use of Lancashire and South Cumbria Health and Care Partnership identity.

Integrated Care System (ICS) Board

Date of meeting	3 November 2021
Title of paper	Place-Based Partnerships: Proposed Governance and Leadership Arrangements for 2022/23
Presented by	Geoff Jolliffe Chair, Place-Based Partnerships Development Advisory Group
Author(s)	Victoria Ellarby, Programme Director – System Reform, LSC ICS Sarah James, Place Based Partnership Director, Central Lancashire Philippa Cross, Head of Place Based Partnership Development (Interim), Pennine Lancashire Karen Kyle, Morecambe Bay Place Based Partnership Director
Agenda item	10(b)
Confidential	No

Purpose of the paper

The purpose of this report is to provide the ICS Board with an update on development of place-based partnerships in Lancashire and South Cumbria, including setting out the proposals for governance and leadership arrangements for 2022/23.

Executive summary

In December 2020, the ICS Board approved a common strategic narrative for place-based partnerships (then referred to as integrated care partnerships), and in May 2021 the ICS Board approved a development programme for 2021/22.

This paper provides an update on the delivery of this development programme.

The Integrated Care Systems: design framework was published by NHS England in June 2021. The guidance sets out five place-based governance arrangements that could be established by the NHS ICS body in partnership with local authorities and other partners to jointly drive and oversee local integration. Further national guidance was published in September 2021, entitled: “Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems”. This additional guidance is provided further detail beyond that contained in the ICS design framework.

This paper sets out a summary of the approach to engagement around the options for place-based governance arrangements, together with proposals on future ways of working for place-based partnerships and a timeline for next steps.

Recommendations

The ICS Board is asked to approve the proposals set out in section 5 (and relevant Appendices) for future ways of working from 1st April 2022, as recommended by the Place-Based Partnership Development Advisory Group and the ICS development Oversight Group.

Governance and reporting (list other forums that have discussed this paper)		
Meeting	**Date**	**Outcomes**
Place-Based Partnerships Development Advisory Group (PBP DAG)	15th September 2021	Endorsed. Recommended to ICS OG
ICS development Oversight Group (ICS OG)	12th October 2021	Endorsed. Recommended to ICS Board

Conflicts of interest identified
N/A

Implications				
If yes, please provide a brief risk description and reference number	**YES**	**NO**	**N/A**	**Comments**
Quality impact assessment completed			N/A	
Equality impact assessment completed			N/A	
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	Risks related to the System Development Programme (including the development of Place-Based Partnerships) are reported via the PBP DAG and the ICS OG

Place-Based Partnerships:
Proposed Governance and Leadership Arrangements for 2022/23

1. Introduction

1.1 The purpose of this report is to provide the ICS Board with an update on the development of place-based partnerships in Lancashire and South Cumbria, including setting out the proposals for governance and leadership arrangements for 2022/23.

1.2 These proposals have been endorsed and recommended by the Place-Based Partnerships Development Advisory Group (PBP DAG) and the ICS development Oversight Group (ICS OG).

2. Context – work to date in Lancashire and South Cumbria

2.1 In December 2020, the ICS Board approved a common strategic narrative for place-based partnerships (then referred to as integrated care partnerships), along with an approach to working across the five places that was used to shape a development programme for 2021/22.

2.2 This development programme was approved by the ICS Board in May 2021 and focused on three key areas:

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

2.3 For each area, the ICS Board agreed to a two-part approach, running concurrently from May 2021 to March 2022:

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

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

2.4 The ICS Board received a report in September 2021 regarding progress on these actions. A further update is provided as Appendix A.

2.5 The majority of the immediate actions have been completed, and those contained within the broader development programme are either underway or have been delayed (often due to awaiting publication of national guidance). These will form part of the next phase of the development programme as described in section 6.

3. Context – national guidance and future governance and leadership proposals

3.1 The Integrated Care Systems: design framework was published by NHS England in June 2021. The guidance sets out five place-based governance arrangements that could be established by the NHS Integrated Care Board in partnership with local authorities and other partners to jointly drive and oversee local integration.

3.2 There was no stipulation within the guidance as to which model is preferred; indeed, it was indicated that the partners in each area, should determine the best approach for its places.

3.3 NHSEI confirmed that a combination of these arrangements could be used to support place-based partnerships to operate effectively within the wider system partnership.

3.4 Further national guidance was published on 2nd September 2021, entitled: "Thriving places: Guidance on the development of place-based partnerships as part of statutory integrated care systems". This additional guidance was beneficial as it provided further detail beyond that contained in the ICS design framework. It also provided clarity around the ask of ICSs and place-based partnerships in terms of the need to confirm the responsibilities and functions to be carried out at place level.

3.5 This paper sets describes the approach to considering the five options for place-based governance arrangements, as overseen by the PBP Development Advisory Group (PBP DAG), before setting out proposals for future ways of working for place-based partnerships and a timeline for next steps.

4. Approach to engaging on the five options

4.1 A robust approach to engagement on the five options (or possible combination of options) has been overseen by the PBP DAG and enacted in the place-based partnerships during August/September 2021.

4.2 This engagement approach included:

- Identification of three key principles which describe our intended ways of working as five place-based partnerships supported and enabled by the LSC system.

- Consideration of each of the five options (or possible combination of options) in relation to their ability to meet these three key principles.

- Use of a small number of key questions to support structured discussions in relation to these options and key principles.

- Discussions in the PBP DAG (which has representation from all five place-based partnerships and all sectors working as part of the LSC system), in each of the five place-based partnerships, through 1:1 / small group conversations with a range of sectoral representatives across the system and in places, and through a number of existing sectoral / professional leadership groups.

4.3 Feedback from this engagement was collated into a number of key themes, which were used to influence the proposals for future ways of working. In addition, the feedback has been used to shape a supporting Frequently Asked Questions document, and the next phase of the place-based partnership development programme.

5. Proposals for future ways of working

5.1 Based upon feedback received during engagement across place-based partnerships and the LSC health and care system, the following ways of working are proposed from April 2022, having been endorsed by the PBP DAG on 15th September 2021 and the ICS OG on 12th October 2021:

- A Place-Based Leader, with duties discharged with the support of
- A Place-Based Partnership Committee of the LSC Integrated Care Board, which is chaired by
- A Chair of the Place-Based Partnership

5.2 Detailed proposals for each of the above is provided in Appendices B, C and D.

5.3 These will be consistent across each of the five place-based partnerships from 1st April 2022 and for the duration of 2022/23.

5.4 It is envisaged that the Place-Based Partnership Committees of the LSC Integrated Care Board will evolve as the maturity of the place-based partnerships and the system grows, with aspirations expressed by the majority of places for this to become a Joint Committee between multiple partners in the place. This potential change will be reviewed by the place-based partnerships and the LSC Integrated Care Board during 2022/23.

5.5 A Frequently Asked Questions document has also been developed which is intended to clarify some queries raised through the feedback received during the engagement approach. This is provided in Appendix E.

6. Next steps in the development of place-based partnerships

6.1 Further work is now required to provide specific detail that underpins the above proposals, as noted in the feedback received in the engagement approach. In addition, several requirements are set out in the Thriving Places guidance which systems and places must consider.

6.2 Key areas of work are set out below, with a high-level timeline provided in Appendix F (noting that this is interdependent with national recruitment timeframes and the publication of remaining national guidance).

- **Responsibilities and functions to be carried out at place level**: This will be informed by the place-based strategic narrative, which was agreed by the ICS Board in December 2020, the subsequent place-based development programme, considerations provided in the Thriving Places national guidance, and LSC work to consider which activities will be undertake at system and in place.

- **Delegations from the LSC Integrated Care Board to the Place-Based Partnership Committees (and the Place-Based Leader):** This will include the required deliverables set out by the LSC Integrated Care Board and the NHS resources that are delegated from the LSC Integrated Care Board to the place. It will link to wider pieces of work to develop a financial framework for the LSC system and its place-based partnerships, and a Memorandum of Understanding between the system and each of the place-based partnerships.

- **Membership, decision-making and accountability of the Place-Based Partnership Committees of the Integrated Care Board, and how this relates to accountability arrangements for different partners:** This will consider the different partners in place, their delegated authority to make decisions, and their accountabilities for delivery through various different routes. The place-based partnerships and the system will need to agree the arrangements required to fulfil each of these relationships appropriately. It will link to wider pieces of work on clinical and care professional leadership, and resident engagement and how these voices are represented at system, place and neighbourhood. Partners in each place will also wish to agree their own local ambitions / priorities, based on local factors and wider public sector strategies.

- **Representation on, and reporting relationships with, the LSC Integrated Care Board and the LSC Integrated Care Partnership (referred to locally as the Health and Care Partnership):** This will link to wider pieces of work on the membership of the Integrated Care Board and the developing LSC Health and Care Partnership (referred to nationally as the Integrated Care Partnership).

