
NHS
Lancashire and
South Cumbria
Integrated Care Board
NHS Lancashire and South Cumbria
Integrated Care Board
INFRASTRUCTURE
STRATEGY
2023 - 2040

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Abbreviations

AI	Artificial Intelligence
ARRS	Additional Roles Reimbursement Scheme
BC	Blackpool Council
BWDBC	Blackburn with Darwen Borough Council
BMS	Building Management System
BTH	Blackpool Teaching Hospital
CCG	Clinical Commissioning Group
CDC	Community Diagnostic Centre
CDEL	Capital Departmental Expenditure Limit
CHP	Community Health Partnerships
CIL	Community Infrastructure Levy
DHSC	Department of Health & Social Care
DTOC	Delayed Transfer of Care
ELHT	East Lancashire Hospitals Trust
EPR	Electronic Patient Record
GIA	Gross Internal Area
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
INT	Integrated Neighbourhood Team
IoT	Internet of Things
JFP	Joint Forward Plan
LIFT	Local Improvement Finance Trust
LCC	Lancashire County Council
LSCFT	Lancashire and South Cumbria Foundation Trust
LTH	Lancashire Teaching Hospitals
NHSE	NHS England
NHP	New Hospitals Programme
NHS	National Health Service
NHSP	NHS Property Services
NYC	North Yorkshire Council
OPE	One Public Estate
PC	Provider Collaborative
PCN	Primary Care Network
PCT	Primary Care Trust
PFI	Private Finance Initiative
RAAC	Reinforced Autoclaved Aerated Concrete
RDEL	Resource Departmental Expenditure Limit
S106	Section 106
SDS	Site Development Strategy
UHMB	University Hospitals Morecambe Bay
WFC	Westmorland and Furness Council

Acknowledgements

The conversations which shaped this strategy

Lancashire and South Cumbria Integrated Care Board would like to thank all stakeholders involved in the shaping of this strategy; from staff across the ICB; each of the provider Trusts who make up the Lancashire and South Cumbria Provider Collaborative (Blackpool Teaching Hospitals NHS Foundation Trust, East Lancashire Hospitals NHS Trust, Lancashire and South Cumbria NHS Foundation Trust, Lancashire Teaching Hospitals NHS Foundation Trust and University Hospitals of Morecambe Bay NHS Foundation Trust); North West Ambulance Service NHS Trust, NHS England and the NHS Property Companies (Community Health Partnerships and NHS Property Services).

Conversations were held with NHS staff from a range of disciplines; including strategic estates and infrastructure, finance, sustainability, health inequalities, digital, health and care integration, and planning and delivery to ensure multiple perspectives have been considered and are reflected within this final document.

Further engagement will occur across place and with other public sector partners through the Integrated Care Partnership as we develop our thinking and start our local planning.

Assumptions and baseline

The information used to inform this strategy

It should be noted that throughout this strategy reference may be made to different areas of our infrastructure, segmenting our system across acute and hospitals, mental health, learning disabilities and autism, community and primary care and neighbourhoods. We recognise that an integrated system should not require this type of delineation but have used this for the purpose of this strategy only to illustrate thematic challenges and opportunities.

Data

All data included and/or referenced within this strategy is based on data available at the time of the strategy development in April 2023. No detailed validation has been undertaken of any information, but standard and national datasets have been used to ensure as much consistency as possible. Updating and validating data should be done on an ongoing basis, with figures within this report updated to reflect any changes/ corrections.

Provider information

Provider information has been extracted from the information submitted as part of the 2021/22 ERIC return (published in October 2022)
https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection.
In relation to ERIC data: It should be noted that these figures will not yet reflect the true impact of increases in energy costs seen during 2022 and into 2023. Some illustrative assumptions have been made in Section 1 of this strategy.

NHS property company data

NHS property company information has been provided by Community Health Partnerships and NHS Property Services, with occupancy costs for 2023.

Primary care data

Primary care information has been extracted from the datasets collated as part of the Primary Care Data Gathering and downloaded from SHAPE.

Where specific assumptions have been made around primary care data and/or data has been aggregated for illustrative purposes, the detail of these assumptions will be included in appended documents.

References

This strategy seeks to minimises repetition from other strategy and policy documents, providing context only. This Infrastructure Strategy should therefore be considered alongside several other ICB strategies and plans including; the Integrated Care Strategy, the Joint Forward Plan (in draft at time of strategy development), the Digital Strategy (to be updated in Summer 2023) and the State of the System report. It should also be considered in the context of national guidance and policy.

Many documents will be referred to and all reference documents (including those that have been hyperlinked in the main body) will be attached and/or hyperlinked at the end of this strategy (see Contents for page numbers).

Foreword

Radical transformation, visionary ambition and a bold new narrative for infrastructure.

'I want to be up front with you. We are a system approaching a cliff edge and will need to make fundamental changes to avoid falling off.'

Turning challenges into opportunities: The state of our system report
An overview of the health and care system in Lancashire and South Cumbria in 2023

'We are ready to take action and work very differently'.

Lancashire and South Cumbria Integrated Care System – Our NHS Joint Forward Plan for 2023 onwards

We are at a time of enormous challenge for health and care services. Today, we need to completely re-imagine the way we deliver services across Lancashire and South Cumbria. A paradigm shift is needed to transform our system; to create a streamlined and efficient network for acute and specialist care, deliver more care locally in our communities, and focus on prevention. We will need the **right infrastructure** if we are to achieve our vision of longer and healthier lives for our population across Lancashire and South Cumbria.

The importance of our built and digital infrastructure should not be underestimated, however we have continually under invested in buildings and technology for many years. Today's infrastructure can neither enable nor facilitate the scale and pace of transformation we need.

We face huge infrastructure challenges today in 2023; from the suitability of our physical buildings, to the limited connectivity across built and digital workstreams, to financial and environmental sustainability, to the lack of capital and CDEL restrictions causing inertia, to a lack of resource, to little autonomy over some the spaces we use in health buildings. **We need a strategy that is visionary, holistic and robust. It must be a deliverable, system-wide, multi-partner and mixed-economy strategy, and it needs a fluidity to it that enables us to respond to the inevitable future changes**.

In recent years, we have **made huge progress** across Lancashire and South Cumbria, yet we need to be even **more ambitious**. We are going to need to make increasingly **daring and intrinsic changes to our strategic approach, and in our operational and commercial infrastructure delivery**. The challenges we face today and the need to change gives us huge opportunity for **innovation, imagination** and **creativity** in how we deliver transformation across our system.

This strategy sets out, at a high level, where we are now, where we need to be and the enablers we will need to get there. It is our NHS infrastructure framework for how we re-imagine, transform and transition to 2040.

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Introduction

Our vision for 2040

We will have the right network of NHS and partner infrastructure that enables us to deliver integrated health and care services in safe and quality environments, and that helps prevent people across Lancashire and South Cumbria becoming ill; supporting our population to live healthier, longer lives.

Our future built infrastructure is shaped by our six core infrastructure principles that are at the heart of this strategy. These are:

TRANSFORMATIONAL – our infrastructure will be transformational; enabling new integrated models for both clinical pathways and prevention, whilst improving long term health outcomes. It will support the strategic priorities of our Lancashire and South Cumbria Joint Forward Plan, centred around 3 ambitions:

- **Change the way organisations work together and how the NHS provides services to improve our financial situation.**
- **Move care closer to home, work with partners to prevent disease and reduce inequalities**
- **Enable a standardised, network model of care for the delivery of our clinical strategy**

DIGITAL & SMART – we are blending physical and digital infrastructure together to create a smarter network of intelligent and connected buildings, data and people.

USERSHIP – we will have usership of the right types of spaces to support consistent and high quality care. Our spaces will be in the right place, they will be the right size and with the right occupancy arrangements in place.

GREEN – creating infrastructure that is zero-carbon, zero-impact where possible, environmentally friendly and sustainable, and nurturing to health.

AFFORDABLE – spending within our means and finding new, sustainable, efficient ways of delivering the infrastructure we need.

PLACES – we will actively use our NHS infrastructure in a way that benefits the health of our local communities, supporting and facilitating prevention and addressing health inequalities.

OUR SIX INFRASTRUCTURE PRINCIPLES

Our infrastructure is **transformational;** supporting our three ambitions

Our future is **digital, smart** and intelligent

We have **usership** of the right infrastructure

Our future is **green** and environmentally sustainable

Our future infrastructure is **affordable** and financially sustainable

Our infrastructure shapes healthier **places**

Introduction

A 17-year strategic approach

‘This strategy should begin a step-change in our focus, where we create an irreversible shift towards a long-term, holistic and system-wide health infrastructure, building on the already excellent collaboration across our system.’

What is health infrastructure?

For the purposes of this strategy, ‘health infrastructure’ means the interconnected and interdependent ecosystem of buildings, equipment and technology which supports the delivery of health services to our population. It is both a key enabler, and a significant overhead.

Our NHS infrastructure strategy has evolved from the 2018-19 Lancashire and South Cumbria system estates strategy and has been developed during 2023 through engagement and discussion with a range of stakeholders from across the Lancashire and South Cumbria health system; with open conversations with staff across several different areas of work, organisations and geographies. It reflects and responds to the vision and strategic priorities set out in our Lancashire and South Cumbria Joint Forward Plan.

The ICB will produce a separate digital strategy, and this infrastructure strategy focuses on interconnectivity between buildings, digital systems and technology.

We have never been as well placed as we are today to plan and deliver as a system; supported by the formation of the ICB and our Provider Collaborative we have the ever-increasing mechanisms and emerging governance for more streamlined collaboration and easier integration. By contrast, in previous years we have worked in collaboration, but were not supported by organisational structures that truly enabled long-term system planning and delivery.

This strategy marks a significant point in time for Lancashire and South Cumbria; it is one where we can create an irreversible shift towards collectively building a long-term, holistic and system-wide health infrastructure.

Poor, inefficient and ineffective infrastructure and buildings not only cost the NHS money, but it has a significant contribution towards poor health outcomes. Without high quality environments, supported by the right workforce, excellent digital systems and medical equipment, we struggle to deliver the quality of care we need for our patients and our population. Furthermore, we cannot start to impact and reduce health inequalities locally without the right infrastructure; an infrastructure that both enables health care delivery and prevents people needing health services in the first place.

2018/19 Lancashire and South Cumbria Estates Strategy

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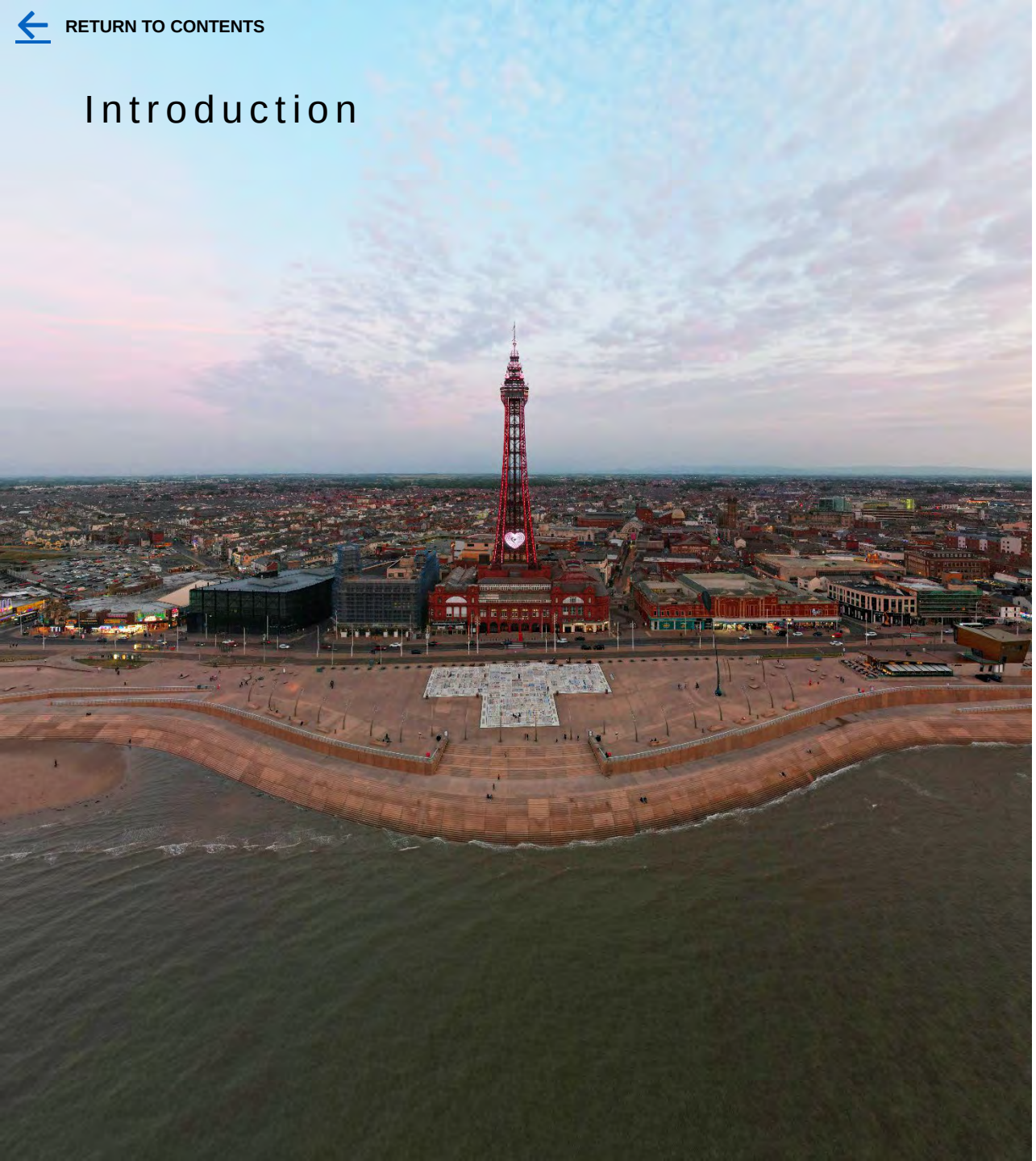
Introduction



We have some big infrastructure challenges across our Lancashire and South Cumbria health and care system that need to be addressed; contextualised by years of under investment, property ownership fragmentation and organisationally siloed working.

During the development of this strategy, discussion was centered around identifying the very real challenges of today and the fundamental, big-system change that is required to address these challenges moving forward. At the same time, we discussed the realistic and smaller-scale opportunities we have at this moment in time. We considered where the NHS needs to facilitate others, where it should lobby, how it can better use its collective voice for healthier infrastructure, and where it needs to be more active as an anchor institution as part of local infrastructure development. We talked about the potential for innovation and the collective determination to create the system-wide network of infrastructure that we need for Lancashire and South Cumbria.

We have a big vision; but we are also pragmatic. We know we want to create a world-leading health infrastructure in Lancashire and South Cumbria, but we know that this must be deliverable.

To start seeing the scale and pace of infrastructure transformation we need, we need increasing system collaboration; working together as network of partners with, and for, each other to deliver a sustainable, efficient, smart and integrated infrastructure ecosystem. We need this strategy to give our system absolute clarity in our collective direction of travel, supported by a framework that forces us to be bold, brave and visionary, with the resulting strategic delivery plans being fully grounded in today's reality.

Our strategy has been developed across several key areas:

Section 1: **Where are we in 2023**
Section 2: **The road to 2040: our infrastructure principles**
Section 3: **How do we get there: approach, buildings and enablers**
Section 4: **The future**
Section 5: **Next steps**

Section 1 of the strategy sets out where we are now. We will set out our local context and the challenges and opportunities for a new model of delivery across our system. We will look at our new ICB organisational landscape and how we can build on the work we are already doing to create the environment for change. We will explore and summarise the context for this strategy and the way that our infrastructure must respond to enable transformation. We will also highlight wider context in relation to changing societal infrastructure; from intelligent buildings to an increased general focus on environmental issues (alongside the NHS requirement for a net-zero NHS by 2040).

We will look at our current position and existing built infrastructure, considering our digital development, our progress to date and our backlog. We will articulate our existing challenges; from delivery, to a lack of funding, to resource pressures, to the areas we need to be clearer on across our ICB before we can progress this strategy further and develop costed delivery plans. We will also consider the areas in which we are already doing brilliant work; from the new hospital programme, to collaboration across our providers, to examples of excellent use of NHS land and buildings for developments that support our health system in the short, medium and long term.

Section 2 of the strategy will consider our infrastructure principles; where we need to be by 2040 and how we will get there. We will consider our requirements for infrastructure transformation to support the short, medium and long term transition in line with ICB strategy across system, place and neighbourhoods. We will consider here how we need to think about reshaping our infrastructure to respond to local and national policy to enable a streamlined and sustainable network model of care across our hospitals and to support more care in our communities.

We will set out our infrastructure principles in more detail; the things that underpin every decision we will make from now until 2040. Our principles are fundamental to our future; we need to develop all our system plans for infrastructure against a shared vision and priorities that everyone is working towards. We know we will need to invest across all parts of our infrastructure, but we also know we need to first do more detailed planning in order to accurately identify how we need to reconfigure our buildings and digital services to support our health and care system.

Section 3 of the strategy will look at the approaches we will take, at how our built infrastructure needs to change, and at our infrastructure enablers. We will look specifically at the requirements across each of the interdependent parts of our system; from how we might transition to providing a network model of care with appropriate infrastructure, to ensure we have a long term strategy for mental health, LD and autism services, to considering the impact moving care closer to home will have across place and neighbourhoods, and the supporting infrastructure ask.

We will explore the way we our infrastructure enables transformation, whilst ensuring we place strategic infrastructure at the centre of the development of our clinical models.