- **The role description and appointment process for the Place-Based Leaders**

- **The role description and appointment process for the Chairs of the Place-Based Partnerships**

6.3 Many of these have interdependencies with each other, with wider system and public sector development work programmes and/or with national activities and will be overseen by the PBP DAG and the ICS OG as appropriate. They can be assisted by

support offers being made available nationally via NHSEI and the Local Government Association.

7. Recommendations

7.1 The ICS Board is asked to:

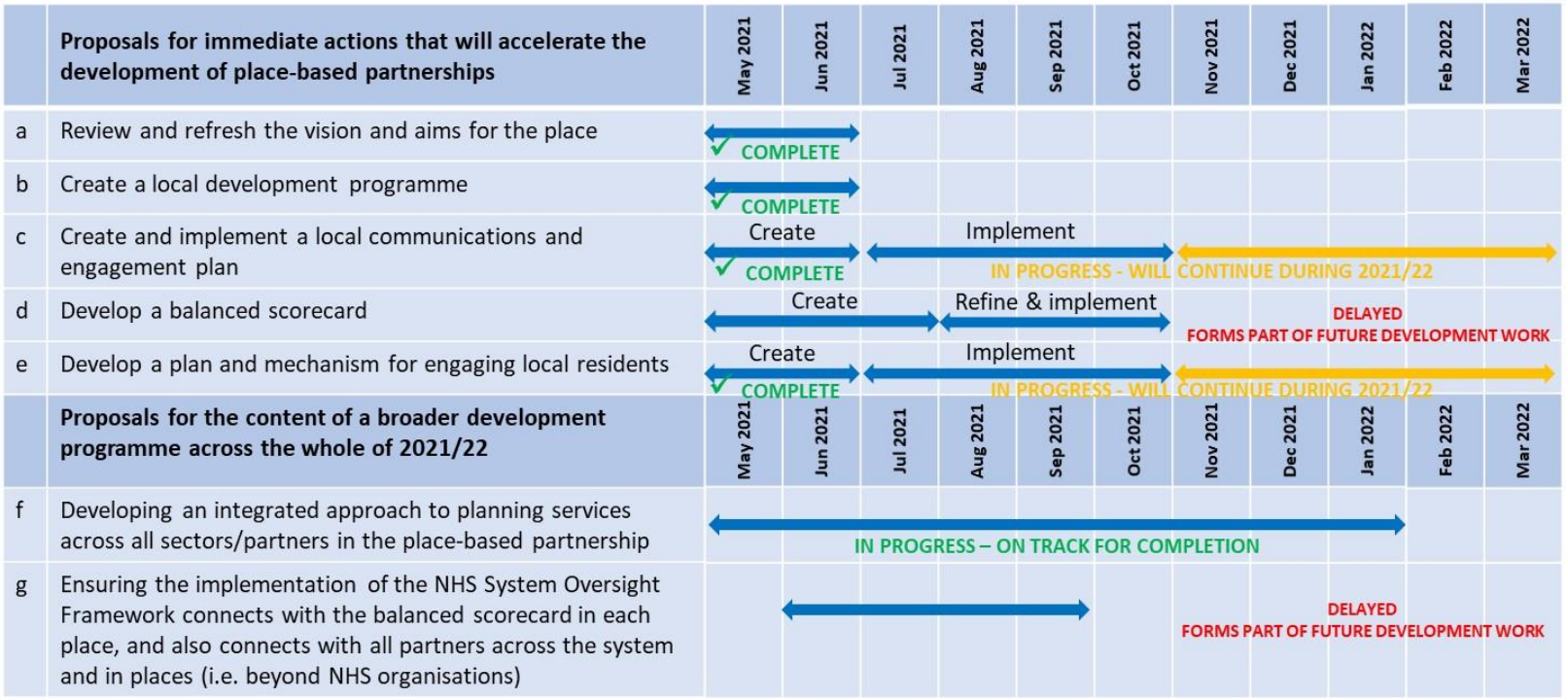
7.1.1 Approve the proposals set out in section 5 (and relevant Appendices) for future ways of working from 1st April 2022, as recommended by the Place-Based Partnership Development Advisory Group and the ICS development Oversight Group.

Lancashire and South Cumbria Health and Care Partnership

Appendix A: Progress on development programme agreed in May 2021

Section 1: Overarching themes and success measures

Proposals for next steps in ICP development



Section 2: How we will organise ourselves to work together as partners

Proposals for next steps in ICP development

	Proposals for immediate actions that will accelerate the development of place-based partnerships	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
a	Ensure that the place-based partnership has meaningful involvement of all partners	✓ COMPLETE										
b	Implement a partnership agreement between all partners	✓ COMPLETE										
c	Have a place-based partnership board	✓ COMPLETE										
d	Have formal place-based groups that have accountability for planning and delivering		✓ COMPLETE									
e	Adopt an open-door policy across organisational committees / groups	✓ COMPLETE										
f	Have a cross-organisational, multi-professional clinical and professional leadership body	IN PROGRESS - WILL CONTINUE DURING 2021/22 LINKED TO SYSTEM-WIDE WORK										

Lancashire and South Cumbria Health and Care Partnership

Section 2: How we will organise ourselves to work together as partners

Proposals for next steps in ICP development

	Proposals for the content of a broader development programme across the whole of 2021/22	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
g	An accountability framework, setting out what place-based partnerships will be accountable for delivering as members of a wider integrated care system		FORMS PART OF FUTURE DEVELOPMENT WORK									
h	A decision-making framework, considering a scheme of delegation from organisations to place-based partnerships to support integrated working		FORMS PART OF FUTURE DEVELOPMENT WORK									
i	A financial framework, including how place-based allocations will be made within the future integrated care system		FORMS PART OF FUTURE DEVELOPMENT WORK									
j	A clear understanding of how place-based partnerships will generate a tangible sense of accountability to residents		IN PROGRESS – ON TRACK FOR COMPLETION									
k	A clear understanding of how place-based partnerships fit within the governance of the integrated care system		IN PROGRESS – ON TRACK FOR COMPLETION									

Section 3: Place based leadership and implementation

Proposals for next steps in ICP development

	Proposals for immediate actions that will accelerate the development of place-based partnerships	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
a	Ensure that it has an experienced Chair of the place-based partnership	✓ COMPLETE										
b	Have an executive leadership team for the place	✓ COMPLETE										
c	Have a common set of behavioural principles / values for the place	✓ COMPLETE										
d	Have a nominated senior leader for the place (an executive) who will ensure implementation of the agreed key deliverables	✓ COMPLETE										
e	Have an ICP Director for the place	✓ COMPLETE										

Section 3: Place based leadership and implementation

Proposals for next steps in ICP development

	Proposals for the content of a broader development programme across the whole of 2021/22	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
f	A framework for clinical leadership in the place, and clarity on how this ensures connectivity to clinical leadership in neighbourhoods, PCNs and sectors within the place, and also as members of a wider integrated care system	IN PROGRESS - WILL CONTINUE DURING 2021/22 LINKED TO SYSTEM-WIDE WORK										
g	A framework for ensuring appropriate non-executive / lay oversight in the place		IN PROGRESS – ON TRACK FOR COMPLETION									
h	An organisational development programme that is focused on relationships between individuals and sectors at place, particularly related to developing system leadership behaviours		IN PROGRESS – ON TRACK FOR COMPLETION									
i	The role description and process for implementation of Place Based Leaders	IN PROGRESS - DELAY DUE TO NATIONAL TIMEFRAMES										

Appendix B: A Place-Based Leader

A Place-Based Leader will be appointed for the five place-based partnerships.

The Place-Based Leader will have two key responsibilities:

To be the Place-Based Partnership convenor	Convene the place-based partnership, and facilitate priority-setting, strategic alignment and decision-making between organisations across multiple sectors. Ensure that partners work together to deliver on required outcomes and agreed ambitions. Represent the partnership in the wider governance and leadership of the LSC Health and Care Partnership (nationally described as the Integrated Care Partnership) and the NHS LSC Integrated Care Board.
To be the Executive Lead for delegations from the ICB	Hold authority and decision-making for the delegations from the NHS LSC Integrated Care Board to the place-based partnership, including associated financial governance responsibilities, as set out in the Scheme of Reservation and Delegation for the NHS LSC Integrated Care Board. Be responsible for the management and deployment of people who are allocated from the NHS LSC Integrated Care Board to form the place-based team of the NHS LSC Integrated Care Board.