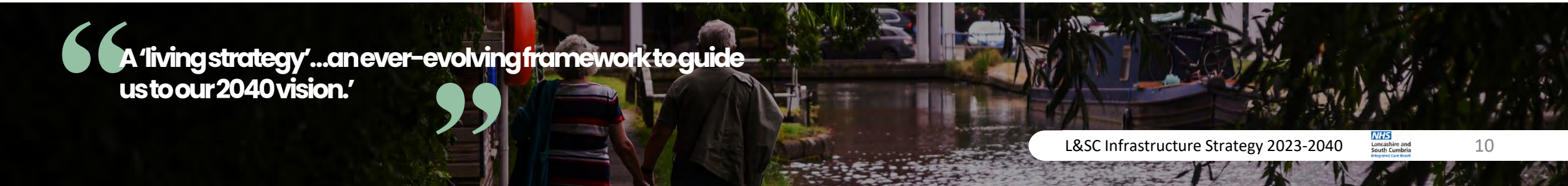
Finally, we will set out the things we need across our infrastructure workstreams, our own enablers for infrastructure transformation; from financial investment to new partnerships, to the evolution of our workforce.

Section 4 will consider our future. We know we must be pragmatic in the development of this strategy, yet we also know we need to be increasingly creative and innovative in how we think and work. Over the coming years, we will need to spend more time looking at the future; horizon scanning and giving ourselves the space and scope to enable generational transformation.

We will consider the 'art of the possible'; some of the areas we should begin to look at over the coming years that can deliver benefits to our NHS system from a fiscal, capacity and outcomes perspective. We will ask questions around how we lever examples of best practice, opportunities to maximise the skills across our system for future generations and start the strategic thinking for the future; where it is probable that AI, robotics, future ways of living, and intelligent design will become integral parts of our NHS infrastructure conversation.

Section 5 of our strategy will consider next steps and recommendations for the remainder of 2023 that have been identified through the development of this strategy.

This strategy is intended to be a 'living strategy'; an ever-evolving framework to guide us to our 2040 vision. It is reflective of our position in 2023 and therefore is subject to ongoing revisions.



Executive Summary

Key observations from our 2023 Lancashire and South Cumbria infrastructure strategy

1. We need to plan and deliver our infrastructure in true collaboration over the next 17 years; **working together, with, and for each other across our Lancashire and South Cumbria system.** We must continue to build on collaboration; becoming ever more mature and strategic in our collective long-term plans.

2. Integration must be at the heart of our infrastructure moving forward; **everything we do should enable integration** (within organisations, between providers to support sustainability of services and functions, across clinical pathways, between physical and mental health, across tertiary, secondary and primary care, between health and social care, and between physical and digital services and infrastructure). We will need to have the right systems, autonomy and governance in place to enable integration through, and across, our infrastructure.

3. Our system infrastructure has a **number of significant and critical independencies** that we must recognise and put at the heart of our plans. We must look at areas including the new hospitals programme, community infrastructure, and centralised services; considering wider impacts such as workforce, consultation, programmes and investment requirements.

4. We **must make best use of what we have** by transforming the way we use capacity across our built infrastructure and our workforce; taking a one-public-estate approach in the way we use space (and extending this to other partners), sharing our skills and expertise, and using our infrastructure to reduce demand on health services through innovative and imaginative use of land and buildings.

5. A **digital and smart infrastructure provides us with huge opportunity for transformation**; from at-home care, to new usership of buildings, to greener spaces, to how we utilise and manage our infrastructure, to evolving our workforce.

6. We must establish a **new symbiotic relationship and dialogue between building use and service strategy**; where both inform and shape the other. Infrastructure is an enabler for service delivery, but at the same time the buildings we have must inform and shape our clinical strategies. This will be fundamental to creating sustainability, flexibility and in ensuring a deliverable transition to 2040.

7. There are opportunities to both **improve and streamline our operational estates and facilities functions and connected services**; we must focus on identifying the short-, medium- and long-term opportunities that best support our six infrastructure priorities.

8. We should leave 'no stone-unturned' and consider all viable opportunities for **realisation of opportunity costs and/or financial benefits** through transformation of infrastructure. Particular attention should be given to infrastructure initiatives and transformations that **identify the potential for recurrent savings** for our health and care system.

9. We need **significant infrastructure investment** across all parts of our system, and we will need a robust investment strategy; one where we are more strategic, targeted and tactical with requirements for the future. We need to set out our updated 0–15-year investment requirements by the end of 2023 and we will need NHS capital and revenue investment to support the development of new infrastructure and to improve our core and flex buildings. Where capital is available, we need to ensure this is spent where it is most needed, with strategically driven system prioritisation. At the same time, we need to develop **alternative funding approaches and solutions** moving forward as part of a **system-wide commercial strategy** to support our wider infrastructure needs.

10. We must consider the **skills we will need across our infrastructure workforce** as we move to an increasingly green, sustainable, data-driven and digital NHS and align this to our workforce strategy.

11. The scale of **decarbonisation is huge**, and we need to fully integrate our journey to net-zero into our infrastructure plans and our service strategy from today.

12. Partnerships will be core to our future success; we need to do more work in developing and realising scalable **partnerships with local stakeholders to maximise opportunities** in infrastructure development, across one-public-estate, through facilitating opportunities for health, care and social value through different use of our land and buildings, in innovation, and in shaping healthier places.

13. To truly create our infrastructure of the future, consideration will need to be given around how to **harness and apply creative approaches, futures thinking and innovation** to realise both qualitative and fiscal benefits to the health and care system across Lancashire and South Cumbria.

Executive Summary

Key areas of focus for transformation 2023-2028

Our core areas of focus for infrastructure transformation **over the next five years** are:

1. Strengthen the existing primary care provision and improve access to primary care.
2. Integrate primary care with community services into primary care networks and develop greater detail around local investment requirements.
3. Develop integrated neighbourhood teams that support proactive prevention and provide integrated care within the community, reducing downstream demand on hospitals, by September 2025.
4. Significantly improve the quality of our provider estate across acute, mental health and learning disabilities pathways – this includes the New Hospitals Programme, the future of the site at Whalley, and improving the quality of life for those with learning difficulties by moving people out of hospitals. It also includes major improvements, refurbishments and new-build phases across other acute and mental health sites.
5. Plan and begin delivery of our out of hospital requirements to support the New Hospitals Programme and wider programmes (including new builds).
6. Improve operational efficiencies across our system's health infrastructure; from acute to primary care.
7. Support achievement of NHS net zero ambitions, including reaching net zero emissions by 2040 for both existing and new estate.
8. Harness our role as an anchor institution. The ICB and its NHS partners have acknowledged the five anchor roles for the NHS in Lancashire and South Cumbria and are working individually and collectively to contribute to the local economy as land and capital asset holders. This is particularly important in consideration of our demographics across our various places and localities.

9. Develop integrated neighbourhood teams that support proactive prevention and provide integrated care within the community, reducing downstream demand on hospitals, by September 2025.
10. Improve health and well-being by offering people personalised choices about their care.
11. Evolve and develop our NHS estates and facilities workforce to respond to our changing infrastructure
12. Develop cross partner digital and intelligent systems to support our infrastructure efficiency, management and transformation
13. Understand our requirements for technology and investment into medical equipment and develop a Lancashire and South Cumbria delivery strategy.

Our infrastructure is **transformational;** supporting our four ambitions

Our future is **digital, smart** and intelligent

We have **usership** of the right infrastructure

Our future is **green** and environmentally sustainable

Our future infrastructure is **affordable** and financially sustainable

Our infrastructure shapes healthier **places**

Section 1

Where are we now

Section 1: Where are we now

Where we are today – our infrastructure landscape in 2023

'Our (Joint Forward) plan has been developed at a time of enormous challenges for health and care services'

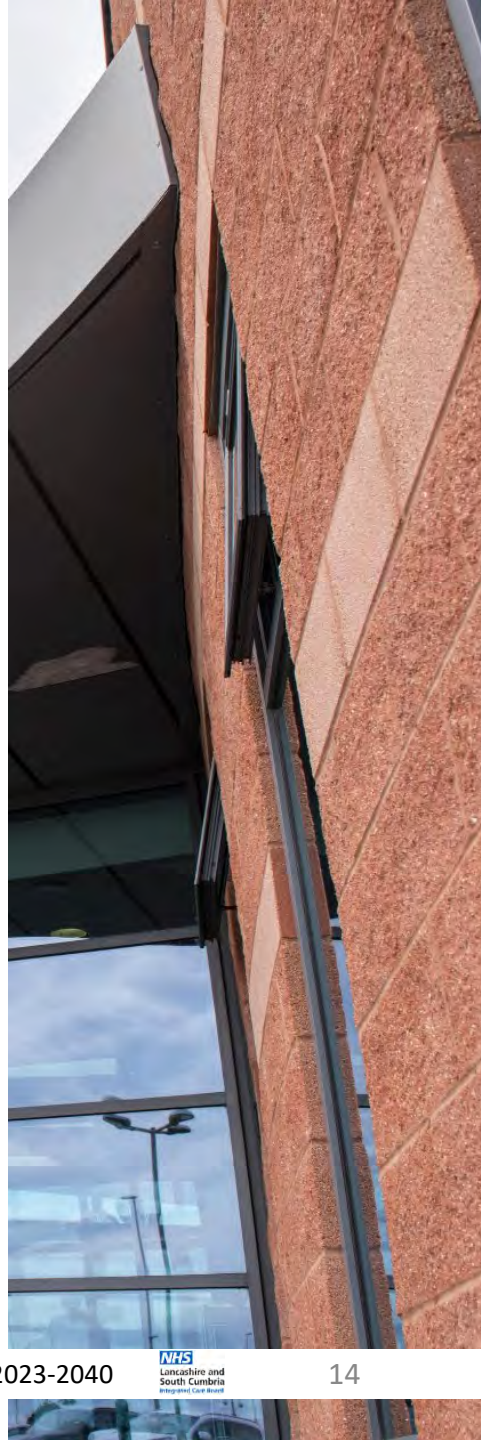
Joint Forward Plan, 2023 (here)

There is a mis-match between the demand for healthcare in Lancashire and South Cumbria and the available capacity, and this gap is widening over time. It impacts on our population, our patients, our staff and our finances. As demand grows, so do waiting times for care. It also creates additional pressure on our valued workforce. As a system we are spending more money on health and care services than we receive in income and this situation has got significantly worse since the COVID-19 pandemic.

In the financial year 2019/20, five of the six hospital trusts were overspending. During the pandemic, funding was provided to cover all the costs in the system but this masked the true underlying position that has not been addressed. The clinical commissioning groups had deficits that were being covered each year through non-recurrent means. The system financial risk is significant but we know what the underlying causes are and how we need to tackle them. The financial challenges are merely the symptom. We must take urgent action to improve the long-term sustainability of the Lancashire and South Cumbria health system by managing increasing demand on our services and transforming the way we use services, staff, and buildings to provide services.

One of the challenges the ICB has identified in the Joint Forward Plan is the quality of much of our built infrastructure inhibits our ability to provide high quality services. Furthermore, many of the other issues and system challenges are influenced, impacted, and in some places exacerbated by our infrastructure – from workforce recruitment and retention, to health inequalities, to a passive population who consume health services on demand, to having a hospital centric system, to siloed working across providers and between partners.

Infrastructure is **a complex, multi-layered and interdependent ecosystem;** it is far more than just 'bricks and mortar' and no single part of our health infrastructure can be considered in isolation. Since our last strategy we have made excellent progress in unpicking some of the complexities across many infrastructure workstreams and have good foundations on which to build our six infrastructure principles. We are currently working towards our NHS net-zero targets, managing and responding to RAAC, procuring an EPR, and continuing to make progress in reducing our non-clinical building footprint across our provider infrastructure. We have examples of brilliant innovation; from the digital innovation of new hospitals programme, to the re-use of NHS land for housing based care models to the use of partner buildings.



Section 1: Where are we now

However, our built infrastructure is not without significant, and sometimes overwhelming, challenge. Despite our system collaboration and integration, we continue to have a fragmented and siloed property landscape, with often conflicting agendas and difficulties across parts of our system. We have issues with non-compliance of buildings, we have huge inequity across our built infrastructure provision and currently have no clear way forward for some of our upcoming infrastructure deadlines; from locally-driven solutions for the end of the LIFT concessions, to being able to identify the investment source for our decarbonisation. Because of poor accommodation, we have challenges in attracting new staff to many of our services and/or geographies and we need the kind of new, advanced facilities that our patients and staff deserve.

We struggle with low land values and therefore are unable to maximise capital 'value' through disposal of surplus land or buildings; we have examples of where we are addressing this already by rethinking our disposal strategy and working with partners on alternative land uses.

Austerity has reduced investment and **current limits on capital and revenue spending are causing system inertia and decline of our health infrastructure**; we can neither improve what we have, nor invest in the future infrastructure we need. Austerity has had a huge impact on social care; negatively affecting the health of our population and putting huge pressure on our health system. We have continuing bed pressures, with social care unable to respond to enable discharge and at home support as quickly as required.

Ageing hospital buildings are causing issues in terms of condition and layout, longer waiting times, risks to patient safety and are making life harder for staff. We need investment into major medical equipment, mental health, learning disabilities and autism, and across our acute and community buildings (our total requirement currently identified as £5.22bn, subject to further work), and we currently need over £180m just to address our provider backlog. Without being able to deliver this system-vision and without the right investment, we will continue to put sticking-plasters on our biggest issues.

2023 built infrastructure overview

- **Nearly ¼ of our health buildings pre-date the NHS**.
- It costs **nearly £300m** per annum to occupy our NHS and GP buildings.
- Despite **reducing our building footprint by 8.8%, our costs have increased by 10.2%** (based on 2019/20 and 2021/22 ERIC data. n.b. this does not reflect any of the 2022-present energy price increases).
- Our current building footprint is just **over 1 million sqm**, which is equivalent to about **147 football pitches**.
- Our current **backlog across our provider buildings is nearly £180m**, with £108m of this being significant, high risk or critical infrastructure backlog (this excludes any required investment into NHS Property Services buildings)
- We identified in **2023 that we need at least £5.22bn investment** including the investment required to completely replace Preston and Lancaster Hospitals.
- We **do not yet know the financial investment required** we need to get our infrastructure **to net zero** or to **adapt our buildings in response to climate change** to ensure resilience, or how this will be achieved.

Section 1: Where are we now

National context

Over recent years there have been several national drivers for the production of infrastructure strategies. These have included the NHS Long Term Plan, Joint Forward Plan, Next Steps on the NHS Five Year Forward View, the Naylor Report, the Carter Report, One Public Estate, the Net Zero Carbon and Sustainability agenda; and more recently the Fuller Stocktake Report.

National programmes around delivery of Community Diagnostic Centers and the NHS New Hospital Programme are both being delivered locally (with Lancashire and South Cumbria being one of the areas identified as needing new hospitals through the NHP, see local programme here).

National tightening of spending has made it difficult to do anything major with our infrastructure beyond identified programmes and committed capital. Policy around PFI extensions, the impact of IFRS 16 and limits on both capital and revenue spending through CDEL and RDEL have been felt locally.

We are approaching the next general election and any new administration may wish to review and refresh current policy and priorities around NHS infrastructure. Therefore, we recognise that this strategy must be adaptable and responsive to any potential changes at a national level.

More broadly, we see continual shifts in our society and across wider industry that we must be cognisant of when we are planning our infrastructure.

Across the commercial and industrial sectors, smart and intelligent buildings are the 'norm' and artificial intelligence is increasingly being adopted and delivered in relation to both infrastructure planning and management.

Other areas we might start to consider are the shifting working expectations of 'Gen-Z' (who will form our future infrastructure workforce), the increased societal interest and trends for sustainability, patient expectations around on-demand care, use of personal health technology, the changing way people are consuming information, and so much more.

We will consider some of these themes in more detail Section 4.

Section 1: Where are we now

Since our last strategy in Lancashire and South Cumbria

Our last system estates strategy was developed in 2018/19. Since then, we have navigated and emerged from the pandemic operating initially in what we thought was our 'new normal'. But we have now transitioned into another stage, one where we see a re-balancing of digital and in-person services, are taking a more blended and agile approach to staff working locations and are seeing increasing use of at home and community patient monitoring using telehealth (including virtual wards).

During Covid, we saw services adapt and evolve at an unanticipated pace across Lancashire and South Cumbria and we worked together as organisations in an unprecedented way; making decisions at pace and with a shared and collective goal. We have been further building on these foundations and are committed to continuing this depth of collaboration moving forward. The 2023 Provider Collaborative Procurement Strategy will further support collaborative working and we now have shared strategic infrastructure resource across several our provider trusts.

Our Provider Collaborative continues to mature and will be key to supporting our health and care system more effectively across our infrastructure disciplines, to maximise the use of our collective resource and expertise.

The formation of The Lancashire and South Cumbria Integrated Care Board as a result of the Health and Care Act 2022 means we now have a statutory body across our health and care system; this will support and enable us to deepen and grow our infrastructure collaboration and our partnerships at both a system-wide and local level, in ways we could not before. Our system in 2023 is clear on its direction of travel, as outlined in our Joint Forward Plan.

Section 1: Where are we now

Lancashire and South Cumbria ICB – governance

Components of the Lancashire and South Cumbria Integrated Care System

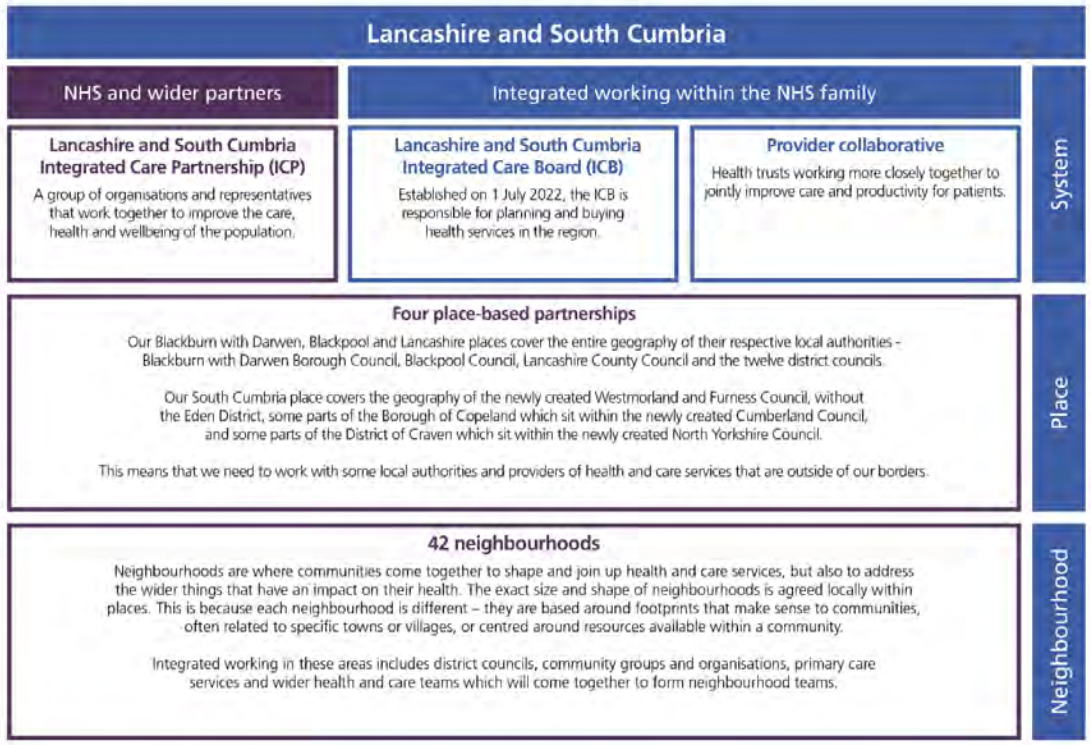


Table extracted from page 7

Lancashire and South Cumbria Integrated Care System – Our NHS Joint Forward Plan for 2023 onwards

*'…we must work in different ways at **three levels** - across the Lancashire and South Cumbria **system**, within our **four places** and at **neighbourhood** level – to organise and deliver services at the most appropriate level and closest to the residents we serve.'*

Lancashire and South Cumbria Integrated Care System – Our NHS Joint Forward Plan for 2023 onwards

How this aligns with infrastructure in 2023

We do not currently have the forums in which to hold the strategic infrastructure conversations at the most senior levels across organisations, and we need to create the right governance. As we develop our infrastructure workstreams, we will need to ensure that our infrastructure governance appropriately reflects the components of our system in 2023, and our ICB governance and decision making across Lancashire and South Cumbria.

For built infrastructure, the ICB takes oversight across all parts of the system where it is responsible for the delivery of services. However, we do not yet have full clarity on who will take responsibility for a variety of strategic and operational workstreams across Lancashire and South Cumbria across system, place and neighbourhood.

Our infrastructure governance must include setting our clearly how we will engage with local authority partners (at both an ICP and place level) in relation to local health infrastructure planning and development, as well as how we work with the provider collaborative who will be responsible for transforming acute care.

Section 1: Where are we now

Lancashire and South Cumbria – our health landscape

System

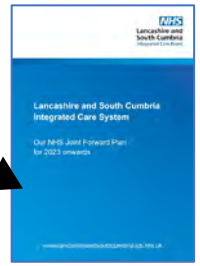
Lancashire and Lancashire and South Cumbria's Integrated Care System was established under the Health and Care Act 2022. It consists of:

Our Integrated Care Board

It is responsible for planning and buying health services in the region for **1.8 million people**, with a budget of around **£3bn per annum** (source).

In March 2023, the ICB published Turning challenges into opportunities: The state of our system report where we set out the very real system challenges we face; along with the huge opportunity for real transformation across our system, for the health of people of Lancashire and South Cumbria.

We have recently developed our Lancashire and Cumbria ICB Joint Forward Plan where we describe how the NHS will meet the health needs of our population. We will consider our strategic priorities in more detail in Section 2.



Our Integrated Care Partnership

A group of organisations and representatives that work together to improve the care, health and wellbeing of the population.

It has developed the Integrated Care Strategy 2023-2028, where it describes how organisations in the Lancashire and South Cumbria Integrated Care Partnership will work together to improve the health and wellbeing of people living and working in Lancashire and South Cumbria.

Our Provider Collaborative

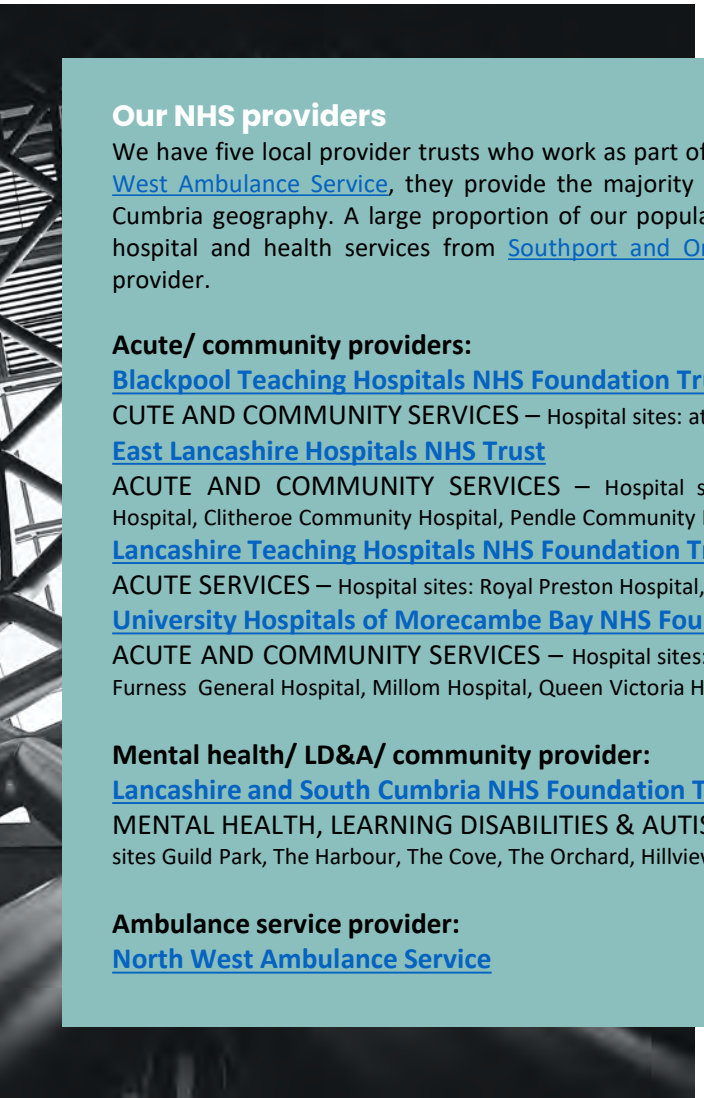
Our local health trusts working more closely together to jointly improve care and productivity for patients.

We know that infrastructure and digital workstreams are all core enablers for the delivery of all our system strategies (including our Joint Forward Plan and Integrated Care Strategy), as well as needing to inform and shape the development of the associated delivery plans over the coming months/ years.

As we evolve this strategy and develop infrastructure plans with partners beyond the NHS, we must consider, and be sensitive to, partner plans and strategies, updating our own infrastructure strategy as required.

Section 1: Where are we now

Lancashire and South Cumbria – our health landscape



Our NHS providers

We have five local provider trusts who work as part of our provider collaborative; along with North West Ambulance Service, they provide the majority of services across our Lancashire and South Cumbria geography. A large proportion of our population in Central and West Lancashire rely on hospital and health services from Southport and Ormskirk Hospital NHS Trust; an out of area provider.

Acute/ community providers:

Blackpool Teaching Hospitals NHS Foundation Trust

CUTE AND COMMUNITY SERVICES – Hospital sites: at Blackpool Victoria, Clifton Hospital

East Lancashire Hospitals NHS Trust

ACUTE AND COMMUNITY SERVICES – Hospital sites: Royal Blackburn Hospital, Burnley General Hospital, Clitheroe Community Hospital, Pendle Community Hospital, Accrington Victoria Community Hospital

Lancashire Teaching Hospitals NHS Foundation Trust

ACUTE SERVICES – Hospital sites: Royal Preston Hospital, Chorley and South Ribble Hospital

University Hospitals of Morecambe Bay NHS Foundation Trust

ACUTE AND COMMUNITY SERVICES – Hospital sites: Royal Lancaster Infirmary, Westmorland Hospital, Furness General Hospital, Millom Hospital, Queen Victoria Hospital

Mental health/ LD&A/ community provider:

Lancashire and South Cumbria NHS Foundation Trust

MENTAL HEALTH, LEARNING DISABILITIES & AUTISM, AND COMMUNITY SERVICES – Hospital sites Guild Park, The Harbour, The Cove, The Orchard, Hillview, Whalley (future)

Ambulance service provider:

North West Ambulance Service

NHS Primary care

42 primary care networks (PCNs) covering 198 GP practices.

VCFSE

There are thousands of voluntary, community, faith and social enterprise (VCFSE) sector organisations and groups in Lancashire and South Cumbria. Partnerships of VCFSE organisations are in place connected through a leadership group called the VCFSE Alliance. A partnership agreement is in place between the ICB and the VCFSE sector, and ever closer working will be strengthened through recent appointments within the ICB.

Healthwatch: Blackburn with Darwen, Blackpool, Cumbria, and Lancashire. All four Healthwatch organisations work collaboratively as Healthwatch Together

Other partners

This includes our local universities, colleges, police, fire and rescue services, and wider industry.

Six upper-tier local authorities

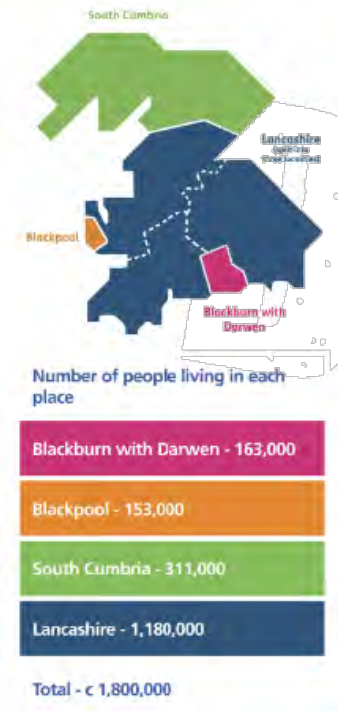
- Lancashire County Council
- North Yorkshire Council (unitary)
- Cumberland Council (unitary)
- Westmorland and Furness Council (unitary)
- Blackpool Council (unitary)
- Blackburn with Darwen Council (unitary)

Twelve district councils

- Preston City Council
- Chorley Council
- South Ribble Borough Council
- Fylde Council
- Wyre Council
- West Lancashire Borough Council
- Lancaster City Council
- Burnley Borough Council
- Hyndburn Borough Council
- Pendle Borough Council
- Ribble Valley Borough Council
- Rossendale Borough Council

Section 1: Where are we now

Lancashire and South Cumbria – the health landscape



Place

These place partnerships are collaborations of health, local authority, VCFSE organisations, independent sector providers and the wider community, working in a joined-up way and taking collective responsibility for planning and delivering services. By working in partnership and with local communities, organisations can better address the biggest and most challenging issues that affect people's health and well-being. Our places will be the engine room for driving delivery of the Integrated Care Strategy and this will be underpinned by the development of our place integration deal. Our Lancashire and South Cumbria places are:

- **Blackburn with Darwen**
- **Blackpool**
- **South Cumbria***
- **Lancashire (3 localities)**

Lancashire localities – Lancashire as a place covers a large area and population and so has been divided further into three localities; North Lancashire, Central and West Lancashire, and East Lancashire.

** There are some areas of South Cumbria which do not perfectly tesselate with the local authority boundaries, but these 'misalignments' are not problematic, rather they are reflective of the populations and local rurality. They do however present us with some challenges around governance and the development of appropriate infrastructure forums at place.*

Neighbourhood

Our 42 neighbourhoods include 198 GP practices, and each cover a much smaller geography that place; based around footprints that make sense to communities, where integrated working will include primary care, district councils, community health and care teams and others. Some of our neighbourhoods are not currently fully defined, and others are not always logical geographically. As we progress our local strategies and plans, we will need to do more detailed work to understand the geographies of our neighbourhoods and how this translates into infrastructure needs.

At system, place and neighborhood level, we will need robust short-, medium- and long-term infrastructure plans.

RETURN TO CONTENTS

Section 1: Where are we now

Our places and their geography

We have a population of 1.8million people across Lancashire and South Cumbria. **Our geography is mixed**; from coastal communities to urban centres, with excellent motorway and road connectivity in some areas, and extreme rurality with mountainous terrain and narrow, single-track roads in others. We have pockets of affluence but **some of the most deprived neighbourhoods in the country; along with some of the worst health inequalities (see our Joint Forward Plan for more detail, with a summary of our places detailed below)**.

Lancashire and South Cumbria is an exciting place to be; we are at the forefront of the future of healthcare infrastructure with the work underway with the NHP; our local authorities and community groups have received over £400m from the Levelling Up funds to support a variety of projects and local investment programmes and there is extensive regeneration underway across many of our towns and places.

We will need a built and digital infrastructure responsive and receptive our places. Whilst we will take a common approach as set out within this strategy, we must develop local solutions in the context of place, their geography and their populations; there will be no one-size-fits-all solution.

South Cumbria **has a resident population of around 311,000 people.**
A mixture of coastal and rural areas, with some wealthy and some disadvantaged communities. The area stretches from Barrow-in-Furness - a busy shipbuilding town and port and Millom on the west coast, through South Lakeland with its rural, land-based and thriving visitor economy, across to the area around Bentham in North Yorkshire. This is England's most sparsely populated local authority area, which makes it hard to deliver services and to provide public transport and transport connections.

Lancashire **has a resident population of around 1.2 million people.**
It is a varied place from the high moorland of the South Pennines to the flat expanse of the Fylde Coast and the countryside of the Ribble Valley and Forest of Bowland. A combination of urban areas including Preston and Lancaster, former textile towns such as Burnley, coastal resorts, and market towns. A mixture of wealthy and disadvantaged communities. In the more rural areas, poverty and social exclusion happen alongside people living in luxury. Large areas of deprivation can be found in East Lancashire, Morecambe, Skelmersdale and Preston.

Blackpool **has a resident population of around 153,000 people.**
An urban coastal area, with a thriving tourist economy and a strong sense of community. With high levels of deprivation and a transient population, Blackpool residents have some of the most complex health needs in the country.

Blackburn with Darwen **has a resident population of around 163,000 people.**
A semi-rural borough with urban areas around the towns of Blackburn and Darwen, and several small rural villages and hamlets. A multicultural borough, the area is home to many people with diverse ethnicities and identities.

Section 1: Where are we now

Our demographics

Increasing demand

Some 1.8 million people are registered with Lancashire and South Cumbria GP practices and this number is expected to rise to 2.05 million by 2033. The health and well-being of our population is variable, depending on the neighbourhood and place in which people live. We have a **significant number of people living with complex long-term diseases** (sometimes called the disease burden) and the **demand for healthcare is rapidly increasing**. This is being driven by deprivation and unhealthy lifestyle choices but is also affected by ways of working that often see the NHS largely working separately from the other organisations which support health and well-being.

Life expectancy

Life expectancy in Lancashire and South Cumbria is **lower than the national average** – by almost a decade in some areas. There is also a **large variation in the number of years people can expect to live a healthy life**. Babies born in this area today have a healthy life expectancy that is lower than the expected state pension age of 68. In some areas, healthy life expectancy is as low as 46.5 years, although this varies significantly across our communities. The health of our communities also varies significantly.

The healthy life expectancy across Lancashire and South Cumbria is affected by **the levels of deprivation and poverty** within our communities. Factors such as housing, the quality of the living environment, levels of education, crime, digital exclusion and employment all have an impact on health. The level of deprivation in an area is measured by the Index of Multiple Deprivation (IMD). Statistics show that in the most deprived areas in England, the healthy life expectancy is only around 50 years, whereas those in the least deprived areas, can expect to live in good health until they are over 70. This is important because **almost a third of people in Lancashire and South Cumbria live in some of the most deprived areas of England**.

Our areas of significant deprivation include wards within Blackpool, Blackburn with Darwen, Burnley, Hyndburn and Barrow. It is a real concern that 11 of the 14 areas in Lancashire became more deprived between 2015 and 2019. At ward level, 17 (or six per cent) of the wards in the Lancashire area are in the one per cent most deprived of all the 7,408 wards in England. These include six wards in Blackpool, eight in East Lancashire and one each in Preston, Lancaster and Wyre. The level of deprivation can have a real, daily impact on people's lives and their ability to feed their families, heat their homes and support their children.

The percentage of children living in poverty across Lancashire and South Cumbria ranges from a low of 12 per cent to a high of 38 per cent, compared with the national average of 30 per cent. **Our health inequalities were starkly exposed during the COVID-19 pandemic**, where people from our deprived communities had a higher-than-average likelihood of being admitted to hospital with the disease. A significant proportion of children in these communities experience poor living conditions which can affect their development, readiness for school and their future life chances. This can also have long-term impacts on their health and well-being and leave them more likely to need healthcare in future.

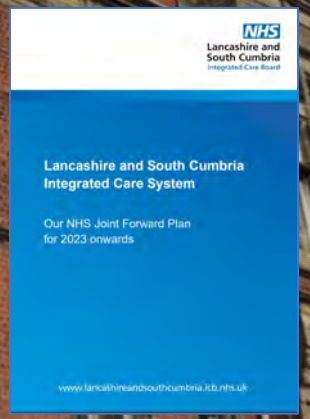
Section 1: Where are we now

Lancashire and South Cumbria ICB Strategy

The ICB corporate strategic objectives

At the inception of the ICB, we set six **corporate strategic objectives** (these include the NHS triple aim to improve the health and wellbeing of our population; improve the quality of services provided; and achieve a sustainable use of our resources). The ICB will take account of contributions towards these objectives within its decision-making and evaluation processes.

Equalise opportunities and clinical outcomes across the area	Improve quality, including safety, clinical outcomes, and patient experience	Meet financial targets and deliver improved productivity
Make working in L&SC an attractive and desirable option for existing and potential employees	Meet national and locally determined performance standards and targets	Develop and implement ambitious, deliverable strategies



Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

The below information is from our Joint Forward Plan Summary. This infrastructure strategy is shaped by the plan's vision, strategic priorities and the ways we know we are making a difference. We will explore how our infrastructure needs to respond to each of these priorities in Section 2.