The skills and behaviours that will be expected from the Place-Based Leader are set out below. These are drawn from the publication "Thriving Places: Guidance on the development of place-based partnerships as part of statutory integrated care systems", and align well with the LSC common strategic narrative for place-based partnerships:

- openness and honesty with colleagues, as well as acting with integrity
- a commitment to listening to others and understanding different points of view
- strong relationship-building skills, with the capability to work with partners to develop a shared vision around joint priorities and plans
- a readiness to take ownership of complex problems
- curiosity and the ability to understand what is really happening, and not what is supposed to be happening
- encouraging close working between leaders from different organisations to build relationships and solve problems
- fostering a culture of continuous learning, measuring effectiveness and adapting the approach on what is or is not working
- regularly engaging with people who use services, carers and members of the voluntary sector to understand their experiences of care and acting on their views

The Place-Based Leader will be accountable to the Chief Officer of the NHS LSC Integrated Care Board and will be responsible to the Place-Based Partnership Committee of the NHS LSC Integrated Care Board which will have membership drawn from all partners in the place.

Appointment to the Place-Based Leader roles will follow a robust application and assessment process that will be common across all five places. It will involve the senior representatives from the partners in each place, the Designate Chair and Designate Chief Officer of the LSC Integrated Care Board.

This will retain a single Senior Responsible Officer for **some** decision-making, which will be set out in the Scheme of Reservation and Delegation for the NHS LSC Integrated Care Board. However, the Place-Based Leader will be supported by, and embedded within, a culture of partnership working and therefore will discharge the majority of decision-making through a Place-Based Partnership Committee of the NHS LSC Integrated Care Board.

Appendix C: A Place-Based Partnership Committee of the NHS LSC Integrated Care Board

Each place-based partnership will have a Place-Based Partnership Committee of the NHS LSC Integrated Care Board which will be provided with delegated authority to make decisions about the use of NHS resources that are delegated from the NHS LSC Integrated Care Board to the place.

The committee will have delegated accountability for delivery of requirements set out by the NHS LSC Integrated Care Board. These will be supplemented with place-based delivery requirements linked to local ambitions / priorities that will be agreed between partners in place.

The Terms of Reference and scope of the Place-Based Partnership Committees of the NHS LSC Integrated Care Board will be co-produced and mutually agreed by place-based partnerships and the NHS LSC Integrated Care Board, and will allow for appropriate localisation regarding membership. As the statutory body, the Terms of Reference will be formally approved by the NHS LSC Integrated Care Board (this is noted in the "Thriving Places" guidance).

In confirming the membership of the Place-Based Partnership Committees, we would anticipate that places would look to consider the suggestions on membership outlined within the Thriving Places guidance, which suggests that representation from the following should be considered:

- primary care provider leadership, represented by PCN clinical directors or other relevant primary care leaders
- providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate
- people who use care and support services and their representatives including Healthwatch
- local authorities, including Directors of Adult Social Services and Directors of Public Health and elected members
- social care providers
- the voluntary, community and social enterprise sector (VCSE)
- the ICB

Partners within each place will build on current ways of working by embedding principles of mutual accountability, where all partners, irrespective of their own formal accountability arrangements, consider themselves mutually accountable to each other and to the population and communities they serve. This will be important to ensure there is collective ownership of the partnership's vision, priorities, plans and delivery and the cooperation required to deliver this.

This place-based partnership committee will be chaired by a Chair of the place-based partnership.

Appendix D: A Chair of the Place-Based Partnership

A Chair will be appointed for each of the five place-based partnerships.

The Chair of the place-based partnership will have two key responsibilities:

To Chair the Place-Based Partnership Committee	Chair the Place-Based Partnership Committee of the NHS LSC Integrated Care Board Hold members of the Place-Based Partnership Committee of the NHS LSC Integrated Care Board to account for delivery of requirements set out by the LSC Integrated Care Board and place-based delivery requirements linked to local ambitions / priorities as agreed between partners in place Lead the Place-Based Partnership Committee in its development activities and evolution to any future governance arrangements.
To be the Chair of the Place-Based Partnership	Act as an ambassador for partnership working in place and across the system Support the Place-Based Leader in the role of 'partnership convenor' Ensure equity of voice across all partners within the place-based partnership Enact any required place-based conflict resolution activities within an agreed framework

The skills and behaviours expected from the Chair of the place-based partnership are similar to those set out above in reference to the Place-Based Leader, with a particular focus on:

- a commitment to listening to others and understanding different points of view
- strong relationship-building skills, with the capability to work with partners to develop a shared vision around joint priorities and plans
- curiosity and the ability to understand what is really happening, and not what is supposed to be happening
- encouraging close working between leaders from different organisations to build relationships and solve problems

Appointment to the Chair roles will follow a common appointment process across all five places. It will involve the senior representatives from the partners in each place, the Designate Chair and Designate Chief Officer of the LSC Integrated Care Board along with representatives from the LSC Integrated Care Board.

Appendix E: Frequently Asked Questions

Q.1	**What is the ICS NHS Body?**
A	The ICS NHS Body, known as the NHS LSC Integrated Care Board (ICB) will be established as a new statutory organisation, to lead integration within the NHS, to improve population health and care. The ICB will have a unitary board, responsible for ensuring the body plays its role in achieving the four purposes of: 1. improve outcomes in population health and healthcare 2. tackle inequalities in outcomes, experience and access 3. enhance productivity and value for money 4. help the NHS support broader social and economic development. NHS England and NHS Improvement expect that ICBs will be created from 1st April 2022, with the functions currently performed by CCGs conferred on ICBs. Each CCG's staff, assets and liabilities will be transferred to the relevant ICB, and some NHS England and NHS Improvement direct commissioning functions will be delegated. All ICBs have to put arrangements in place to ensure they can effectively discharge their full range of duties and functions. This is likely to include arrangements for other committees and groups to advise and feed into the board, and to exercise functions delegated by the board. You can find more integrated care terminology explained in our glossary of terms: https://www.healthierlsc.co.uk/about/glossary
Q.2	**What are Place-based Partnerships and what are they intended to do?**
A	Place-Based Partnerships are collaborative arrangements formed by the organisations and sectors responsible for arranging and delivering health and care services in a locality or community, within Lancashire and South Cumbria there are five local areas (we have historically referred to these as Integrated Care Partnerships). These Place-Based Partnerships cover the following areas: • Central Lancashire (Our Central Lancashire) • Fylde Coast (Healthier Fylde Coast) • Morecambe Bay (Bay Health and Care Partners) • Pennine Lancashire (Healthier Pennine Lancashire) • West Lancashire (West Lancashire Partnership) In Lancashire and South Cumbria we are clear that our Place-Based Partnerships are a collaboration of planners and providers across health, local authority and the wider community, who take collective responsibility for improving the health and wellbeing of residents within a place, with a population of up to 500,000.
Q.3	**The report distinguishes between partnership governance arrangements and partnership operating/delivery models. What does this mean?**
A	A Place-Based Partnership is not a statutory body. It can only hold accountability for delivery and for decision-making if this is delegated from one of more of the partner organisations. In order to do this, it requires formal governance arrangements. The term "partnership governance arrangements" refers to how decisions will be made within a partnership and how accountabilities will be overseen. Usually this is in the form of formally constituted boards and/or committees, but this can also be enacted via individual directors through a formally agreed Scheme of Reservation and Delegation. The term "partnership operating/delivery model" refers to how services will be delivered within a partnership, how resources will be deployed on a day-to-day basis (both clinically

	and those supporting development of the partnership) and how the delivery will be overseen and coordinated. Governance structures are traditionally responsible for agreeing priorities for organisations/a partnership and overseeing delivery of agreed standards i.e., they determine the **"what"** and monitor the **"knowing whether we are succeeding"**, whereas the operating/delivery model determines the **"how".** The report is proposing that governance structures are consistent across each of the five Place-Based Partnerships, in order to ensure there is absolute clarity and transparency in relation to delegations to each place and decision making across Lancashire and South Cumbria. However, how each Place-Based Partnership choses to enact and deliver on its accountabilities will be for local determination.
Q.4	**The report talks about place-based partnership committees of the NHS Lancashire and South Cumbria ICB. What does this mean?**
A	Place-Based Partnership Committees of the NHS Lancashire and South Cumbria ICB will be provided with delegated authority from a single organisation (i.e. the ICB), to make decisions about the use of NHS resources. The Committees can include members from outside the ICB, i.e. members from partner organisations or alliances. The Terms of Reference and scope of the Place-Based Partnership Committees of the Lancashire and South Cumbria ICB will be co-produced and mutually agreed by Place-Based Partnerships and the Lancashire and South Cumbria ICB. A delegated budget can be set by the NHS LSC ICB to describe the level of NHS resources available to deliver the remit of the Committee. This arrangement is helpful to ensure that decisions made on behalf of the NHS LSC ICB are done so based on a range of views of partners in each place.
Q.5	**The report also talks about a joint committee, what does this mean and how is it different to a "partnership committee of the ICB"?**
A	A joint committee can only be formed when more than one statutory partner (e.g. a local authority and the NHS LSC ICB), chooses to delegate decision making and resources to a committee. The relevant statutory bodies then agree to delegate defined decision-making functions to the joint committee in accordance with their respective schemes of delegation. A budget may be defined by the bodies delegating statutory functions to the joint committee, to provide visibility of the resources available to deliver the committee's remit. A joint committee differs to the "partnership committee of the ICB" because it has delegated authority from more than one statutory organisation.
Q.6	**Will places be able to determine their own membership for the partnership committees?**
A	The Terms of Reference and scope of the Place-Based Partnership Committees of the Lancashire and South Cumbria ICB will be co-produced and mutually agreed by Place-Based Partnerships and the Lancashire and South Cumbria ICB and will allow for appropriate localisation regarding membership. However, in confirming the membership of the Place-Based Partnership Committees, we would anticipate that places would look to consider the suggestions on Membership, outlined within the Thriving Places guidance, which suggests that representation from the following should be considered: • primary care provider leadership, represented by PCN clinical directors or other relevant primary care leaders • providers of acute, community and mental health services, including representatives of provider collaboratives where appropriate • people who use care and support services and their representatives including Healthwatch