Our shared vision

NHS organisations across Lancashire and South Cumbria have a shared vision for our population to live longer and healthier lives which will be enabled by:

Healthy communities	**High-quality and efficient services**	**Health and care services that are centred around the needs of our communities and offer high-quality employment opportunities for our workforce**

Our strategic priorities

The NHS in Lancashire and South Cumbria is committed to working with health and care partners on five priorities:

1. **We must strengthen our foundations by changing how organisations work together and how the NHS provides services to improve our financial situation.**
2. **We must take urgent action to reduce the level of long-term disease, working with partners to prevent illness and reduce inequalities.**
3. **We must move care closer to home wherever possible, strengthening primary and community care and integrating health and care services.**
4. **We must make sure there is more consistent and high-quality care. We will standardise, network, and improve our pathways of care.**
5. **We must take targeted action to deliver world-class care for priority diseases and conditions, population groups and communities.**

How will we know we are making a difference?

Strengthen our foundations	Improve prevention	Improve and transform provision	World-class care
We will have improved sustainability and an improved financial position.	We will have improved healthy life expectancy in our communities.	We will have improved and seamless care provision within our neighbourhoods. We will have improved quality of care across organisations	We will have improved pathways of care across Lancashire and South Cumbria and deliver national recommendations for world-class care.

Section 1: Where are we now

Our principles; where are we in 2023

Our six core infrastructure principles are at the heart of this strategy. This is where we are today in relation to each of our principles.

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

Our infrastructure is **transformational**

Our infrastructure has already enabled significant transformation, but this is no longer at either the scale or the pace we need. We find ourselves **needing to accelerate our plans and timelines for transformation**; from our strategic service planning, to our strategic infrastructure planning, to the transformation of our operational estates delivery.

Our infrastructure is **too hospital-centric, does not focus on prevention and does not maximise economies of scale** across providers, or wider partnership opportunities as much as it could. We have not yet mapped and assessed the impact of the new hospitals model of care across existing tertiary, secondary and out-of-hospital infrastructure, or defined the resulting future needs for community and non-clinical infrastructure . Our new hospitals programme is leading some of our most innovative thinking, but we have not yet translated how we use this as a catalyst for change more broadly across our wider infrastructure; sharing, testing and implementing innovation from today to enable system-wide improvements.

Our future **is digital, smart** and intelligent

We are in the process of developing our updated digital and data strategy, which will be published in 2023. We are increasingly **considering the requirements for, and impact of, a digital infrastructure on our health and care system**; from the connectivity of our medical equipment to the possibility in usership opened up to us through better systems, to new opportunities for at home patient monitoring. Technology and digital systems are becoming increasingly significant; they are the bedrock of our health system's infrastructure. Currently, we are in the process of procuring an EPR across our providers which will support us to enable a more flexible and agile model of service delivery and building use. We have new telephony systems across primary care to support a more agile workforce, but we have issues with connectivity across many of our more rural areas.

We have BMS systems across our providers, but these are not always used to their full potential. We **have not mapped the potential for a digital and intelligent built infrastructure**; we do very little with IoT technologies, we do not use our data in a connected and intelligent way, and we are not yet fully aligning our infrastructure delivery plans with our digital strategy (outside of the new hospital programme) across all parts of the system.

We have **usership** of the right infrastructure

The term 'usership' is now a frequent part of our vocabulary and we are increasingly moving away from the need to own buildings for the use of individual organisations in Lancashire and South Cumbria. **We continue to make excellent progress in developing our concept of usership**; this is supported by all our provider trusts and is echoed in the work being done across the provider collaborative to make best use of 'system infrastructure'.

Section 1: Where are we now

Our principles; where are we in 2023

We **continue to take a one-public-estate approach**; the ICB having consolidated ex-CCG accommodation and moved into two new workspaces with Lancashire County Council HQ at County Hall in Preston and alongside Lancaster University at their Health Innovation Campus. Not only has this generated significant recurrent savings, but it supports our local authority and academic partners through use of their space and facilitates the development of closer and more integrated working through co-location. We have also worked with local partners to place ARRS (Additional Roles Reimbursement Scheme) staff across primary acre networks.

Less traditional locations – During Covid, we delivered vaccine centres using high-street spaces and we are currently looking at options for health on the high street for several of our other services. We are delivering clinics and consultations in leisure centres in South Cumbria to support local economies and to facilitate a 'left-shift' through environment and infrastructure choices (see more information).

Flexibility - Whilst applying the user-ship principle, we currently **do not always have the right relationships/ occupancy agreements in place with landlords** and building owners to enable us to have enough local flexibility and autonomy of the space we use.

The right infrastructure - Alongside taking a user-ship approach, we should also ensure that we are using infrastructure that is good quality and is supporting our other infrastructure principles. We are starting to strategically categorise each of our buildings as core, flex and tail (see Section 3) in line with service needs, backlog, compliance, net-zero and other investment requirements.

Our future is **green** and environmentally sustainable

The environmental sustainability and the decarbonisation of the NHS is building in momentum and traction across our system, and we have been doing lots of great work as we continue our journey to net-zero, but there is still an incredibly long way to go.

Each of our provider trusts now has a Green Plan (see right), as do each of the NHS property companies and our ICB. The ICB has recently completed a review (undertaken by Ramboll) across the majority of provider sites, looking at the potential cost of, and ability in, achieving net-zero across buildings on each site. We are at the point we need to progress this work to understand the potential for re-shaping provider sites and identifying investment requirements for decarbonisation in line with our core, flex and tail categorisations, but we currently do not have enabling money to progress this work. We do not have clarity in relation to the responsibility of/ funding for the decarbonisation of buildings owned and managed by to the property companies (including the LIFT portfolio).

Across our provider sites, we have increased EV Charger provision by 87.8% from 2019/20 – 2021/22, however the numbers are still very small, with only 77 chargers at the time of the last ERIC return.

Green plans

NHS Lancashire and South Cumbria ICB here

Blackpool Teaching Hospitals NHS Foundation Trust here

East Lancashire Hospitals NHS Trust here

Lancashire and South Cumbria NHS Foundation Trust here

Lancashire Teaching Hospitals NHS Foundation Trust here

University Hospitals of Morecambe Bay NHS Foundation Trust here

North West Ambulance Trust here

Community Health Partnerships here

NHS Property Services here

Section 1: Where are we now

Our principles; where are we in 2023

Our infrastructure is **affordable** and financially sustainable

Our infrastructure is **an NHS overhead that currently costs a significant amount of money** to own, use and manage; £274m per annum. We have a hospital-centric infrastructure; hospitals by their nature are more expensive to build, run and occupy, yet we deliver a lot of services out of our hospital buildings that we could deliver elsewhere. Across all parts of our system, **our building running costs continue to increase even as our footprint reduces**, and we have not yet seen the 2022/23 energy increases reflected in our data. We have duplication and replication across our estate and facilities workforce and in the provision of accommodation across our built infrastructure, whilst we have gaps in other areas. We have excellent examples of infrastructure used for system-benefit and long-term financial sustainability; such as the use of land at Burnley General Hospital for the delivery of affordable extra care and key worker accommodation.

Our infrastructure shapes healthier **places**

In 2023, we are making the connections between place and health and infrastructure in more tangible ways; we are beginning to develop our land for prevention and hospital-avoidance, we have implemented health on the high street, are delivering one-public-estate projects and are co-locating health in leisure, voluntary sector and academic buildings. We do not currently have visibility around a lot of the spaces we could use locally; we know we need to build our infrastructure from the 'bottom up' across place and neighbourhoods to help to reduce health inequalities.

We are evolving as anchor Institutions to be able to support and develop the broader economy and society and we will start to cement this at place and through system wide strategic infrastructure conversations. Lancashire and South Cumbria have been granted £400m Levelling Up funding across a number of projects, but we have not yet mapped as a system if there may be any opportunities to better align health requirements with these projects as they progress.

Section 1: Where are we now

Our NHS buildings in 2023

We have a ‘mixed bag’ of buildings; pockets of excellent quality infrastructure and some of the poorest NHS sites in the country.

We have had significant investment in some locations, with NHS capital builds, PFIs, LIFT and third-party GP developments across some geographies. But we have incredibly poor buildings in other areas. This means we have great inequity and disparity around quality across our built infrastructure. We need extensive community investment, two new hospitals and significant investment across our mental health, learning disabilities and existing hospital sites.

The built infrastructure landscape

Our building ownership is complex. It is fragmented across multiple NHS providers, NHS property companies, GPs and public and private sector landlords.

The impact of a fragmented system

Like many other NHS systems, infrastructure planning across Lancashire and South Cumbria has often been siloed and disconnected. We saw this intensified over a decade ago with the impact of the Health and Social Care Act (2012); both through the transfer of PCT buildings to national property companies, and through estates decisions that were taken commercially as part of various tender process that were misaligned with a system wide infrastructure approach.

Ongoing fragmented management and planning has meant that cross-organisational opportunities have not always been maximised. In recent years, the ICS made significant progress in bringing together partners, especially across the provider trusts and this continues to strengthen through the Provider Collaborative.

Making further progress at pace is hindered by a lack of ICB-wide strategic infrastructure resource to engage in local, regional and national conversations about funding, innovation, partnerships, digital and built infrastructure.

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

Section 1: Where are we now

Our NHS buildings

How much do our health buildings cost to occupy each year?

£274m

Our provider trusts spend 8% of this (over £22m) in energy & water each year
(as per most recent ERIC returns)

Our total footprint is over 1 million sqm

Our building types

Hospitals	59%	total GIA &	49%	total occupancy cost
Comm hospital	3%	total GIA &	2%	total occupancy cost
MH and LD	7%	total GIA &	5%	total occupancy cost
Community	14%	total GIA &	27%	total occupancy cost
Primary care	7%	total GIA &	5%	total occupancy cost*
Ambulance	0%	total GIA &	0%	total occupancy cost
Staff workspace	4%	total GIA &	3%	total occupancy cost
Other	6%	total GIA &	9%	total occupancy cost

Most activity takes place here, but it only represents 21% of our footprint

*notional rent only
Occupancy includes E&F and energy for all other building types (and full occupancy for community)

We currently need to invest over £178m in our providers' built infrastructure, just to address our backlog maintenance.

The NHS property companies collectively have over 164,000sqm across their buildings. This is 15.7% of our total footprint. It costs over £50m each year. This is about 21.2% of our occupancy costs.

We have nearly 400 health buildings

24% of them were built pre 1948
46% of our buildings were built from 1948-1994
30% were built between 1995 and today

Section 1: Where are we now

Our NHS buildings

We have looked at our existing NHS buildings across each of our places and localities to give an overview of current condition, suitability and quality. This is a summary for each area only and is not representative of individual buildings, rather a general picture across the place/ locality. For example, there may be an example(s) of an excellent primary care premises in a place where overall the condition of the primary care buildings has been identified as Poor (in red).

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

Table key

- Generally building quality and suitability is excellent or good (some investment required)
- Building quality and suitability is generally okay, or there is mix of building quality across this category (significant or extensive investment required)
- Generally building quality and suitability is poor or very poor (significant and extensive investment required)
- Category n/a (no identified site exclusively in this category*)

**there may be buildings of this type, but these are not identified as individual sites on the ICB database – for example, there will be staff workspaces on may hospital sites, but these will be included under the hospital site category.*

RAG rating by building type

Blackburn with Darwen

Hospitals	Comm Hospitals	MH, LD&A	Community	Primary Care	Staff workspace
Green	Black	Yellow	Green	Yellow	Green

Blackpool

Hospitals	Comm Hospitals	MH, LD&A	Community	Primary Care	Staff workspace
Yellow	Black	Green	Green	Yellow	Green

Lancashire (Central and West Lancashire)

Hospitals	Comm Hospitals	MH, LD&A	Community	Primary Care	Staff workspace
Red	Black	Yellow	Red	Yellow	Green

Lancashire (East Lancashire)

Hospitals	Comm Hospitals	MH, LD&A	Community	Primary Care	Staff workspace
Yellow	Yellow	Yellow	Green	Yellow	Black

Lancashire (North Lancashire)

Hospitals	Comm Hospitals	MH, LD&A	Community	Primary Care	Staff workspace
Red	Yellow	Yellow	Red	Yellow	Green

South Cumbria

Hospitals	Comm Hospitals	MH, LD&A	Community	Primary Care	Staff workspace
Yellow	Yellow	Yellow	Yellow	Yellow	Black

Section 1: Where are we now

Backlog in 2023

The **condition of our hospital estate has a marked impact on the quality of care** we can provide, impacts our ability to recruit, and limits our ability to transform care. Our capital allocation is being spent on maintaining our ageing estate and equipment rather than on innovative transformation projects. All our hospitals were built many years ago, developed for far fewer patients and to meet historical care standards. They are now functionally and physically obsolete. This impacts on overcrowding, and creates risks around infection and patient experience.

£165.7m across our acute and community hospitals
£1.5m Accrington Victoria Community Hospital, Accrington (ELHT)
£19.2m Blackpool Victoria Hospital, Blackpool (BTH)
£1.7m Royal Blackburn Hospital, Blackburn (ELHT)
£18.2m Burnley General Hospital, Burnley (ELHT)
£6.1m Chorley and South Ribble Hospital, Chorley (LTH)
£3.9m Clifton Hospital (BTH)
£0m Clitheroe Community Hospital, Clitheroe (ELHT)
£21.2m Furness General Hospital, Barrow (UHMB)
£36.1m Royal Lancaster Infirmary, Lancaster (UHMB)
£0.5m Millom Hospital, Millom (UHMB)
£0.4m Queen Victoria Hospital, Morecambe (UHMB)
£1.7m Pendle Community Hospital, Nelson (ELHT)
£46m Royal Preston Hospital, Preston (LTH)
£9.2m Westmorland Hospital, Kendal (UHMB)

£3.1m across our mental health and LD
£1.2m Guild Park, Whittingham (LSCFT)
£1m Hillview and Pendle View, Blackburn (LSCFT)
£0.8m Whalley site, Whalley (currently Mersey Care)
£0.09m The Harbour, Blackpool (LSCFT)

£9.6m across other

Plus £2.3m across primary care

£15.6m high risk

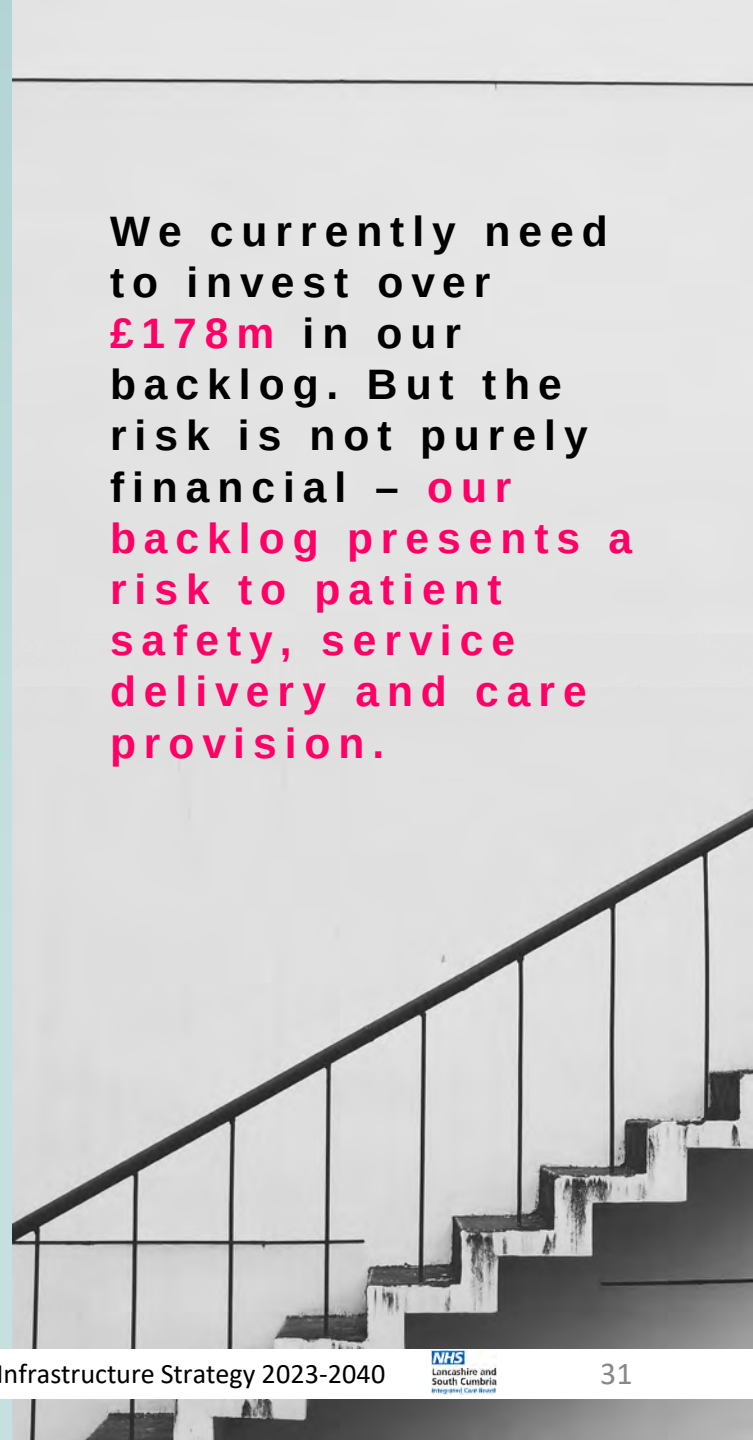
£77.5m significant risk

£38.9m moderate risk

£24.2m low risk

£22m critical

We currently need to invest over £178m in our backlog. But the risk is not purely financial – our backlog presents a risk to patient safety, service delivery and care provision.



Section 1: Where are we now

Our NHS buildings in 2023

Our current built infrastructure

We have nearly 400 NHS buildings. This includes buildings that our providers and the ICB own and lease, the NHS property company buildings, and GP owned/ leased premises. Together, they cost the NHS over £274m per annum to occupy.

The average cost of our space is **£262 per square metre**.

Our provider infrastructure

Our provider built infrastructure has a total GIA of 814,000sqm. We have seen a 10.57% reduction in overall provider footprint from 910,793sqm in 2019/20. At the same time, our overall occupancy costs have increased from £195m to £207m per annum; an increase of 5.98%.

Energy
Our space has reduced, but our energy usage has remained broadly the same; increasing slightly from 332m kWh to 337m kWh per annum. Our energy costs decreased by just over £3m between 2019/20 and 2021/22, but this does not reflect the energy price increases seen across the UK during 2022 onwards. If we assume a conservative 50% increase, our energy costs are likely to have gone up by £9.8m. If they were to see an increase of 100%, like many NHS trusts have seen, then we are likely to see an increase of c. £19.6m.

Carter operational productivity
In relation to targets within the Carter report, we have made some **good progress** from 2019/20 to 2021/22; Clinical space across our provider buildings increased from 56.8% to 59% of the total GIA and medical records space reduced by over 5,500sqm, dropping from 2.9% to 1.1% of the total GIA

Backlog
Our backlog position has deteriorated over the past 2 years, we now have nearly £180m backlog investment requirements, with £108m of this being high risk, significant risk or critical infrastructure risk.

Provider built infrastructure in 2022*

* Taken from ERIC return 2021/21

£207.4m	£179.1m	814,530 sqm
Total occupancy per annum	Total backlog investment requirements	Total GIA
Change since 2019/20 ERIC return	+10.2%	+7.8%	- 8.8%

Section 1: Where are we now

The NHS property companies

Much of our community and out of hospital infrastructure is owned and managed by the two national NHS property companies:

- NHS Property Services **(NHS PS)**
- Community Health Partnerships **(CHP)**

The Health and Social Care Act 2012 created a somewhat fragmented estates landscape, where the local ownership, management and shareholding (in the case of LIFT) of community estate moved in most cases from the PCTs to the two national NHS property companies. With this, we lost a lot of local connectivity, and we still feel the impact of this today in many areas. **We do not work as closely as we need to with our property companies** to align strategies and collectively take a system approach to usership.

Challenges

There is a perception of there being additional layers of management, bureaucracy and cost that can sometimes cause challenge to the transformation of buildings locally. Furthermore, there is sometimes seen to be a disconnect between local requirements and national approaches.

Lease and license occupancy arrangements in some areas do not offer enough flexibility and restrict our ability to integrate where individual organisations have demised spaces. Integrated Neighborhood Teams and local provision of care needs to be enabled by occupancy agreements that are reflective of our NHS needs in 2023 and into the future where integration is at the heart of building occupancy.

TOTAL NHS PROPERTY COMPANY BUILT INFRASTRUCTURE:

£58.36m — Total occupancy per annum
21.4% — of total system cost
GIA: 164,715 sqm
15.7% — of total system GIA

CHP

£22.2m — Total occupancy per annum
53,184 sqm

NHS PS

£36.1m — Total occupancy per annum
111,531 sqm

Change since 2021/22
Average across providers 10.2% cost increase and 8.8% decrease in GIA

+36.3% | +10.4% | +23.7% | -2.7%

It should be noted that NHS property company costs include service charges and associated staffing costs, and this must be taken into account when considering these costs.

Section 1: Where are we now

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

9* LIFT buildings
2 LIFT companies

£22.2m
2023 occupancy cost

The first concession at Bacup Health Centre ends in 2030

Our LIFT companies and for LIFT buildings

We have two Local Improvement Finance Trust (LIFT) companies and ten* CHP managed buildings across Lancashire, South Cumbria and Blackburn with Darwen. We have **53,184 sqm across our LIFT portfolio** and a total occupancy cost of over **£22m per annum**: this represents **5% of our total health GIA and 13% of our annual building occupancy costs**.

We need start working imminently on our **local ICB strategy for the long-term future of the LIFT buildings**. We also need to consider the future of LIFT in the context of decarbonisation and our journey to net-zero, and we will explore this in more detail in Section 3.

We need to focus some of our place work on identifying specific local requirements for the LIFT buildings, in line with their categorisation as **core, flex or tail**. Once this work is complete, we should work more closely with CHP to work up building strategies and opportunities for transformation across the LIFT portfolio, identifying investment requirements if required. We know our LIFT portfolio is vastly underutilised and must address this.

End of term planning – We have not yet taken a local independent exercise to understand the options available to Lancashire and South Cumbria at the end of the terms; mapping how projected reductions in occupancy costs could support our medium to long term requirement for community health infrastructure delivery, and we will need to do this. We also need to align end of term options with our wider ICB commercial and investment strategy; exploring opportunities with local partners as detailed in Section 3.

Shareholding and head tenant role – We are considering the potential for Lancashire and South Cumbria to take both the NHS LIFT **shareholding and the head tenant** role back from Community Health Partnerships. We must fully consider all implications of this including management responsibilities and potential debt liabilities. If we do progress, we know this will need careful consideration and must be full aligned with local cross-system workforce development to ensure that all contractual obligations under the Lease Plus Agreements can be effectively and efficiently discharged and managed locally.

**It should be noted that one building, Rossendale Health Centre, was built using NHS capital and therefore the ICB should ensure it is treated as such in respect of end of term planning. There are 9 buildings excluding Rossendale.*

Section 1: Where are we now

New Hospitals Programme

We need new hospitals in Lancaster and Preston, replacing over 18,000 sqm of existing built infrastructure with hospitals of the future; this work is being delivered by our New Hospitals Programme. In May 2023, there was an announcement of two new hospitals to replace Royal Preston Hospital and Royal Lancaster Infirmary as part of a rolling programme of national investment in capital infrastructure beyond 2030, and will require investment in Furness General Hospital. In our new hospitals, only services that need to happen in a hospital setting will be delivered in hospital, and this will lead to a fundamental re-shaping of our health infrastructure across our whole health and care system, including place and neighbourhoods.

The quality of the existing in-scope buildings is very poor and in severely impacting the ability to deliver care in a suitable environment or enable transformation. Backlog across the two sites is over £81m. It should be noted we also need investment across our hospital infrastructure on other sites that are not part of the NHP (see here).

Our new hospitals programme has several critical interdependences with a variety of other infrastructure workstreams (plus associated investment requirements into new and/or remodelled infrastructure) and we need to start mapping and planning these in detail now. We must fully understand programmes of work that are essential in enabling the new hospital programme, including investment in community infrastructure and bringing non-clinical services together. We are ensuring the new hospital programme work is informing our core, flex and tail catagorisation, and we recognise the critical requirement for robust and deliverable supporting infrastructure plans aligned to Lancashire and South Cumbria system, place and neighbourhood strategies.

Across place and neighbourhoods

Our 2019 **Local Asset Review agreed several principles for how we would work locally across our local communities**, making the best use of collective health and wider public and third sector infrastructure. We need to re-invigorate this work at place; embedding these principles in our new property landscape.

We have very poor community infrastructure in some areas; notably Central & West Lancashire, North Lancashire and South Cumbria where there has been barely any NHS investment over the past 10 years and **we urgently need new primary and community health buildings** (though this is not to suggest we do not need investment in other geographies too).

Our current infrastructure plans are not always currently aligned with those of local authorities, and part of the next steps for this strategy will be to start this conversation so that strategies can be aligned where it makes sense to do so. We must consider the potential options for the delivery of more care closer to home; taking services to our communities and using community buildings to deliver services; from local hubs, to leisure centres, to places of worship to high-street stores.

Section 1: Where are we now

Primary care

Our primary care infrastructure is varied in quality, suitability and functionality. Many of our practices are located within NHS PS and CHP buildings across Lancashire and South Cumbria, noting that NHS PS buildings are of mixed quality and suitability.

We have 203 properties that are either owned or directly leased by GP practices (from a landlord other than an NHS property company). The total cost of notional rent to the NHS for these properties is nearly £9m annually. We have made some assumptions around additional costs and anticipate that these GP-owned/ directly leased premises have a likely indicative additional £7.5m in non-reimbursable property costs per annum. Our investment requirements to **address backlog across GP owned buildings is around £2.3m.**

Quality and overall functionality of GP owned/ directly leased buildings is mixed; about half of our primary care owned/directly leased buildings were not deemed to be either sufficiently functional or in good condition.

When looking at overall functionality in our most recent GP 3 facet surveys, only 40% of buildings were RAG rated Green, with 60% being determined to be Amber/Red. Overall condition was identified as slightly better, with 53% of buildings being rated as Green for condition, with 47% rated as Amber.

GP buildings

£8.9m
Total notional rent/ reimbursables per annum

5%
of total system cost

GIA: 69,669 sqm

7%
of total system cost

£2.3m
Total investment required to address backlog maintenance

Overall functionality
4% RED
56% AMBER
40% GREEN

Overall condition
0% RED
47% AMBER
53% GREEN

Resource and capacity
Our community and primary care infrastructure support has been decimated and we are spreading resource more thinly than ever before. Many GP practices are lacking infrastructure resource and skills and this is often widening the primary care premises quality gap. The right support will be required for the development and implementation of agreed plans as part of the Fuller work, as well as for developing green plans.

A lack of space capacity across primary care infrastructure in some areas of Lancashire and South Cumbria is impeding the ability for primary care to integrate fully across PCNs and neighbourhoods, and infrastructure challenges and inability to co-locate staff with GP premises causes challenges with recruitment and retention (especially to new roles across PCNs). We need to urgently remove the built infrastructure barriers to enable recruitment of ARRS roles; these barriers include the lack of reimbursement to cover space costs, alongside a lack of building capacity locally.

New infrastructure for primary care
We have identified the need for several primary care and community new builds; including across West & Central and North Lancashire (we will explore in more detail in Section 3). We continue to be challenged by issues with negative equity and/or valuation variances across primary care owned buildings. This presents a huge barrier to development, further exacerbated by; an increasingly out of data Premises Directions, space calculation models based on a superseded-model of primary care, and a seemingly increasing lack of interest in a property-based partner GP model for new GPs.

We do not have full clarity on our neighbourhoods and how these align with local geographies, which makes planning across these footprints more difficult.

The national PCN Toolkit support and assessment of primary care plans is currently underway, overseen by CHP. The toolkits, supported by the 2022 Primary Care Data Gathering information, should help support more detailed plans to be developed for primary care. There are complexities with the primary care infrastructure; including premises (open market) valuations versus practice valuations (the debt secured on the building by the practice – e.g. a mortgage), historic subsidies and a lack of standardisation (including strategy and management).

In 2022, the ICS completed the Lloyd George Digitisation programme; a £8m investment into primary care infrastructure locally, that enabled many practices to free up space across their premises that had previously been used for records storage. Some of this space has been able to be reused and refurbished to support practices with capacity issues.

Beyond the digitisation of records, there are still a number programmes of work for primary care infrastructure that have not yet been considered in depth; including the journey to net-zero.

Section 1: Where are we now

Our infrastructure workforce

Our infrastrcture workforce is fragmented across ICB, providers and NHS property companies, and both strategic and operational workstreams. Locally, providers have historically focused on their own provider buildings, where the NHS property companies take a local and more regional/ national focus.

The ICB provides a strategic and coordination role across system, place and neighbourhoods. However, our **ICB strategic infrastructure resource is currently very limited**; which restricts our ability to take forward many key strategic programmes of work to enable system transformation.

Across each of our local places, localities and neighbourhoods, we **have incredibly limited capacity**. We have only a few staff working locally on primary care and community infrastructure transformation; it is nowhere near enough. In our East Lancashire locality, we have no identified resource at all.

Our workforce model is changing across our providers, where an increasingly collaborative approach is being taken, with shared resource already being seen across our provider trusts. We know that both our strategic and operational workforce will need to transition to support our evolving infrastructure vison and that we need new skills as we move forward, some of which we would need to 'buy in' currently.

We have lots of skill and expertise across our property company partners, but we do not always use this as we could.

We are not alone

We are not alone in many of our current infrastructure workforce pressures. The NHS Estates and Facilities Workforce Action Plan has identified a number of challenges with the NHS workforce across infrastructure workstreams. It sets out a number of the themes we need to focus on around our national workforce; looking after our people, belonging in the NHS, new ways of working and delivering care, and growing for the future. Further themes are picked up in the NHS Long Term Workforce Plan.

Section 1: Where are we now

Funding - availability and access

Scare capital and existing limits on progressing schemes via current avenues for non-NHS capital (finance leases, PFI, 3PD, LIFT) have stifled progress across several of our infrastructure workstreams.

Despite working more collaboratively, we still often invest into new builds and refurbishments too reactively, without a longer-term investment and funding strategy to align our plans to. We also do not always have visibility or awareness of upcoming funding streams or grants that might be available, or we do not have the resource to develop bids and business cases (for example, with primary care improvement grants).

We need clarity on all our provider infrastructure requirements, with a 15-year plan for development that our investment, divestment and delivery requirements are fully aligned to. We have several currently required schemes and investments.

Governance

The formation of the ICB has shifted some of our collaboration footprints; with a change in places', we find ourselves with a mis-alignment between our current governance requirements and the arrangements we had before. We will need to establish governance for strategic health infrastructure that are reflective of our new landscape.

Since our 2018/19 strategy, we have lost many of the forums where we were able to initiative and progress strategic infrastructure discussions; from the Lancashire Property Board, to the various Strategic Estates Groups. We will consider the re-invention of these groups as 'Strategic Infrastructure Groups' in Section 3 of this strategy.

There are several areas where we are unclear on responsibilities for landlord/ tenant, especially in buildings owned and/or managed by the property companies, but we need to start the conversation around workstreams like the RAAC review, as well as the journey to net-zero.

Poor utilisation

Despite pressure across our infrastructure, we do not use the space we have that effectively. We know anecdotally and through conversations to develop this strategy that we have diagnostic facilities, theatres, equipment and clinical spaces across our whole system that are not used, when we have significant capacity pressures in other parts of the system. Under-utilised space is not just a financial annoyance; it is missed potential to transform and optimise our ability to shape better health.

Utilisation studies completed across community buildings in some areas of Lancashire about 5 years ago identified very poor utilisation; with average building use of the LIFT portfolio being between 50%-70%.

The 'price' of under-utilisation
If we take the average cost per sqm of our buildings, then for every 16sqm consulting room we have unused, we are allocating £4,192 of our NHS budget to fund empty space each year.

There is huge opportunity for both rationalisation and consolidation of buildings to realise costs savings, as well as opportunity costs in using spaces more effectively. If we take a scenario; we might conservatively assume that we have 5% in un-used space across Lancashire and South Cumbria that we could either fully utilise or remove from our footprint – in this example, we could realise efficiency benefits/ direct cost benefits of over £10m per annum (assuming our average cost per sqm).

Data and information

We have done a lot of work across the system over the past few years to standardise our ERIC data, but more broadly, we still have inconsistent access to data and information. We neither actively nor proactively use all the data we have, with no live central dataset. We have a lack of capacity to effectively analyse data, impacting on our ability to be clear with our prioritisation requirements. Our fragmented property landscape contributes to our lack of detailed information for much of our built infrastructure, but we know that data, transparency and analysis will be a key enabler to our future planning.

Furthermore, we do not have system visibility across all our health built infrastructure; from costs to utilisation data, to space that is available, to system capacity that could accommodate service delivery. We will look at this in Section 3, but we need to start embracing digital systems, connectivity and better analysis of our information to start to support a better use of our resource; from investment to using the space we have better.

Section 1: Where are we now

Our current identified NHS capital requirements

We have identified our capital requirements in autumn 2023. These are based on currently identified needs, but we will need to review and refresh and update this as we move into 2024. We know our capital requirements will be further influenced following the completion of several pieces of work, including; our strategic site catagorisation (core, flex and tail), further decarbonisation mapping and feasibility, development of a strategy for the future of Whalley, and the identification of our out of hospital requirements as we move more care closer to home (including the impact of the NHP).

We need **£5.22bn** investment

This is based on currently identified needs and excludes digital, the system response to the climate challenge (including decarbonisation)

£2.5bn is for our **new hospitals programme**.

£2.1bn is for our **acute** built infrastructure (outside of NHP)

£264m is for **mental health, learning disabilities and autism*** built infrastructure

£146m is for our **ambulance** service

£220m is for our **out of hospital, primary and community** built infrastructure.

We also require investment for the **digital infrastructure**, **decarbonisation** (and climate mitigation and adaption) - **£TBC**

*includes £32m for LD&A beds

Section 1: Where are we now

Why infrastructure needs a long-term view

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

2040 may be 17 years away, but this is not long in the life of NHS property; in 2006, the 'new' Royal Blackburn Hospital opened. Today 17 years later, Royal Blackburn Hospital is still considered amongst our newest NHS built infrastructure.

There is a fundamental difference between buildings and many of our other enablers; buildings are static and fixed points in our system; expensive to build, costly to maintain, often difficult and time-intensive to change, and usually come with long term commitments around finance. The same is often true of our major equipment. It is why we can no longer afford to develop clinical strategies in isolation, without our clinical strategies being informed by our existing infrastructure.

Many of the things we already know we need to do will take us many years to complete. Long-term strategy and planning is already happening in relation to our New Hospital Programme, but we must extend across all our infrastructure programmes and areas of work.