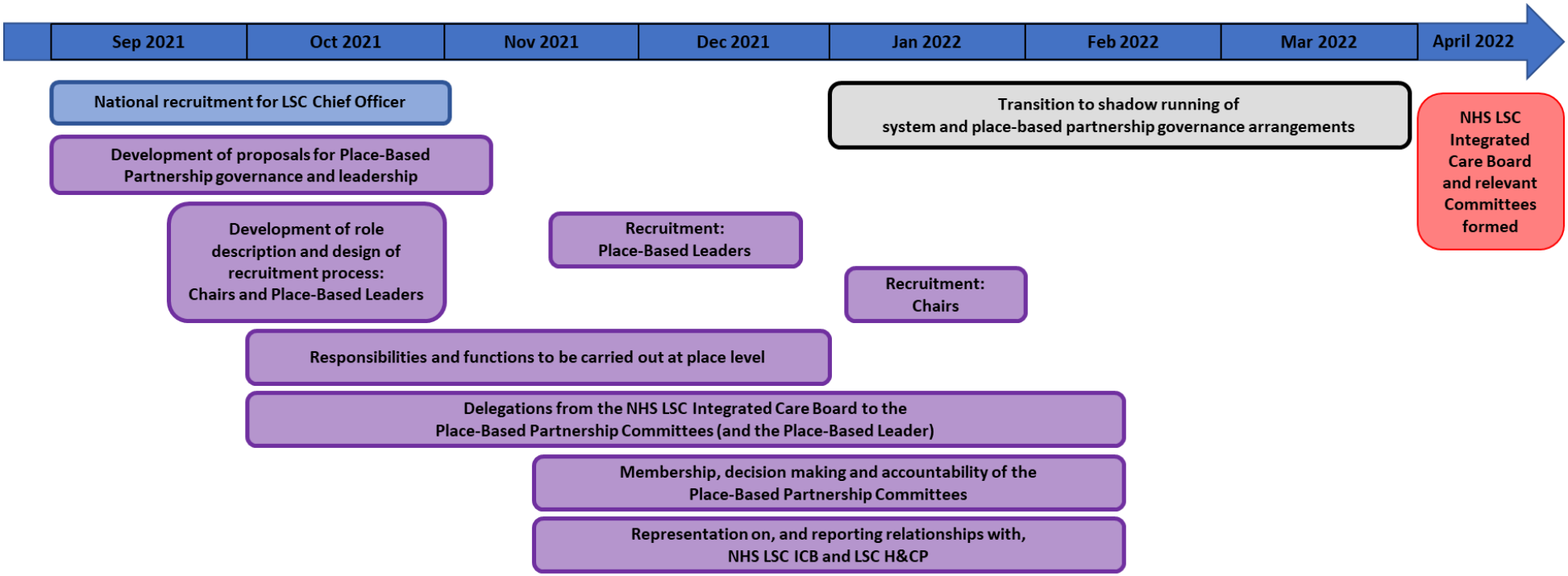
	• local authorities, including Directors of Adult Social Services and Directors of Public Health and elected members • social care providers • the voluntary, community and social enterprise sector (VCSE) • the Integrated Care Board
Q.7	**It is difficult to agree the best or preferred governance structure without knowing what decision making will be devolved, or what we will be governing at place. When will we know what our delegations and functions will be?**
A	The Developing Place-Based Partnerships Strategic Narrative, agreed with the ICS Board in December 2020, outlines the purpose and aims of a Place-Based Partnership. It sets out what as a Partnership we will do together and how we will work together as partners. This gives an initial view of the functions and service provision that will be delivered at place, which will be used as a starting point for discussions on delegations and decision making. In terms of functions, these are outlined as follows: • Place-based leadership and collaboration • Listening to the voice of our communities • Planning integrated services • Delivering integrated services • Population health management • Improving quality of services • Maximising the use of resources • Valuing and developing the workforce In terms of service provision, it is anticipated that the following will be coordinated and/or delivered through the Place-Based Partnerships: • Public health and wider community development • Community-based wellbeing support, including social prescribing activities, VCFSE provision and local access to green spaces, and leisure facilities • GP and wider primary care, delivered through Primary Care Networks • Community health care • Community mental health care (including for those with learning disabilities • Urgent and emergency care, including physical and mental health (noting that some emergency services will be provided in a networked model across Lancashire and South Cumbria) • Ongoing management of long-term conditions, including the use of skills, expertise and resources that have historically been accessed via referral to acute care services. • Local acute hospital services (noting that some services will be provided in a networked model across Lancashire and South Cumbria, and there will be tertiary services provided in some places for the system-wide population). • Social care, education, housing, employment and training support. • The wider care sector within the place The work to scope and determine the delegations to Place-Based Partnerships will commence imminently and be completed in line with the national ICS Establishment Timeline, which currently indicates that the Integrated Care Board Scheme of Reservation and Delegation and Functions and Decisions Map, must be completed and submitted by 18 March 2022.
Q.8	**How will members of the Place-Based Partnerships be involved in determining future delegations?**
A	The Thriving Places guidance is clear that the allocation of decision-making functions between system and place should be shaped through collaborative discussions.

	The current Lancashire and South Cumbria PBP Development Advisory Group (PBP DAG) will play a key role in leading the discussions regarding future delegations and this group is representative of all health and care system partners and all Place-Based Partnerships. The PBP DAG will ensure that any working group established to oversee the development of the delegations framework will have representation from all partners and all places.
Q.9	**It is important to us that we retain flexibility over our governance arrangements, will this be possible?**
A	As part of our engagement activities, it was agreed that core elements and principles of the place-based governance arrangements will be consistent across all five Place-Based Partnerships. However, it is intended that local flexibility will be afforded with regards to how the governance arrangements are implemented and ways in which they may be enhanced locally. For example, places will be able to determine their own membership (in line with common principles as outlined above, drawn from the national Thriving Places guidance) and will be able to determine their own supplementary governance arrangements that support the effective and collaborative delivery of local priorities.
Q.10	**Will Places have to maintain the same governance model once it is agreed?**
A	It is intended that the governance model recommended in the paper (i.e., a Committee of the Integrated Care Board) serves only as an interim model, which will allow us to operate effectively as a system from 1st April 2022. However, it is intended that this will be starting point for our arrangements and future governance models will evolve/emerge as we learn from our joint working and as further national guidance and requirements are issued.
Q.11	**How will "non-statutory" partners, such as the VCFSE, be able to influence decision making?**
A	The Voluntary, Community, Faith and Social Enterprise sector is key to the success of place-based partnerships. As outlined in question 6 above, the Thriving Places Guidance is clear that Voluntary, Community, Faith and Social Enterprise sector providers should be considered as core members of a Place-Based Partnership and that they should be represented throughout the delivery arrangements as well as in decision making groups. The Thriving Places Guidance also references that Place-Based Partnership Committees "may appoint representatives of non-statutory providers to participate in the committee or attend meetings to take part in discussions without being members". However, it will be up to each Partnership to determine how best the VCFSE should be represented.
Q.12	**How will primary care be involved in developing the partnerships and in future decision making?**
A	Primary care is key to the success of place-based partnerships. As outlined in question 6 above, the Thriving Places Guidance is clear that primary care providers should be considered as core members of a Place-Based Partnership and that they should be represented throughout the delivery arrangements as well as decision making groups. However, it will be up to each Partnership to determine how best primary care should be represented.
Q.13	**Will the proposed Place-Based Partnership Committee arrangements have implications for GP contracts?**
A	GMS contracts for GPs will continue to be held nationally, as there is currently no proposal to change this within the Health and Care Bill. As such, changes to these arrangements will not currently fall within the remit of the Integrated Care Board or the Place-Based Partnership Committee.
Q.14	**How soon will we be able to progress to our ultimate ambition of joint committees for place?**