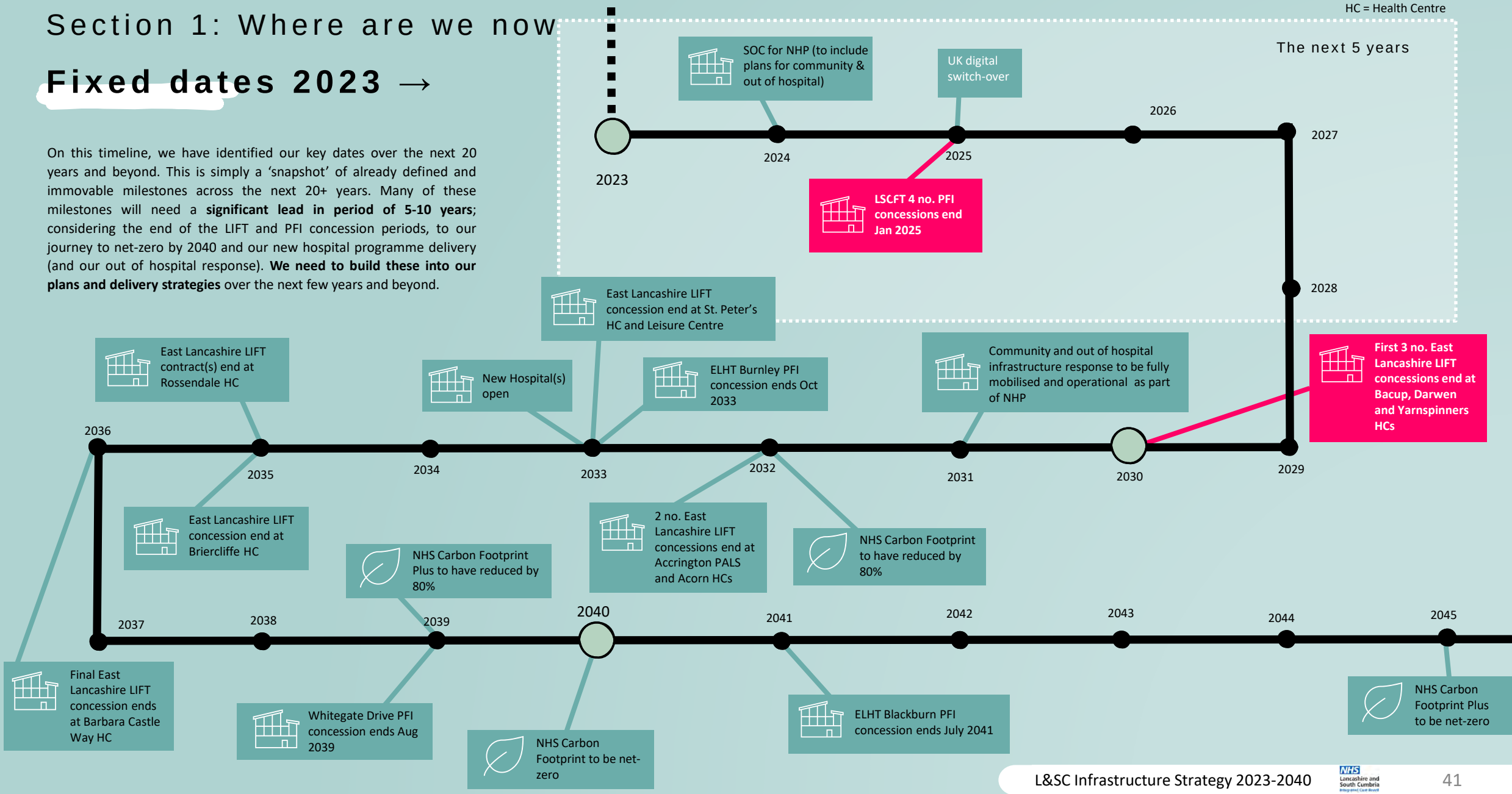
Whilst we will develop agile, short-term solutions in line with this strategy, it is still the case that **most of our infrastructure-related decisions require us to take a significantly longer-term view**.

Furthermore, we have several immoveable key dates over the coming years that mean we must start planning our long-term future today – from PFIs and LIFT buildings coming to the end of their concessions to the national net-zero mandates and the new hospitals programme delivery (and its associated out of hospital response). We simply cannot be without a solution to these situations; and the planning that needs to be done will take us many years.

Section 1: Where are we now

Fixed dates 2023 →

On this timeline, we have identified our key dates over the next 20 years and beyond. This is simply a 'snapshot' of already defined and immovable milestones across the next 20+ years. Many of these milestones will need a **significant lead in period of 5-10 years**; considering the end of the LIFT and PFI concession periods, to our journey to net-zero by 2040 and our new hospital programme delivery (and our out of hospital response). **We need to build these into our plans and delivery strategies** over the next few years and beyond.



Section 2

The road to 2040: our infrastructure principles

Section 2: The road to 2040

Building on our foundations: the road to 2040

'We must take a pragmatic and grounded approach to blending innovation, investment, and maximising our use of the infrastructure we already have.'

The first few years of our infrastructure journey will focus on identifying where it is we need to get to, enabling us to strategically build on existing foundations whilst shifting and evolving our focus and delivery plans as we move to 2040. At the same time, we will drive efficiency across our NHS system.

We have our vision for 2040, and we will break this down as we explore what we need our infrastructure to enable across each of our six infrastructure priorities. As we plan how we transition to this future vision and in the delivery of the Joint Forward Plan, we know we must be realistic; we recognise we cannot do everything. Therefore, we must be pragmatic with our prioritisation, around our areas of focus, our investment, our timescales, and in our system's ability to deliver.

We will need to be able to navigate our way through often conflicting drivers. Some of these include; balancing the short-term 'keeping the lights on' with the need for long-term transformation; taking a local delivery approach to help reduce health inequalities with the potential consolidation of services across the ICB; and carefully planning investment into buildings that we need today but that do not have longevity as part of our plans (see catagorisation).

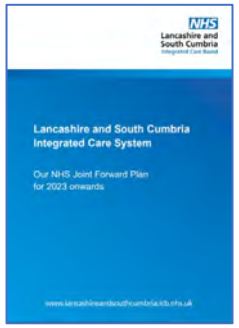
We must progress reimagining and reshaping how we deliver, streamline and operate our infrastructure, at the same time as building on and improving the things we already have established: we should not overlook the great things we already have, and we do not need to redesign everything we do simply for the sake of 'new'. We must take a pragmatic and grounded approach to implementing innovation, delivering investment, and maximising our use of the infrastructure and resource we already have.

As we start to answer the question of 'how do we get there', we will see there are lots of areas of overlap and connectivity across our principles, ambitions and enablers. These connections will become increasingly strong and interwoven as we develop our holistic system-driven plans.

We will need to map where we need to be by 2040, and how we get there, against each of our infrastructure principles.

Section 2: The road to 2040

Infrastructure in the delivery of our Joint Forward Plan



Infrastructure is fundamental to the delivery of our Joint Forward Plan; it provides the physical, digital and technological means by which to deliver our vision and address our strategic priorities.

This page summarises the ICB's strategic infrastructure response to the Joint Forward Plan vision and each of the strategic priorities that the ICB will work with health and care partners to deliver.

Our shared vision

NHS organisations across Lancashire and South Cumbria have a shared vision for our population to live longer and healthier lives which will be enabled by:

Healthy communities	High-quality and efficient services	Health and care services that are centred around the needs of our communities and offer high-quality employment opportunities for our workforce
We will enable the delivery of health and care services and shape healthier places	We will provide high quality spaces and places for the delivery of services and we will develop our workforce to support this	We will create a community health infrastructure that is shaped at place and neighbourhood. We will develop our infrastructure, estates and facilities workforce; offering evolving and future-focused high-quality opportunities for our existing workforce and new staff.

Our strategic priorities

The NHS in Lancashire and South Cumbria is committed to working with health and care partners on five priorities:

1. We must strengthen our foundations by changing how organisations work together and how the NHS provides services to improve our financial situation.
2. We must take urgent action to reduce the level of long-term disease, working with partners to prevent illness and reduce inequalities.
3. We must move care closer to home wherever possible, strengthening primary and community care and integrating health and care services.
4. We must make sure there is more consistent and high-quality care. We will standardise, network, and improve our pathways of care.
5. We must take targeted action to deliver world-class care for priority diseases and conditions, population groups and communities.

1 We will fundamentally change the way we work and we will take a long-term approach to infrastructure. We will blend workforces, share resources, and plan collectively as a system for the infrastructure that supports more financially balanced and sustainable models of care; being more innovative, creative and holistic in our solutions.

2 We will embed prevention and reducing health inequalities in all infrastructure planning through our shaping healthier places principle; whether this is use of our buildings, in the future use of our NHS land (by ourselves or partners), or more broadly in relation to social value. We will use our role as anchor institutions to support the reducing of health equalities, and we will work alongside partners and use our NHS voice to drive change locally.

3 We will create a robust local infrastructure that supports moving care closer to home, but this will need both significant financial investment and new ways of truly integrated working (supported by the right infrastructure governance across place). There will be no one-size-fits-all to the and requirements will be locally by places and neighbourhoods, though we have some priority areas for strategic investment.

4 We will ensure the places we deliver services enable high quality care; this may mean investing in new buildings and equipment, divesting/ reimagining some of our hospital and community sites, transforming our existing spaces, or strengthening our digital infrastructure. We will plan our future infrastructure as a system to enable the standardised network for care, taking an 'ecosystem' view.

5 We will create the spaces required to support work across the system, and locally at place and neighbourhood. We will work more closely with clinicians, commissioners and population and public health colleagues to identify opportunities for greater infrastructure support to address this Lancashire and South Cumbria priority.

Section 2: The road to 2040

Our future is transformational

Transformation is our overarching infrastructure principle, and it frames our three core and interdependent strategic ambitions.

The long-term sustainability of the system depends on reducing the reliance on delivering healthcare within hospitals which is an expensive way to care for people. To become more sustainable as a system we will need to strengthen primary and community care, integrating them further with social care, wider local authority services and the VCFSE sector to create integrated neighbourhood teams that harness the use of digital technology. We need to be using infrastructure as a tool for improving prevention and targeting health inequalities and utilising our anchor status and civic leadership role locally to better influence and shape healthier places.

1. Change the way our organisations work together and how the NHS provides services to improve our financial situation.

WHERE DO WE NEED TO BE?

We need to be transforming both the quality and sustainability of our health system's infrastructure across all our pathways and optimising the efficiency of our infrastructure delivery.

HOW DO WE GET THERE?

We will transform both the quality and sustainability of our health system by taking a system-wide approach to enabling our network model of care, in moving more care closer to home, and in increasing our focus on prevention. We will use our infrastructure to support new models of delivery where we need them, and to facilitate others to improve health by using our infrastructure in a different way. We will need to consider long term financial system sustainability in the context of our investment prioritisation. In some instances, the changing models of service delivery may mean we need to invest in additional and new types of accommodation and digital infrastructure to embed a more financially viable and sustainable service model for the future.

We will ensure we are optimising the efficiency of our infrastructure delivery; from reducing our buildings footprint, to targeting investment to where it is most needed, to maximising operational efficiency through innovation and creating shared resource, systems and processes across the provider collaborative and beyond.

1. Change the way our organisations work together and how the NHS provides services to improve our financial situation.

2. Move care closer to home, work with partners to prevent disease and reduce inequalities

3. Enable a standardised, network model of care for the delivery of our clinical strategy

Section 2: The road to 2040

Our future is transformational

2. Move care closer to home, work with partners to prevent disease and reduce inequalities

WHERE DO WE NEED TO BE?

We need to be providing much more health and care in the community, with the right infrastructure to support people's health locally. As we reduce the time that people spend in our hospitals, we need to create a new and improved ecosystem of connected infrastructure across our communities that will require improvements to existing spaces, as well as new buildings and different types of infrastructure.

We need to be using infrastructure as a tool for improving prevention and targeting health inequalities and utilising our anchor status and civic leadership role locally to better influence and shape healthier places.

HOW DO WE GET THERE?

Work will need to be done at **place and through the ICP to ensure we have cross system infrastructure responses to support moving services from a hospital to a community setting**; we will need robust and clear infrastructure plans that include the **new health buildings and spaces we need**. This will include primary care, and new and different types of infrastructure; from intensive rehab, to day hospitals, to more housing-based solutions. Many of these infrastructure requirements have already been identified, but others will have to be **developed as part of our place plans, with our capital plans updated in response**. They should include a detailed understanding of the potential impact of our plans on social care, and mapping the potential infrastructure requirements alongside our partners.

We should have developed these detailed place infrastructure plans within the next 12-18 months as we will need to be able to mobilise our response across the community in order to support the redesign across our hospital network. We will need investment; with a strategic delivery and investment/ divestment/ re-purposing plan for our community infrastructure (informed by core/flex/tail). This will include solutions and options for primary care and PCN investment, local options in relation to the future of LIFT and community health buildings, and the re-imagining of some of our NHS sites to support place. Where we need community facilities at place, we should look at opportunities for co-location and co-development with other partners to reduce capital cost and carbon impact where possible.

We need to target more thinking around **the infrastructure we need for prevention**. We will not be able to deliver most of this ourselves, and partnership, collaborative and development of the NHS's civic and anchor role is essential. We should become ever-more **strategically active at place** with local authorities so we can influence and shape future infrastructure plans; from identifying at an early-stage our future health requirements, to ensuring that developer contributions are targeted to where they need to be, to ensuring housing requirements support health.

Section 2: The road to 2040

Our future is transformational

3. Enable a standardised, network model of care for the delivery of our clinical strategy

WHERE DO WE NEED TO BE?

We need to be creating a system-wide integrated network model of infrastructure that supports our clinical strategy and pathways across our provider collaborative. This will mean we need a re-shaping of our hospital sites, including delivery of our two new hospitals, to support tertiary and secondary care with an overall reduction in our hospital footprint as care moves into the community.

HOW DO WE GET THERE?

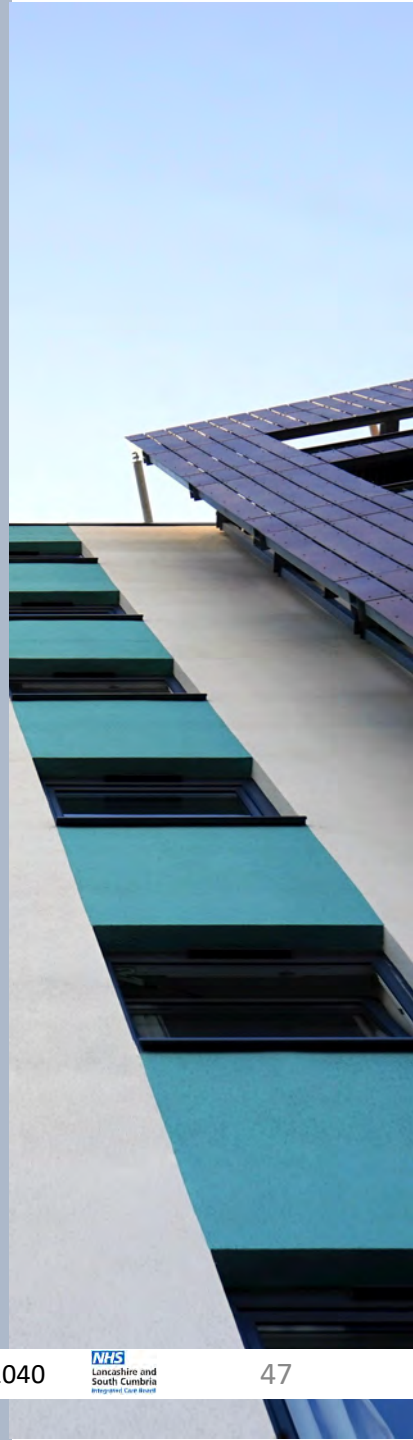
We will need to consider a number of significant infrastructure projects and reconfigurations to support the transformation of our provider infrastructure. Our hospital and inpatient sites will be reconfigured across Lancashire and South Cumbria, aligned to a 15-year+ programme of investment and divestment, which in turn is aligned to our backlog strategy and core/flex/tail catagorisation. Our investment plan will include digital infrastructure and medical equipment.

One of the first things we need to do is an exercise to understand how our infrastructure should be reshaped; aligning clinical strategy with existing buildings and our future requirements. From this, we will create a series of 'site development strategies' (SDS); phased to enable the service and infrastructure transformation we need (see detail on developing the site development strategies **through core, flex and tail catagorisation** here and here).

We need investment into our two new hospitals, as well as across our other hospital, mental health, learning disabilities and autism sites. **Much of our equipment needs to be upgraded and replaced** to ensure we are providing effective and efficient care as well as provide equity of access and services, and **we need to develop robust plans around our technology requirements**. **We need to ensure appropriate investment to create a cost-effective equipment system where equipment and technology have a suitable level of prioritisation to support the improvements in services**.

We will need other investments in technology; we will need to invest in pharmacy manufacturing across our ICS along with improvements to mechanise production and distribution via robotics (where optimal), and we will need new technology to support our existing and planned pathology services.

At the same time as investing into new buildings, we will identify where we already have capacity across our existing infrastructure, especially where we know we have **under-optimised core buildings and start to use this space better**. Where we may have identified buildings or land no longer required at one of our existing sites for network delivery, we will start to plan for how we can re-use this to support our ambitions in relation to more community delivery and left-shift.



Section 2: The road to 2040

Our future is digital, smart and intelligent

WHERE DO WE NEED TO BE?