A	It is anticipated that the pace of progress will be different within each Place-Based Partnership, dependent on the maturity of relationships and delivery arrangements between the statutory partners. However, it is expected that most places will be working to develop from their initial governance arrangements during 2022/23 and that joint committee arrangements, if considered suitably well-developed, could be enacted from 1st April 2023.
Q.15	**The report and the national guidance views partnership working through a "health prism" but we need to consider partnership working from all perspectives. How will this be considered as part of our arrangements moving forward?**
A	It is acknowledged that much of the national guidance focuses heavily on health and the NHS. This is mainly because we need to articulate how the functions and assets of our current Clinical Commissioning Groups will be transferred into the Integrated Care Board. Such processes must be undertaken with due diligence, as such the guidance remains quite technical. However, other guidance is much clearer about the important role of all partners in the planning and delivery of an ambitious step change in integrating health and care, with a clear focus on the overall wellbeing of the population. This can be seen in the Thriving Places documentation, as well as the principles for establishing a health and care partnership across the system. In developing our Place-Based Partnerships Strategic Narrative and determining our future arrangements for Place-Based Partnerships, all partners have been involved in discussions and ambitions to move beyond a focus on health care service provision, and instead into improving population health, addressing inequalities and improving health outcomes. All partners will need to continue to work collaboratively to ensure these ambitions are achieved.
Q.16	**How will our communities be involved in future decision making and prioritisation?**
A	National guidance ("ICS implementation guidance on working with people and communities"), outlines the expectation that Integrated Care Boards will develop a system-wide strategy for engaging with people and communities by April 2022. There is also the expectation that ICBs should work with partners to develop arrangements for ensuring that Place-Based Partnerships have representation from local people and communities in priority-setting and decision-making forums. Work is currently underway across the five Place-Based Partnerships to identify a consistent framework for ensuring resident engagement in priority setting, decision making and operational delivery and it is expected that this work will be completed in early 2022.
Q.17	**Who will be involved in the recruitment of the Place-Based Leader and Place-Based Partnership Chair?**
A	Recruitment to the Place-Based Leader and Place-Based Partnership Chair roles will follow a robust and transparent process that will be common across all five places. It will involve senior representatives from the partners in each place, the Designate Chair and Designate Chief Officer of the Lancashire and South Cumbria ICB.

Lancashire and South Cumbria Health and Care Partnership

Appendix F: Timeline for next phase of development



Integrated Care System (ICS) Board

Date of meeting	**3 November 2021**
Title of paper	**New Hospitals Programme Quarter 2 Board Report**
Presented by	**Jerry Hawker, Programme SRO**
Author	**Rebecca Malin, Programme Director** **Matthew Burrow, Project Manager**
Agenda item	**11**
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 2 period; July – September 2021. The report includes the evolution of the programme scope, progress on the key products that have been developed to support business case development along with the public, patient and workforce communications and engagement activities underway. This quarterly report is presented to the following Boards; • University Hospitals of Morecambe Bay FT • Lancashire Teaching Hospitals FT • East Lancashire Hospitals Trust • Blackpool Teaching Hospitals FT • Lancashire & South Cumbria FT • Integrated Care System (ICS) • Provider Collaborative • And the Strategic Commissioning Committee.
Recommendations
It is recommended the Board; • Note the progress undertaken in Q2. • Note the progress in developing key products to support business case (section 4).

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

NEW HOSPITALS PROGRAMME Q2 BOARD REPORT

1. Introduction

1.1 This report is the 2021/22 Quarter 2 update from the New Hospitals Programme (NHP).

2 Background

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

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

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

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

3 Programme governance and risk

3.1 During Q2, MIAA (Mersey Internal Audit Agency) have begun working with the programme to undertake an independent review of the programme governance

arrangements. This will include completion and agreement to a decision making matrices in line with programme and statutory body governance frameworks as well as that of the business case processes. The report is due to conclude in November 2021.

3.2 The programme has continued to embed the governance arrangements approved by the Strategic Oversight Group (SOG) in August 2021. The Governance Advisory Group has provided valuable guidance to the programme through the input from the Trust Executive and Non-Executive Directors and members of the Strategic Commissioning Committee. In addition, the monthly Trust Engagement Meeting has supported the communication of progress and key messages with the Trusts management teams.

3.3 The Oversight Groups have met and delivered assurance to the Programme Management Group throughout Q2 on key products.

3.4 The programme undertook a review of key and strategic risks in Q2 to strengthen the risk register with stakeholders, which has further embedded those risks within the programme. In August, the risk management strategy, policy and risk appetite statement were approved. The full risk register is reported to the Programme Management Group on a monthly basis with risks scoring 15 and above reported to the SOG each month.

4 Progress against plan (for the period July – September 2021)

4.1 Programme scope

Members will recall that in Q1, system partners were integral to refining the scope of the programme to focusing on hospital facilities/sites, with the integrated care system's clinical strategy determining the clinical model, including configuration of services.
A number of interconnected initiatives have brought further intelligence and thinking to the scope of the programme. Firstly, discussions between the ICS and NHSEI regarding wider system delivery focusing on achievement of sustained operational, quality and financial improvement have enabled the programme to be firmly placed in the scope of longer term system improvement. Secondly, further evidence published in the system diagnostic on the ICS financial position has provided clarity on productivity and efficiency opportunities. Finally, alongside the review of a hospitals clinical strategy, the programme has supported the progression of a primary and community care programme and the development of a draft infrastructure plan. These present an

opportunity to further align the scope of the programme with these linked, emerging strategies. In response to this, the programme is rapidly developing how these work in tandem with the programme and inform the next steps.

4.2 **Key products to support business case development –** During Q2, a number of key products were developed and reviewed by the SOG. These products represent key building blocks in the development of the business cases, including the process and methodology that supports progressing from a long list of proposals to the final short list of options. Statutory Bodies are not required to approve all these products, but the programme has ensured that all statutory boards and committee members have been engaged, sighted and supportive of them recognising the final business cases will be constructed using them. Each product has been subject to significant engagement, input and challenge from all the programme working and oversight groups and was presented to SOG with their support. The products are:

4.3 **Framework model of care** – clinical leads have worked to develop a framework model of care. This is the clinical vision and outlines the aspirations for what future care should look like within our hospitals. The document will be iterative throughout the course of the programme. The latest version of the framework model of care was approved by the Clinical Oversight Group (COG) and SOG in August 2021. The framework has been shared with the ICS Provider Collaborative Board (PCB) to ensure alignment, and reviewed by the North West Clinical Senate in the role of critical friend to help support the programme to further develop the document.

4.4 **Publication and formal approval of the longlist –** the programme held a Longlist and Critical Success Factors (CSFs) Workshop on the 4 October 2021, in which the stakeholders (clinical and non-clinical staff, Healthwatch and patient representatives) approved the longlist and CSFs providing constructive feedback to strengthen the CSFs. An online survey about the longlist was launched to capture feedback from members of the public, which received more than 100 responses in the first 24 hours.

4.5 **Estates prioritisation exercise –** the programme has held several joint workshops with finance, clinical and estates colleagues across the system to prioritise areas for investment. This is in support of any proposals for new infrastructure on existing sites.

5 Programme timeline

5.1 The programme remains on track to start building in 2025, with new hospital facilities opening by 2030.

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

6 Public, patient and workforce communications and engagement

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

6.2 Our Case for Change went live on the New Hospitals Programme website– https://newhospitals.info/CaseForChange. A proactive communications campaign followed to create awareness of the existence of the Case for Change and to highlight key themes, this included media releases; the launch of a new Case for Change conversation on the Big Chat and internal communications updates across the local NHS. In addition, a summary version of the Case for Change and draft Easy Read has been published online on the New Hospitals Programme Case for Change hub.

6.3 The longlist was published and an online survey created to capture feedback from members of the public, which obtained more than 100 responses in the first 24 hours. As of 19 October, more than 2,000 responses have been received.

6.4 Several key reports have been produced throughout the quarter sharing insights on views and aspirations for the New Hospitals Programme: A report on the 'Big chat' conversation highlighting strong support for a solution that embraced holistic care and tackled health inequality, but travel and location were the most discussed issues. A benchmarking insight report was received and polling indicates that people North and South of the region do not wish to travel in either direction for anything but the most complex treatments and for no more than an hour. The report demonstrated a very

high public awareness of the programme (30%) and over half of the people who are aware of the programme think it is about building a brand-new hospital somewhere.

7 Stakeholder management

7.1 The Board will recognise there will be a breadth of stakeholders in such a programme. During Q2, there has been a continuation of internal and external communications including stakeholder updates with MPs and local authorities. Engagement has continued with MPs across the region with a focus on the process the NHP is following and the longlist of proposals. Finally, work on the socio-economic benefits of new hospital facilities continues working closely with with the Lancashire Local Enterprise Partnership (LEP).