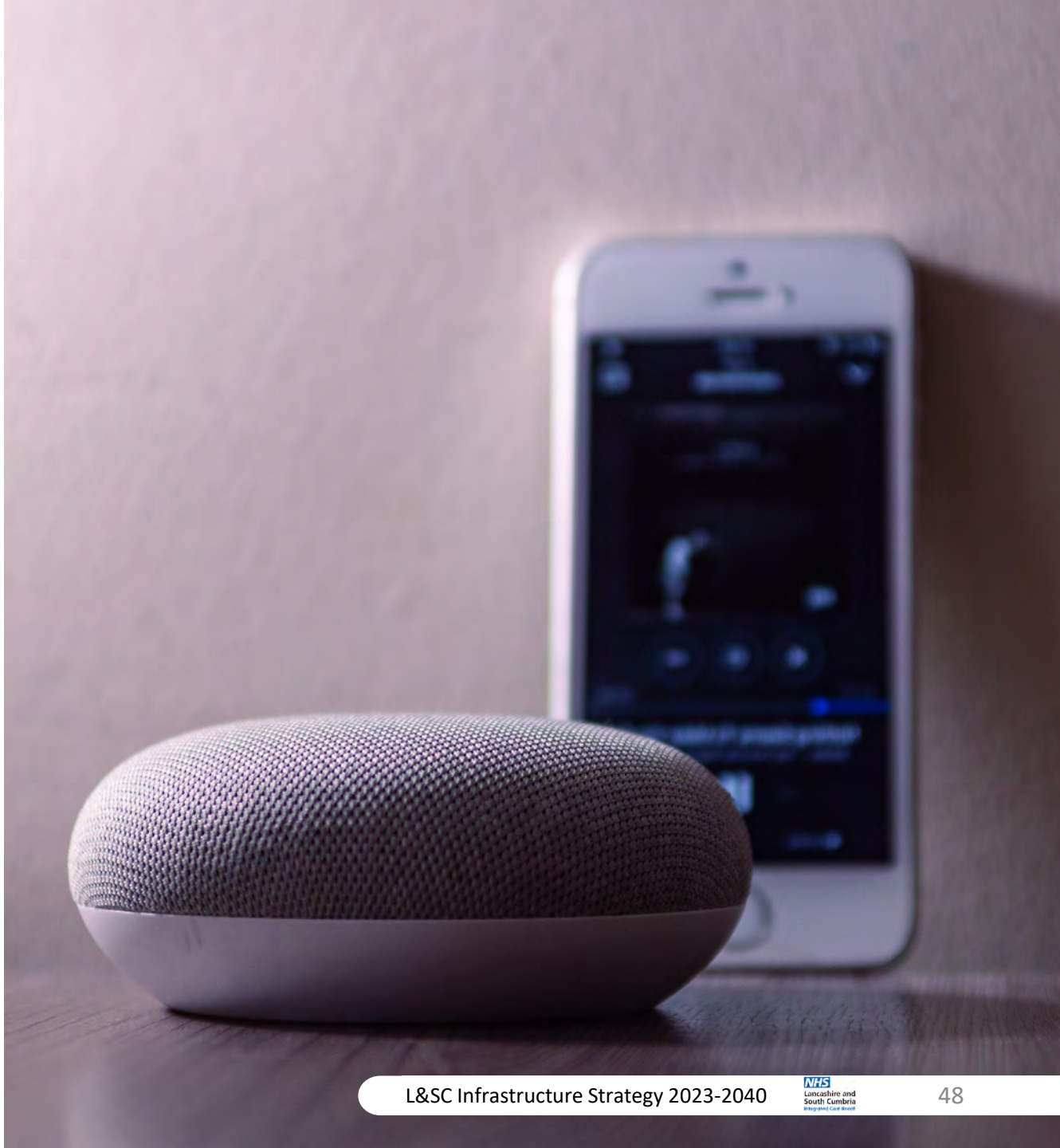
No longer can we separate built infrastructure from digital infrastructure as our physical and digital worlds become ever more interconnected and integrated with one another. When we talk about 'smart and digital' in the context of this strategy, we really mean the way we use technology to deliver our clinical plans and associated infrastructure ambitions.

Technology continues to advance at such a pace that we simply cannot predict where we will be by 2040. But we do know that by 2040, we will need to be a digitally mature system; with smart, intelligent buildings where built and digital infrastructure seamlessly operate together.

A smart, intelligent infrastructure is a fundamental part of in realising our ambitions; from more fluid models of delivery, to decarbonisation of our buildings, to enabling care at home, to streamlining patient flows around hospitals, to ensuring we are utilising our space efficiently.

Digital buildings will be our norm. We will have interoperable systems that enable better and more sophisticated connectivity across our organisations, support preventive and proactive maintenance, help us target investment more effectively and support us with optimising space utilisation. We will have increasingly digital service offerings, where the digital space will be as importance for future health delivery, self-care and prevention as physical spaces.

We will need a digitally astute and competent workforce with a different blend of skills, including systems, data and AI digital specialists as a part of our Lancashire and South Cumbria estates, facilities and property function(s). We will actively use data to inform our ongoing strategy and planning.



Section 2: The road to 2040

Our future is digital, smart and intelligent

HOW DO WE GET THERE?

We need to start the transition to a more digitally astute 'estates' function – where we work with digital colleagues to understand the impact of a digital NHS on our buildings, as well as mapping how we maximise the use of current and emerging technology. We will need to understand what digital technologies and a digital health service means for the future of our NHS built infrastructure, and we need to increasingly learn from the new hospital programme as we move forward, adopting its models across all our infrastructure.

We will use the potential of technology not to simply digitise our manual processes, but to radically transform the things we do. We will need to look to the future, horizon scanning to ensure we are building the foundations today to support our future evolution where we increasingly incorporate technologies such as artificial intelligence, augmented reality and virtual reality into our health services and our infrastructure delivery and management.

Investment - We will need to identify our requirements for investment in digital infrastructure, detailed as part of our digital strategy and ensure our built infrastructure plans are aligned. We need to consider digital and technological investment in the context of connected medical equipment, building management systems, booking systems, and EPR. We must identify the investment we need in equipment that enables at-home and in-community care (including wearables and other connected devices).

In relation to our buildings, we will need to make Lancashire and South Cumbria-wide investments into the right systems to support our infrastructure efficiency; learning and building on the work of the new hospitals programme and current best-practice from the commercial and industrial sectors.

Connectivity - We need to be developing and assessing the connectivity of buildings, devices, systems, staff, patients and citizens; for service delivery, prevention and personalised and person-centred care. We will also need better WiFi and 4/5G connectivity and should work with internet and phone providers to enable this where it is needed. We should map all digital systems to understand what is possible in terms of interconnectivity; to join the dots in different ways to identify opportunities to better align pathways, service delivery and buildings to improve and streamline our health provision.

Smart and intelligent buildings - We will assess the digital tools and systems we need (today and into the future) to support us to use and manage our buildings more effectively, undertaking an initial review of 'what we already have' across our digital building systems to ensure we are using our existing tools effectively.

We will then map where the short, medium and long-term opportunities are in relation to digitising our properties and develop intelligent and smart buildings that work better for us. We can better use technology across our estates management, for instance intelligent asset tagging and augmented reality for maintenance and FM, aligned to our core, flex and tail prioritisation.

Data - We will need to use our data more intelligently (see Section 3)

Green – Smart infrastructure will be essential in our journey to a net-zero NHS (see Section 2)

Workforce - Our workforce must start to get comfortable with everything from IoT, new systems, digital twins, integrated booking/ space management systems, BMS and data analytics; learning how to make best use of digital technologies and being supported to incorporate them into their roles where appropriate. We will need to consider training needs and communication.

Cross partner opportunities - We should work more closely across digital infrastructure workstreams to better explore all partnership opportunities. This might include opportunities with social care around maximising benefits of telehealth and telecare.

Usership - We will need to support the digitisation of our services and workstreams, prioritising investment in these areas. The more agile and fluid our staff and service delivery can be, the greater the opportunity for increasing user-ship of spaces across our various NHS organisations, the wider public sector and other local partners.

Integration and interoperability - We will work with interoperable systems and open architecture across all providers and will standardise collection and use of our data. We will create frameworks for commonality of systems, with flexibility to bespoke locally.

Section 2: The road to 2040

We will have user-ship of the right infrastructure

Where do we need to be?

We can no longer afford to be parochial about building and equipment ownership as we move to 2040. We need to have fully embedded our user-ship approach across safe, quality and sustainable buildings that are accessible, fit for purpose that we have the autonomy to manage locally, and that are organisationally agnostic. We need the right sized buildings, in the right configuration, in the right place, supported by the right systems and containing the right medical equipment. We should be assured of the statutory compliance of all the health infrastrcture, as per specific requirements. We need the ability to inexpensively flex and adapt our spaces as our needs change and evolve and therefore need an infrastructure that is responsive to transformation.

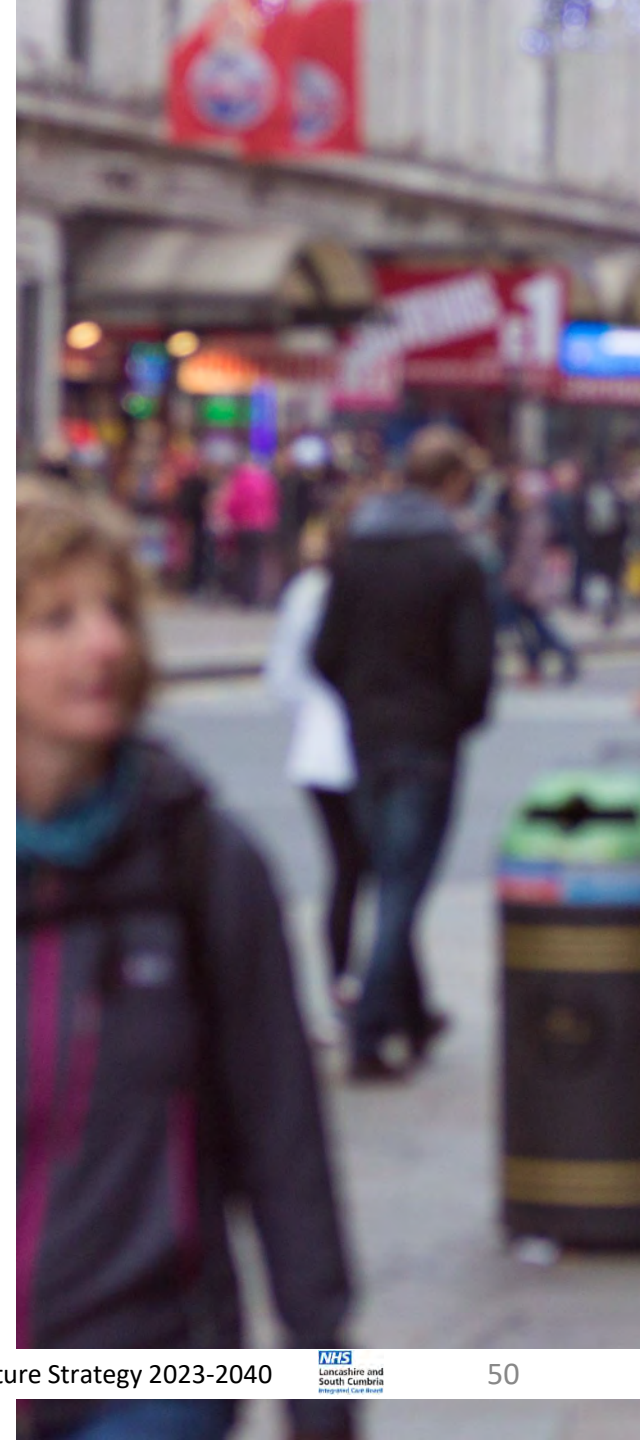
How do we get there?

We will continue our work to identify the right infrastructure for our health system; across our system network, at place, and at neighborhood. This includes identifying and prioritising major equipment, digital and technological systems as well as the built infrastructure we need.

In order to have safe and quality buildings across the NHS owned infrastructure, we need to have reduced our backlog, improved compliance and ensured we are making the right level of progress towards decarbonisation. We need to replace our older, not fit for purpose (tail) buildings with high quality and appropriate accommodation and we need a 15-year+, system-wide, collaborative investment and divestment strategy across our partner organisations.

We will take a one-public-estate and user-ship approach to all our infrastructure and will continue to develop new, different and novel ways to use spaces that meet our needs; from the high street to home. We will better define the 'right infrastructure' and will make intelligent choices around where we deliver services; especially where this contributes to our strategic ambitions around financial sustainability and prevention. We will need to understand where there are opportunities across place in partner infrastructure (from community buildings, to space with local organisations such as registered social landlords, to libraries and cultural buildings. This visibility should be developed through our local infrastructure groups using, and extending, our one-public-estate principles. We will have effective and integrated systems that will enable us to make best use and fully optimise our built infrastructure across all our system partners.

We will increasingly design flexibility into our infrastructure as much as we are able; from agility of occupancy to adaptability of physical spaces, to flexibility of use enabled through digital systems (such as shared staff access and booking). It is essential what we plan for future adaptability as healthcare needs evolve; allowing for easy reconfiguration without significant changes or cost implications and we must build this into new builds, refurbishments and discussions with current and future landlords.



Section 2: The road to 2040

Our future is green and environmentally sustainable

WHERE DO WE NEED TO BE?

We will have a green and environmentally sustainable infrastructure, that will be net-zero by 2040 (in line with the NHS targets and our ICB commitment) and be well on our to achieving our carbon footprint plus net-zero target. We need a greener infrastructure for more than just delivering the commitments to government; our green plans are essential to shaping a healthier future for the communities that we support.

We need to be working holistically with all our Lancashire and South Cumbria partners (in the NHS and far beyond) to develop solutions to addressing climate change in collaboration and at scale (from net-zero to building resilience against climate changes from heat to flooding). We need to be developing 'big' solutions across our geographies at the same time as we are doing 'the small stuff'. We need to align our own plans with wider strategies including the Local Nature Recovery Strategies

Our greener infrastructure should mean we have a more affordable infrastructure as our energy costs decrease over time. We need to have fully embraced a smarter infrastructure so we can realise our green ambitions; using data and intelligence to be better target investment and improve performance on an ongoing basis. We need to be focusing on net-zero for everything; our new hospitals and all other new builds (£15m+) from 2023 onwards will be net-zero carbon. We need using our buildings and land differently, using spaces to support out long term environmental sustainability, and working with our local partners to connect research and innovation to our Lancashire and South Cumbria NHS evolving green plans.

We will have increased use and access of our own NHS green spaces, supporting local community engagement with nature and improving biodiversity.

HOW DO WE GET THERE?

We need a comprehensive approach, building on the work completed to date, where we take an increasingly green approach to everything we do in relation to infrastructure; from sustainable procurement to our on-the-ground maintenance approach to our land use.

Expand the ambition of our green plans – we will build on the plans we have developed to date (as well as the Ramboll reviews) and align these will our infrastructure programmes and core, flex and tail catagorisation. We need to start to expand and scale our green plans, with them being fully aligned to our system wide infrastructure plan over the next 10-15 years. Future updates to our ICB green plan will need to be aligned with our evolving infrastructure delivery plans. We need to ensure we are fully engaged in the development of the opportunities mapping in line with the development of Local Nature Recovery Strategies.

Alignment with site planning – We will align all our site planning with our green ambitions (specifically decarbonisation); one of the assessment criteria around categorisation will be the ability to achieve (and the potential cost) of decarbonisation.

Section 2: The road to 2040

Our future is green and environmentally sustainable

Transport, fleet and EV infrastructure – As we review our transport and fleet as part of our green plans, we must ensure this is integrated with our site development strategies. We need to ensure there is sufficient EV charging capability for vehicles and, where relevant, NWAS's electric ambulance fleet - it is critical this considered early enough to ensure we have appropriate power to meet our ambulance and wider fleer needs.

EV chargers – when considering EV charger provision, we need to be an intelligent client; recognising that there is financial value associated with our charging needs. We should consider a cross-system strategy for this as our EV network expands to ensure we are getting best value across our sites, potentially generating an income back to the NHS. We need a separate plan for NWAS, aligned to our site strategies and plans.

The Lancashire and South Cumbria energy network - We need to engage with the electricity providers to ensure our net-zero energy requirements are met (especially for the new hospital demands but is applicable everywhere).

Workforce - We need to embed environmental sustainability as a core remit across our estates and facilities workforce.

Investment - We will need investment into our locally NHS owned infrastructure (core) and this will form part of our 15+ investment strategy, utilising a range of funding to support our transition to net-zero.

Alignment with capital priotisation and investment – we must ensure we align our green plans with our capital investment. This might mean that we do not make any significant or long-term investment in relation to decarbonisation for several years; knowing that these buildings are part of a long-term divestment strategy (as flex or tail). We should ensure that all reporting on progress against net-zero targets is full reflective of this to avoid a misrepresentation of our net-zero progress being taken nationally.

Reducing our footprint and improving efficiency – We do not wish to be emitting carbon against space we are not using, so one of the simplest ways we can reduce our carbon emissions is to reduce our buildings footprint and use space more efficiently. We will look at this in line with our site development strategies as well as the potential for consolidation and rationalisation through improved utilisation. We will extend this thinking across our wider partners, in line with OPE.

Translating the impact of digital – we must consider the impact of an increasingly digital NHS on our green plans and integrate this. Paperless systems (including an EPR) will reduce the need for storage and waste as well as enabling a whole new model of care. Telehealth and remote consultations will reduce some of the footprint we need and reduce the need for excessive patient travel and hospital visits. Ongoing post-pandemic use of virtual working/ meetings has reduced the carbon footprint from staff travel and we must ensure it continues to do so.

Digital platforms could be embraced to provide opportunity for patient empowerment in relation to more sustainable healthcare practices.

A shift to cloud-based services reduces our need to have excessive physical infrastructure and space requirements for data centres and servers on our inefficient sites. We need to ensure at the same time we understand the environmental impact of our digital NHS: digital infrastructure still has a carbon footprint.

Green buildings need to be smarter buildings – we need smarter building that integrate technologies and systems to optimise energy efficiency, reduce resource consumption, and enhance overall sustainability. We can use technology to improve energy efficiency: using systems to make positive adjustments in real-time, use energy monitoring and analytics to reduce energy waste, and enable more efficient resource utilisation.

Maximising the opportunity through planned and preventive maintenance - when undertaking planned maintenance, we will ensure we take every opportunity to make positive improvements such as new light fittings and improved insulation. Whilst we do not wish to make any significant investment into tail buildings, where we are doing necessary maintenance, we will still make these changes (to support net zero journey/reduce costs).

Use of data to measure and report – We will monitor and measure our environmental performance, regularly tracking key metrics such as energy consumption, waste generation, and water usage. We will report on progress across the ICB partners and share achievements, opportunities and challenges transparently.

A new approach to refurbishments and developments – we will adopt the Net-Zero Building Standard and take a fabric-first approach to developments. All new developments over £15m from 2023 will be net-zero, with the ambition that all new builds are net-zero (to reduce the need to invest in the future). We will explore less-traditional construction methods to benefit from the advantages of offsite construction and MCC.

We will use our land and buildings differently – We can use our land and buildings to support our journey to net-zero; from extension of existing initiatives such as installation of photovoltaic panels, to new areas that could include greener energy generation, micro-grids, energy and battery storage, potential offsetting (eg wetlands, re-wilding, tree planting etc), or becoming a community net-generator and aggregator of energy. Some of our sites may have the potential to be developed by partners to assist our emerging plans to achieve net-zero.