8 Next period – Q3 2021/22

8.1 The next quarter will require critical actions to be undertaken by the programme. These include further developing potential estates solutions, clinical strategy, social value and articulating and quantifying the benefits new hospital facilities bring to the region.

9 Conclusion

9.1 This paper is a summary of progress on the New Hospitals Programme throughout Quarter 2 2021/22.

10 Recommendations

10.1 The Board is requested to:

- Note the progress undertaken in Q2.
- Note the progress in developing key products to support business case (section 4).

Rebecca Malin
Programme Director
October 2021

Jerry Hawker
Programme SRO

L&SC ICS System Reform Programme
Monthly Highlight Report

Lancashire and South Cumbria Health and Care Partnership

Workstream Summary

Worksream	ID No	Scope, Objectives, Deliverables	Workstream Leads	Programme Status
ICS Development	A	*Develop a statutory ICS, including a strategic commissioning function and place-based functions, in line with national publications and local thinking*	Chair = David Flory	Programme Minor Delays
Place-Based Partnerships	B	*Design and implement five mature Place Based Partnershipss within the ICS, in line with national publications and L&SC Place Based Partnerships strategic narrative*	Chair = Geoff Jolliffe	Programme Minor Delays
Commissioning Reform	C	*Plan and implement the transitional commissioning arrangements for 2021/22 and the transactional arrangements to close down eight CCGs by June 2022*	Chair = Roy Fisher	Programme Minor Delays
Acute Provider Collaborative	D	*Planning and implementing models of provider collaboration for acute services*	Chair = David Flory	Programme Minor Delays
Mental Health Lead Provider Collaborative	D	*Planning and implementing models of provider collaboration for Mental Health, Learning Disabilities and Autism services*	Chair = Isla Wilson	Programme On Track
Workforce & Organisational Development	E	*Closedown and disestablishment of 8 x CCGs across LSC, including safe and effective transfer of affected workforce to new NHS L&SC organisation*	Exec Lead = Sarah Sheppard	Programme Minor Delays
Finance	F	*Plan and Implement a Financial Framework for system, place and provider collaboratives*	Exec Lead = Gary Raphael	Programme Minor Delays
Communications & Engagement	G	*Ensuring effective communication and engagement with all stakeholders, including those staff who are affected by the transition of activities associated with the closedown of CCGs*	Exec Lead = Andrew Bennett	Programme On Track
Quality & Safety Assurance and Improvement	H	*Designing and implementing a quality improvement approach for the system*	Exec Lead = Jane Scattergood	Programme On Track

Risk & Issues - Residual Score 15 and over

Risk No	Risk or Issue	Risk Oversight	Risk Owner	Risk / Issue Description	Mitigating actions	Residual Risk Score
R0003	Issue	ICS Dev Oversight Gp	Andrew Bennett	Delay in Bill progressing through Parliamentary processes results in a further delay in the publication of national policy / guidance which RISKS a relatively short timeframe for implementation in the second half of 2021/22 which will coincide with operational pressures related to winter and the potential further pressures related to the prevalence of Covid-19 FURTHER DELAYS MEAN THAT THIS IS NOW AN ISSUE	LSC System Development Plan completed based on insight from national/regional team, and workstreams continue to make progress where possible using draft guidance that is available. However, significant dependency on national policy / guidance for system development and workforce workstreams. National guidance all due for publication by mid-September 2021. Majority of guidance now published, although issue remains regarding short timeframe for implementation. Focus now on contents of Readiness to Operate Statement checklist, which outlines minimum requirements by April 2022.	15

ICS Development - Objectives					
ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
A01	**Produce an agreed Strategic Narrative which describes what it means to be an ICS in L&SC**	Andrew Bennett		31/03/22	Complete
A02	**Define the ICS structure**	Andrew Bennett	National guidance published. Further review required to support design of ICS structure. Linked to requirements of ICB and broader governance arrangements. Scoping session re ICS functions arranged for 13.10.21, which will consider CCG statutory functions and wider corporate functions to be undertaken by the ICB, mapped into key groupings (to inform governance and leadership models) and into system/place (to inform potential delegations)	29/06/22	In Progress but with minor issues/delays
A03	**Define the future functions of the LSC NHS Body, aligned to national guidance and local ways of working at system and place**	Andrew Bennett	Three key pieces of work are underway: 1. Strategic commissioning functions 2. Corporate functions 3. 'Accelerator' areas Named directors have been identified for accelerator areas, to act as transitional leads on behalf of the system, giving them authority to direct relevant resources into delivery at system level and across the five places: Primary and community services integration – Peter Tinson Population health management – Dr Andy Knox working with Peter Tinson Nursing and Quality – Jane Scattergood Communications and engagement – Neil Greaves Named Directors will seek to ensure that staff are deployed optimally to deliver system and place-based partnership priorities and support staff to manage any conflicting priorities and workload pressures (staff wellbeing to be a key consideration). A separate piece of work is also underway to consider patient facing services currently provided by CCGs/CSU.	29/06/22	In progress but with significant issues
A04	**Define the future ICS Governance**	Andrew Bennett	Proposals for future system governance in development - originally drafted based on draft national guidance; now being updated against published guidance. This will encompass the national requirements (ICB and its Committees, along with the Constitution) and local recommendations. ICB Establishment Timeline received and proposed approach to key actions within this (and related to the ROS checklist) to be discussed at ICS OG. Further work on the LSC H&CP will be considered in line with national publication on Place Based Partnerships and in conjunction with further local discussions re HWBs and priority areas that the partnership should focus on - these are being progressed initially via UTLAs/health CEOs/Chairs meeting. Engagement completed on options for place-based governance arrangements as set out in ICS Design Framework and Thriving Places guidance. Preferred option agreed by Place Based Partnerships DAG and for agreement at ICS OG. Supporting development programme also agreed.	29/04/22	In Progress but with minor issues/delays
A05	**Develop and agree ICS Leadership model & OD programme**	Andrew Bennett Sarah Sheppard	Chair of LSC ICS confirmed. Recruitment to Chief Officer role now underway, subject to national recruitment timetable - likely to be concluded mid/late October 2021. Recruitment to further mandated director roles (DoF, MD, DoNQ) will follow in Q3/4 - role outlines not yet received from NHSEI. Design of LSC Leadership structure underway and will be further informed by work on system functions and ICB governance. Clinical leadership work - national guidance received, with associated support offer, and national workshop held on examples of good practice. T&F established. Design of OD programme at system level yet to commence, although scoping and design of place-based programme is underway.	31/03/22	In Progress but with minor issues/delays

A06	**System Development Progression - provide assurance to NHSEI & Region**	Andrew Bennett	Further submission of SDP required by mid October 2021, with subsequent peer review process and individual discussions within LSC. Noted that focus by April 2022 is to complete minimum requirements that will ensure safe and effective closedown of CCGs and establishment of new organisation and associated leadership and governance arrangements . Wider transformation will take a longer transition period. Therefore, progress will be assessed via Due Diligence Checklist (focused on CCG closedown, and reported via CCG TB) and on Readiness to Operate Checklist (focused on ICB establishment, and reported via ICS OG).	29/04/22	In Progress no issues/delays
A07	**Develop and agree arrangements for Partnership working with Local Government (LGA Support Offer)**	Andrew Bennett	Areas of focus confirmed as: Intermediate care for adults and Children's complex packages linked to transition. Work is underway with relevant leads from LSC and the LGA to deliver these programmes. Engagement with local government continues across the majority of the system development programme, including ICS governance, clinical/professional leadership, place-based partnership development. Specific discussions ongoing with UTLA CEOs.	30/06/21	In Progress but with minor issues/delays

Place-Based Partnerships - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
B01	**Develop and agree the Place Based Partnerships Strategic Narrative**	Vicki Ellarby		30/06/21	Complete
B02	**Develop and agree the Place Based Partnerships Maturity Matrix**	Sarah James		30/03/22	Complete
B03	**Develop and agree the scope the Place Based Partnerships Development Programme**	Place Based Partnerships Programme Directors		31/03/22	Complete
B04	**Overarching Themes and Success Measures for places**	Place Based Partnerships Programme Directors	Overall there is significant progress with many deliverables being completed at local level. Key issue is the development of the Balanced Scorecard. Timescales for balanced scorecards currently being revised in light of need to connect to work on priority setting with the L&SC Health and Care Partnership. Proposal agreed at ICS Development Oversight Group in September, with revised timescales to February 2022.	31/03/22	In Progress but with minor issues/delays
B05	**How we will organise ourselves to work together as partners**	Place Based Partnerships Programme Directors	Some delays have been experienced due to capacity and timing of meetings to support sign off of Partnership Agreements	31/03/22	In Progress but with minor issues/delays
B06	**Place-based leadership and implementation**	Place Based Partnerships Programme Directors	Steady progress is being made especially re: OD programme however some timescales have hit delays due to capacity and availability of key leads. National timescales have also been delayed in regard to the appointment of the ICS Chief Officer which has moved to October 2021. This in turn has impacted on the development of the Place Based Leader role. Proposals for place based leaders role and recruitment will form part of update to ICS OG on 12.10.21	31/03/22	In Progress but with minor issues/delays

Commissioning Reform - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
C01	**Define transitional Commissioning governance arrangements**	Andrew Bennett		30/06/21	Complete
C02	**Develop and agree transitional functional allocation of resources**	Andrew Bennett	Whilst any proposed significant changes will need to wait until after the establishment of the new ICB, in line with national HR guidance regarding management of change, work to develop new operating models and resourcing proposals to inform transitional arrangements for 2021/22 was due to be presented for consideration at the CCG TB and then ICS OG for agreement during October. Unfortunately it has not been possible to progress this work as planned. The work has been paused pending completion and sign-off of a Data Sharing Agreement between NHS system partners. A revised timeline for this work will be confirmed once the DSA has been agreed by all partners.	31/12/21	In progress but with significant issues

C03	**Agree plan for transactional close-down of CCGs in line with due diligence, checklist and guidance**	Denis Gizzi Helen Curtis	MIAA have provided a briefing note regarding the developments in the guidance to date, the additional guidance was published on 19 August 2021. We are now liaising with MIAA to match the guidance to the outline programme plan in order to finalise MIAA had developed an outline programme plan based on the anticipated due diligence checklist which has now been published as part of the national guidance to base the programme plan. External support secured (from MIAA) who will provide programme management support. Representatives from MIAA attend the executives and governance groups. Programme plan is in the process of being populated and will be submitted to the Transition Board October 2021.	29/06/22	In Progress but with minor issues/delays

Acute Provider Collaborative - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
D01	**Acute Provider collaboration models: Defining the vision and purpose**	Sam Proffitt Gemma Stanion	Initial draft completed, engagement session took place for trust boards and national leads on 23rd September. Work will now progress to finalise	31/03/22	In Progress no issues/delays
D02	**Acute Provider collaboration models: Governance, accountability and leadership**	Sam Proffitt Gemma Stanion	Initial draft completed, engagement session took place for trust boards and national leads on 23rd September. Work currently underway around developing the governance architecture that will sit under the PCB	31/03/22	In Progress no issues/delays

MH Lead Provider Collaborative - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
D03	**Workforce transition: Ensure strategic and placed based commissioning, support impacted workforce through transition .**	Steve Christian Fleur Carney	The system needs to build its commissioning model for mental health, learning disabilities and autism services from a position of certainty and consensus for staff and local organisations. The Programme has established a 3 month baseline diagnostic with the ambition in developing a target operating commissioning model proposal involving CCG/NHSE, LSCFT and ICS teams. This will comprise a 4 stage process, led by a task and finish group: 1. Baseline Current Operating Model 2. Design 3. Test 4. Publish Target Operating Model A group 'commissioning for the future' has been established to formally review current and future level governance and commissioning models for Mental Health, learning Disabilities and Autism services. This group will be aligned to the wider system reforms and report through to the System Transition Board for MH, LD&A. An initial meeting is in place for 6th October to run fortnightly. The diagnostic will assess assets to deliver an effective an commissioning function in line with principles set out in the national guidance for NHS reforms, including people and roles.	31/12/21	In Progress no issues/delays
D04	**Due diligence: Ensure clarity and consistency in commissioning approach, through further development of a governance framework**	Steve Christian Fleur Carney	As per the workforce update, a group 'commissioning for the future' has been established to formally review current and future level governance and commissioning models for Mental Health, learning Disabilities and Autism services. This group will be aligned to the wider system reforms and report through to the System Transition Board for MH, LD&A. An initial meeting is in place for 6th October to run fortnightly. The diagnostic will assess current commissioning activities and contracts through due diligence. This process will help deliver an effective commissioning function for the future in line with principles set out in the national guidance for NHS reforms.	31/03/22	In Progress no issues/delays

D05	**Planning & service development: Development of collaborative commissioning intentions underpinned by aligned strategies, e.g. MH, LD & A, carers and community health and social care services**	Steve Christian Fleur Carney	Progress A group has been set up for each All Age transformation group and the following work has been done: 1) Chairs & SRO's agreed for each group 2) 1 to 1 meetings took place with Programme Lead and Chair/SROs to discuss the initial stage of work 3) All Age System Wide Transformation Group for LD met and discussed Terms of Reference and the need to review the governance of the groups already in existence Next Steps 1) All Age System Wide Transformation Groups all in diary Learning Disabilities – 15th October, Mental Health – 21st October & Autism – 1st October 2) Look at membership and draft ToRs for All Age System Wide Transformation Groups 3) Programme Brief/Mandate being drafted for each All Age work stream as part of next meetings to look at the vision, strategic & operational drivers, outcomes, benefits, membership, assumptions & constraints, budget & resources, risks, communication & stakeholder engagement	31/03/22	In Progress no issues/delays
D06	**Strategy and communication: Lead, develop and finalise a system wide all age strategy for MH LD& A and communication and engagement plans**	Steve Christian Fleur Carney	Initial engagement sessions completed connecting with over 80 colleagues across the health and care system including VCFSE, LA, primary care, NHS providers and service user / carer representation. The initial sessions allowed teams to come together to review design principles and key ambitions. The end outcome of the work stream is the development of 3 all age system-wide strategies for Mental Health, Learning Disabilities and Autism by March 2022. There is a dedicated team overseeing this work with commissioned support in place from the Transformation Unit.	30/09/21	In Progress no issues/delays
D07	**Governance and Integration: Develop and implement governance structures that support joint decision making, manage conflicts of interest, prevent further fragmentation of service delivery.**	Steve Christian Fleur Carney	As per the workforce update, a group 'commissioning for the future' has been established to formally review current and future level governance and commissioning models for Mental Health, learning Disabilities and Autism services. This group will be aligned to the wider system reforms and report through to the System Transition Board for MH, LD&A. An initial meeting is in place for 6th October to run fortnightly. The diagnostic will assess current commissioning activities and contracts through due diligence. This process will help deliver an effective commissioning function for the future in line with principles set out in the national guidance for NHS reforms. It is likely that there will be a period of shadow form of the new commissioning models from April 22 once the target operating model is agreed following transfer from CCG into ICS.	30/09/21	In Progress no issues/delays
D08	**NHS E LPC Oversight: Transition of NHSE/I specialist commissioning functions into the Provider Collaborative model by 1 st October 2022**	Steve Christian Fleur Carney	CYP inpatient programme and adult secure programme are on track to go live 1st October. Business cases have been signed off subject to financial approval of EPCs and Historic cost pressure within adult services. Case Manager allocation has been agreed through the NW network and LSCFT LPC programme oversight group.	30/09/21	In Progress no issues/delays

Workforce & OD - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
E01	**Develop critical path and key deliverables**	Cath Owen		14/05/21	Complete
E02	**Development of overarching principles and guidance (local)**	Cath Owen		14/05/21	Complete
E03	**CCG closedown/disestablishment (inc. transfer of workforce and relevant HR systems)**	Cath Owen	Awaiting national HR technical guidance in respect of formal transfer of staff and other key HR priorities - due mid-August, however this is understood to be either TUPE or a nationally supported Transfer Order. This is expected to also advise on Board level posts. Membership of CCG closedown group (managed by Helen Curtis) and have developed key actions that will be required, pending guidance (linked to critical path above) Close down activities are being planned and reported via the closedown group which reports into the CCG TB. 22/9 - HR Framework received and key HR issues being reviewed with recommendations put forward via HRRG and for approval at CCG Transition Board. This includes FTC, Secondments and Board Level posts. Workforce Due Diligence templates now available and have been included in overarching People Service Project Plan to manage workforce closedown and transition activity.	31/03/22	In Progress no issues/delays
E04	**Recruitment into NHS LSC senior leadership team and associated governance arrangements**	Cath Owen	Chair confirmed and authorised by NHSEI subject to legislation being approved by parliament. CEO appointment likely to take place during September. Expected that national process will be issued for local implementation. 22/9 Chair appointed confirmed Chief Officer national advert published with selection process to take place in October. Preferred candidate will require national approval via established authorisation process. Further senior leadership posts and board posts will follow the Chief Officer appointment being confirmed. National position given on remuneration levels for senior posts.	31/03/22	In Progress no issues/delays
E05	**Organisational development**	Cath Owen	OD support programme offer made available by NHSEI for AOs and Senior Directors within CCG. OD support programme for all staff to be developed and made available by end of Q3 subject to HR technical guidance. 22/9 OD Programme for senior leadership developed nationally and regionally and continue to be expanded. Support for all other staff will be focused on Health and Wellbeing via action plan developed following regular survey across LSC and establishment of HWB Sub Group (reporting to HRRG).	31/03/22	In Progress but with minor issues/delays
E06	**Staff engagement and consultation**	Cath Owen	Several communications now issued. 2 x all-staff brieifng sessions taken place with 2 further briefings planned in September. Monthly staff bulletin in place with regular provision of FAQs. Staff Side engaged and being regularly updated via establshed formal mechanisms. NW Social Partnership Forum updated on progress. 22/9 Further staff briefings have taken place with updated FAQs to be issued and regular system wide staff communication bulletin now agreed. CCG Staff Partnership Forum provided with regular monthly update and attendance at LSC and North West Social Partnership Forums have taken place to also provide update.	31/03/22	In Progress no issues/delays

Finance - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
F01	**Influence and understand the design of the system level financial framework and the implications for the financial regime**		National guidance is being issued following engagement with ICS' across the country, including L&SC.	30/06/21	Complete

F02	**Develop the system level Financial Planning Framework in response to national guidance**		Draft financial framework discussion document shared with ICS CO during August and CCG CFO and trust DoFs in September. Facilitated discussions among DoFs and CFOs organised for late September/early October.	30/09/21	In Progress but with minor issues/delays
F03	**Implement the system level Financial Planning Framework in response to national guidance**		Draft discussion document issued and facilitated discussion sessions planned.	31/03/22	In Progress but with minor issues/delays

Communications & Engagement - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
G01	**Strategic narrative documents and toolkits for use by senior leaders to set out language and messaging and to shape communications, engagement, involvement with all stakeholders**	Neil Greaves Hannah Brooks	Care Summary Document complete and shared. Place Based Partnerships common narrative updated and shared. Introductory Provider Collaborative statement agreed for internal briefings. Communications and engagement review panel being established to quality check and challenge communications and engagement approaches and materials relating to the system developments commencing in September. Developed glossary and visual of the system for leaders to address consistency of language.	31/03/22	In Progress but with minor issues/delays
G02	**Co ordinating communications and engagement plans for all stakeholders at system and place levels, including those staff who are affected by the transition of activities associated with the closedown of CCGs**	Neil Greaves Hannah Brooks	First engagement meeting on 15 June with Place Based Partnerships engagement leads and Place Based Partnerships programme directors. Outputs of the session include an approach to align Place Based Partnerships engagement plans with consistent timing, approach communications objectives and evaluation methods. Regular meetings between Place Based Partnerships Communications and Engagement leads have been established. Place Based Partnershipss have identified 2x case studies per Place Based Partnerships which are being developed along with system case studies. A survey has been developed and launched collectively which is being shared with staff across place-based partnership organisations as a tracking study of involvement and understanding of vision and purpose of the partnerships linked to the maturity matrix work. Website information developed and Place-based partnerships have asked to be embedded on their websites. Social media schedule of sharing case studies commencing this week to highlight good practice examples and impact of new ways of working.	31/03/22	In Progress no issues/delays
G03	**Oversight, planning and direction to support communications and engagement of system reform across LSC and consistent key messages for staff, providers, partners and public**	Neil Greaves Hannah Brooks	Monthly staff briefings established (first one sent 14.05.21) for staff affected by transition of activities from closedown of CCGs and regular wider stakeholder briefings established (first one sent 28.05.21). Bi-monthly colleague briefings established in July. Regular communications and engagement network meetings to ensure all partners up to date with key messages and language to be used to describe Lancashire and South Cumbria system. First set of MP letters from ICS Chair and Chief Officer produced with updates about system reform (shared 12.07.21). The ICS website has been updated with latest materials and documents. Delivered first Colleague briefing sessions in July and shared video of the sessions plus responses to staff questions raised. Delivered second set of Colleague briefing sessions in September and shared video of the sessions. Working with HR on responses to staff questions raised. Dates planned in November for next Colleague Briefings. Updates to the website including documents, materials, glossary, videos with leaders and case studies (Sept 2021).	31/03/22	In Progress no issues/delays

Quality, Assurance &Improvement - Objectives

ID No	Scope, Objectives, Deliverables	Workstream Leads	Current Activity	Finish	Current Status
H01	**Establish governance arrangements to ensure that quality and safety is managed during the transitional phase of system reform in accordance with national guidance**	Jane Scattergood	CCG extant Quality and Safety arrangements remain in place, until we reach the point where there is sufficient confidence in the new system to delegate responsibility to an ICS Quality Board. NHSEI Regional Quality oversight remains in place, NHSEI have not yet agreed the thresholds for regional involvement post April 2022 and the remit that will be devolved to ICS Quality and Safety oversight. The ICS has a newly established Quality and Performance Committee which reports to the SCC as an interim. Later on in transition we will seek to establish a Quality Board, incorporating some of NHSEI current remit, and make alternative arrangements for performance oversight with strong read across between the two.	30/06/21	In Progress no issues/delays

H02	**Ensure quality and safety activities are maintained during the transitional phase of system reform in accordance with national guidance**	Jane Scattergood	CCG extant Quality and Safety arrangements remain in place, until we reach the point where there is sufficient confidence in the new system to delegate responsibility to an ICS Quality Board. NHSEI Regional Quality oversight remains in place. The ICS Interim DoN and place based quality leads are assured of maintenance of quality and safety activity at time of reporting (27.09.2021). Vacancies within the extant quality teams are a risk to continued assurance, we need to overcome barriers to recruiting to vacant posts, in particular where we are confident that the post will be required in the new structures. This will be enabled by a revised system of essential recruitment proposed at ICS Execs on 27.09.2021 and approved with immediate effect. Quality and Safety oversight and assurance is in line with national guidance.	30/09/21	In Progress no issues/delays
H03	**Establish leadership and workforce arrangements to ensure that quality and safety is managed during the transitional phase of system reform in accordance with national guidance**	Jane Scattergood	Place based quality leaders in post in CCGs, 2x place leaders for nursing are interim, Morecambe Bay and Fylde Coast - needs formalising; placed based quality teams carrying significant vacancies, particularly - West, Fylde Coast and Pennine, some additional support recently provided to Morecambe Bay, Central team supporting West. Number of vacancies carried now presenting significant risk; refreshed recruitment permissions system approved by ICS Execs 27.09.2021 will enable mitigation of risk. Interim ICS DoN in post - substantive recruitment Q3 / Q4; interim Lead AHP recruited, commences in post 01.10.2021 0.4 WTE, needs review and increase in WTE; DoM 1.0 WTE approved - to recruit when permitted to advertise substantive post. .1.0 WTE Head of Quality / Chief Quality Officer, 0.4 WTE Nursing Lead, 1.0 WTE lead for the interface between Quality and Performance, Quality Business manager proposed but not formally presented in business case - to progress. Dedicated Quality post for Maternity - interface LMS and Place, in progress and approved. Dedicated Quality post for CYP - interface CYP Board and Place, to seek approval. Inter-dependencies: ICS structure in development, Interim ICS Chief in place, substantive ICS Chief and Place Based Leaders to be recruited; Performance Director in post 0.4 WTE. Need to map inter-dependencies and describe governance and relationships - this requires all workstreams and recruitment to move at pace so that structures, reporting, governance can be agreed and described. Engagement with "One Team" Quality colleagues both CSU and CCG employed underway.	30/09/21	In Progress but with minor issues/delays
H04	**Design and implement a quality function and associated ways of working for the new NHS LSC body and associated provider collaboratives / place-based partnerships**	Jane Scattergood	ICS Quality and Nursing Structure in development, Interim ICS DoN in post, interim Lead AHP recruited not yet started, DoM 1.0 WTE approved - to recruit when permitted to advertise substantive post. Proposed: 1.0 WTE Head of Quality / Chief Quality Officer, 0.4 WTE Nursing Lead, 1.0 WTE lead for the interface between Quality and Performance. Dedicated Quality post for Maternity - interface LMS and place in progress and approved. Dedicated Quality post for CYP - interface CYP Board and place to seek approval. Need to map interdependencies and describe governance and relationships. Monthly planning days with Place based Quality and Nursing Leads in place, detailed action driven work with re-group and report monthly. Portfolio leads identified for key topics for ICS footprint - matrix of place and topic leadership for each leader. Need to understand from NHSEI where the regional threshold will be for quality and safety oversight. Interdependencies - particularly CHC / IPA; Primary Care; Comms and Engagement; MD & Clinical Leadership; Provider Collaborative. Safeguarding CCG teams of statutory professionals - designates and named professionals; per capita ratio will remain unchanged post transition, need to operate at Place, interface with LA and partners - system leadership and structure in place.	31/03/22	In Progress no issues/delays