Innovation – Partnerships and innovation are essential and we will collaborate with our academic institutions, and others, to identify radical, yet deliverable solutions that help us towards our net-zero targets.

Working with our property companies – we will work with the NHS property companies to identify where the responsibility for decarbonisation sits and where the funding will come from (including existing funding within contracts, where relevant). We must ensure that net-zero plans for property company buildings are aligned with our ICB strategy (considering strategic building catagorisation and the future suitability of the LIFT portfolio).

More than decarbonisation – being green is about more than just decarbonisation. While reducing carbon emissions is a critical component of achieving sustainability, it is not the only aspect of our NHS environmental responsibility. We should think about the opportunities we have to implement biodiversity conservation, reduce waste, reduce water consumption reduction and our wider social responsibilities.

Section 2: The road to 2040

Our future infrastructure is affordable and financially sustainable

WHERE DO WE NEED TO BE?

We face a very challenging financial climate going forward, and we need to be able to do more, with less. We need to create financial sustainability across our infrastructure by taking a long term, strategic and system wide approach to ensure we can create quality, efficient infrastructure for the future. We need realistic, yet visionary, plans around delivery and operations, that enable us to be streamlined and equitable across all parts of our system.

Inherently connected to our other principles, spending within our means is one of the driving principles for change; from leadership to estates management to investment decisions to strategic requirements; it shapes all our future plans.

We need to be managing space demand and capacity effectively; utilising technology and digital systems to minimise workforce requirements and to reduce complexities around infrastructure management. We need to be ensuring we are maximising the funding available to us and that we take a 'whole-life' view around affordability.

We must be able to think laterally and innovatively, but at the same time must be realistic and ensure our plans are deliverable in the short, medium and long term. It also means we must be realistic and manage our expectations. We will not be able to do all the things we want to do and will need to look at alternative delivery models and re-shaping some of our operational management to enable us to make infrastructure improvements where we need to. We need to be able to re-allocate, re-direct and re-deploy resource as we need to.

In order for us to have a sustainable future, we must think about the economic and financial sustainability of our infrastructure, as well as its impact on our workforce, our services and our system. Building local supply chains and creating circular economies will support our communities, local businesses and the public that we serve. We need to be embedding, embracing and principles of circularity into our health infrastructure planning to ensure long term financial sustainability.

Section 2: The road to 2040

Our future infrastructure is affordable and financially sustainable

HOW DO WE GET THERE?

When we are looking at our NHS infrastructure, we need to be considering the areas we can make cost savings and/or realise financial benefits, especially when these benefits are recurring. Some of the areas we will consider:

- **Reducing our footprint** – with a smaller built infrastructure footprint, we have less space to pay for. We may find some of our costs increase as our quality increases. But, at the same time, as we consolidate and improve our efficiency, our running costs should reduce.
- **Standardisation** – where appropriate we will take a standardised approach to streamline the way we work to achieve greater economies of scale and reduce costs.
- **Energy efficiency** – this will be key to our future infrastructure affordability as energy-efficient buildings, and related initiatives, can significantly reduce operational costs over time.
- **Value for money** – we must be getting value for money across our community infrastructure; as we move more services out of hospital then we need to ensure our buildings represent good value for money.
- **Taking a whole life approach** – We must take a whole life approach to all infrastructure; looking at the whole life costs in everything from new developments, to transformation initiatives, to the catagorisation of our buildings.
- **Efficiencies** - We will continue to explore efficiencies in relation to energy, waste and other areas across our infrastructure. We will reduce our storage needs and will continue to take a consolidated staff workspace approach.
- **Cost savings** – Identify areas where cost savings can be achieved without compromising quality or safety.
- **Sharing resource** – We will develop plans for how we work together to share resource, capacity and expertise across our organisations. This may lead to a re-shaping of our workforce to ensure we are maximising value of our skills and expertise across the system
- **Future workforce** – Where we have ongoing gaps in resource (that we currently fill by bringing in external expertise), we will begin to develop our own ICB-wide infrastructure expertise for the medium-long term. We will ensure we benefit from skills and knowledge sharing when we need to bring in external resource in the short term.
- **Collaborative workstreams** – We are already working across the ICB on a number of collaborative work streams in relation to major equipment and technology. We will continue to plan and change our support services to deliver economies of scale to procure, manage, maintain and service equipment in a consistent way across our ICB.
- **Consolidation and centralisation of back office/ supporting functions** – We should develop opportunities for consolidating back office and support functions and their associated accommodation – we are already doing this through our pathology collaboration and will continue to identify new opportunities e.g. Pharmacy, Sterile Services, Catering Services, finance, HR, estates and facilities etc.
- **Reducing unnecessary work** – We will review the things we do and minimising non-value-added activities, reducing errors, and enhancing communication and coordination across our infrastructure partners.
- **Minimising the need for NHS capital** – We will need to reduce our requirement for NHS capital and revenue to fund non-essential infrastructure, focusing our resources on critical healthcare functions and spaces that directly contribute to patient care.; this may mean that we potentially contract some of our infrastructure service provision in different ways in the future. It also means we will need to do far more with partners in the future, looking at opportunities across place to support health (potentially using our land to facilitate some of these opportunities).

A positive financial impact to the NHS
We will look at how we could generate income across infrastructure programmes; this could be through looking at potential from waste and recycling, to energy generation, to the receipt of ground rents from partners who are using NHS land to deliver wider health benefits.

Use of NHS & public sector infrastructure
We will assess the opportunities to work collaboratively across our partners to make better use of our collective public built infrastructure in order to reduce overheads, maximise benefits to patients to achieve the greatest return to health, drive efficiencies and work more efficiently and effectively.

Use of NHS land for financial benefit
We can also consider here how we use our buildings and land for alternative delivery models, prevention and to address health inequalities. Our land values are generally very low, so we are usually unable to generate capital returns significant enough to enable infrastructure transformation through disposals; however, it does provide us with the opportunity to generate value in a different way. Through a different use of our land (and the option for retention of the freehold), we can potentially realise significant financial, fiscal and capacity benefits; in everything from a reduction in hospital admissions, to GP visits to reducing the pressure on social care.

Section 2: The road to 2040

Our infrastructure shapes healthier places

WHERE DO WE NEED TO BE?

We need to be far more connected, engaged and facilitatory in how we shape healthier places through infrastructure if we are to deliver our strategic ambitions. We need to be increasingly proactive in creating infrastructure for prevention; with an ever-greater focus on influencing, partnering and collaborating to use infrastructure to reduce health inequalities. We need to embed both social value and 'health value' in all our infrastructure decision making, strategies, planning, procurement and delivery.

As local anchor institutions we need to be actively considering how we use our infrastructure to benefit local communities, especially at sites that we consider to be core and/or strategically important. We need to re-think how we view 'surplus' NHS land. Land should not simply be something we immediately dispose of for a capital receipt; it presents up with an opportunity to re-shape our local places, address the wider determinants of health, and significantly contribute to system financial and environmental sustainability (see Building for Health and the need for Creativity and Innovation).

We need better, different and more health infrastructure at place; with increasing provision in the community for early interventions and community diagnostics to reduce hospital attendances – from community centres to the high street. We need to ensure that when people have been in hospital and are discharged, they are supported by social care, housing and community so they can return home quickly and safely.

Where we are making significant and at scale changes to infrastructure, moving service delivery, or shifting to a different model of patient care, we must become far more holistic in our infrastructure planning; focusing on broader considerations from public transport, to road access, to digital connectivity.

We need to be part of local place-led strategies for economic development and regeneration that help us to embed prevention and reduce health inequalities locally. We must be involved in the leadership conversation around infrastructure in all our places so we can influence others' plans, and allow our own plans to be influenced. We need to have strong relationships locally with a breadth and depth of partners who are better able than the NHS to deliver much of the infrastructure we need across place and neighbourhoods; from social businesses and enterprises, voluntary and third sector, housing associations and our network of local SMEs and industry.

Section 2: The road to 2040

Our infrastructure shapes healthier places

HOW DO WE GET THERE?

We will direct more focus towards the infrastructure needed for prevention, and to address local health inequalities. We will use NHS England's Building for Health principles to provide initial guidance, whilst exploring partnership opportunities to do much, much more.

We will become more engaged strategically to **influence** infrastructure that impacts health but might not be directly responsible for the delivery of health services. It is important that we develop our civic role; lobbying, influencing and shaping locally, regionally and nationally in order to reduce health inequalities through infrastructure.

We should become part of the leadership conversation about local infrastructure planning locally as anchors institutions; influencing at the earliest stage and then stepping back, allowing others to deliver. We will start conversations to allow us to develop longer term strategies for health at place that includes infrastructure.

Local authorities - We will work more closely with Local Authorities on our health infrastructure requirements, looking at everything from joint planning, to policy frameworks to influencing development decisions. We will be active participants in Local Plan development for health and will explore potential synergies between health and Levelling Up initiatives.

We will deliver more services in more appropriate settings and with partners – from leisure to community locations.

We will create more spaces across our accommodation for patient activation and empowerment; this could be as simple as providing space for non-clinical activity, including clinical support activities, social prescribing, prevention or digital learning. We need to use our land to address our health needs and health inequalities and we have excellent opportunities that we need to champion and then drive across several locations in Lancashire and South Cumbria.

Section 2: The road to 2040

Focusing on the importance of environment: for people, health and the public £

We cannot underestimate the impact of buildings and environment. They can have both a qualitative and quantitative contribution towards prevention, longer-term health improvement and equity. We should put this idea at the centre of our strategic decision making moving forward.

We will continue to broaden our thinking around where we deliver services. We need to be thinking more holistically about the impact of environments; using environment as a tool for prevention, self-care and improved health, and we must therefore think laterally about our accommodation choices.

An example – Someone has been having long term joint problems and pain and has been referred to a musculoskeletal (MSK) service. Lifestyle changes alone could make a huge difference to their quality of life, and likely reduce their need to access health services now and into the future.

If we choose to deliver the MSK session in a leisure centre, rather than a hospital or health centre, what impact might this have? Do we automatically 'de-medicalise' the consultation through environment? Do we make the leisure centre and gym a more comfortable space to visit for that individual, empowering them to be more confident in becoming more physically active?

The ripple effect beyond the improvement to this individual's health could be huge: Do the NHS build better connectivity with leisure colleagues though co-location? Do we then create more opportunities for development of new non-health 'pathways'? Can we work more efficiently through a blended workforce? Is this space cheaper for us to run a service than it would be on a hospital site? Does this person speak to their family and friends and we see them joining locally-run gyms to improve their own health and contribute to the local economy?

Do we create an upward cycle of change through that one 'estates' decision?

This is already happening locally, including in Kendal. It is not difficult, and we need to start scaling and replicating this way of working more broadly across place and neighbourhoods.

Section 3

How do we get there: approach, buildings & enablers

Section 3: How do we get there

We're in this together: working as a system across Lancashire and South Cumbria

We will need to be more strategic than ever before with our planning; this can only be achieved together, as a system.

Developing scalable and replicable system solutions

We need to be designing and creating scalable and/or replicable infrastructure solutions that we can use across our Lancashire and South Cumbria footprint; considering everything from funding, to processes, to primary care infrastructure development. There will be local nuances to some of our requirements, and a one-size-fits all solution is unlikely to work, but we should be developing blueprints; a series of solutions that can adapted and delivered with ease across Lancashire and South Cumbria.

Within our system: buildings and services

We must also ensure that we take a system approach not only between our different organisations' infrastructure and property functions, but between infrastructure teams and our clinical services. It is important that **the development of clinical delivery plans is undertaken with the awareness and understanding of built and digital infrastructure opportunities and constraints** (including capital). We can then work collaboratively to find a balance that enables service transformation and transition in a way that is deliverable and is aligned to our infrastructure principles.

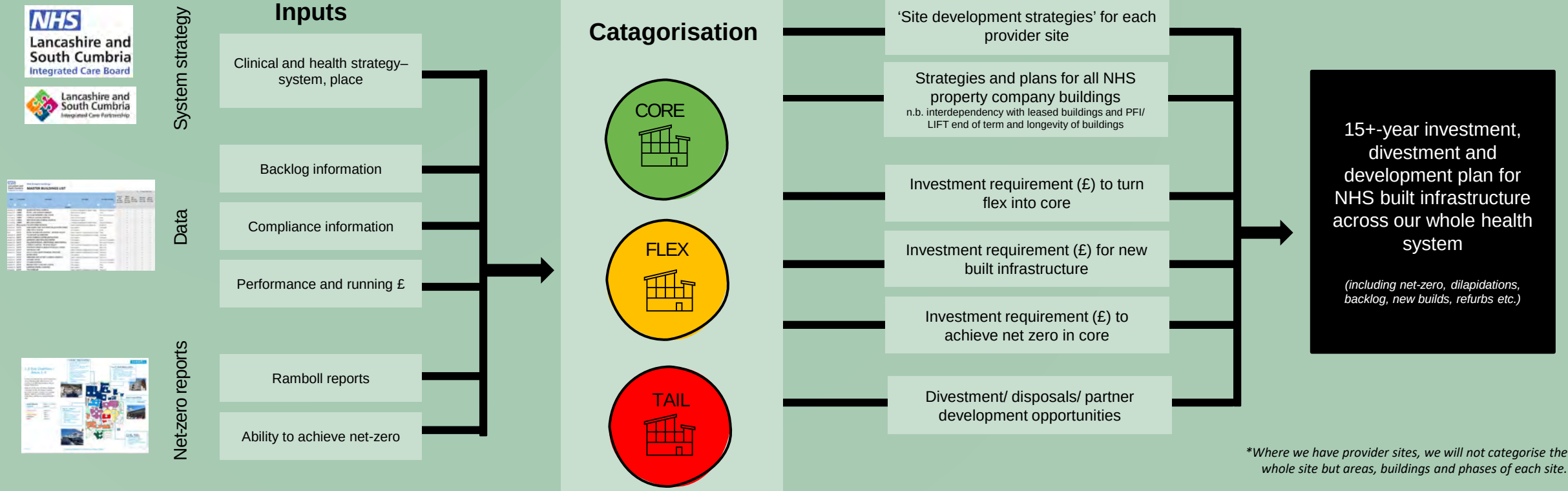
Categorising our buildings; core flex and tail

One of the first things we need to do as a system is to **strategically catagorise our NHS buildings and sites as core, flex or tail**. This will enable us to then develop a series of site development strategies (for provider sites), and a system-wide phased pipeline of investment, divestment, transformation and innovation requirements.

Section 3: How do we get there

Core flex and tail: Strategic catagorisation

It is essential that we undertake a system-wide categorisation of all our built infrastructure; looking at each of our assets and buildings*. This will be a dual catagorisation, categorising them as 'core', 'flex' and 'tail' from both an estates AND a service delivery perspective. To complete this catagorisation across the ICB, we must first analyse and assess clinical service delivery (both locally and across the ICB footprint), our local system context and our specific population needs at place. Then we must undertake our core, flex and tail review in line with our existing building condition information and performance; considering everything from the recent Ramboll reviews and the potential achievability of net-zero, to the required investment into backlog maintenance and more general performance metrics. We must also look at wider interdependencies such as workforce. See detail around the approach we might take in Appendix 1. More detail is provided on core, flex and tail buildings, and the catagorisation criteria and definitions here.



*Where we have provider sites, we will not categorise the whole site but areas, buildings and phases of each site.

Section 3: How do we get there

A system approach to core, flex and tail

**Where we have provider sites, we will not categorise the whole site but areas, buildings and phases of each site.*

Core

Our core built infrastructure is fit for purpose; it is good quality, flexible and adaptable. It provides the right space in the right place, it can be decarbonised and it is needed for the delivery of the ICB's clinical strategy to 2040 and beyond.

We will **prioritize use of our core buildings***. Where we have core buildings, we will work actively with the building owner to ensure that we have longevity of use, that these buildings are fulfilling all our infrastructure principles and that their use is maximising our ability to deliver each of our ICB infrastructure ambitions.

This is where we will **focus most of our attention around long term transformation and strategic investment**, and we will be proactive in ensuring we are improving our use of these spaces, as well as their longevity in line with our clinical strategy.

Where these are NHS PS or CHP, we will work with the property companies to ensure that these buildings **are optimised for long-term occupancy**. We will need to be clear on what we need, with this being particularly important for the LIFT portfolio as we move quickly towards the end of the concession periods *(though we should not automatically make the assumption that all our LIFT buildings are core).*

Flex

Our flex built infrastructure is partially fit for purpose; it is of an acceptable quality, it may be flexible and it might be able to be adapted. It is probably the right space and/or in the right place, it may or may not be able to be decarbonised and is likely needed for the delivery of services, though it does not fully enable the delivery of the ICB's clinical strategy to 2040 and beyond.

Where we have flex buildings, we will **need to do more work to understand whether these buildings will become core, or tail in the long term**. We should either have a robust investment plan in place or a strategy for replacement so these buildings can be phased out.

There will be some flex buildings that may be suitable for investment; with reasonable investment they will become core buildings that are fully aligned with our ICB clinical and infrastructure strategy. Where this is the case, and we can evidence the need using data and intelligence, we will also prioritise investment in these buildings.

We will not prioritise or support works to flex buildings deemed unsuitable for investment in instances where:

- They will never be able to be brought up to core standard because of the building type or fabric
- The cost to bring them to core standard is not 'reasonable' and considered a poor use of public money
- An alternative infrastructure solution can be delivered that better aligns to this and other strategies

Of course, **we will still need to invest some money into our flex buildings** to ensure patient and staff safety, **but this will only be in the short term and alongside the development of a longer-term strategy**.

We will prioritise the development of alternative options and we will not support any changes to service delivery that proposes flex buildings ass a location where they have been deemed unsuitable for investment, unless they are being used in the very short-term on a temporary basis and with a longer-term infrastructure solution in place.

Flex buildings unsuitable for investment should be phased out, with a plan for an alternative infrastructure solution for each flex building being put in place by 2028 at the latest. Flex buildings unsuitable for investment should be considered in the first instance for alternative uses by other public sector and local partners; including redevelopment of buildings and land, especially when these alternative uses are key to supporting the delivery of the ICB's clinical strategy.

Tail

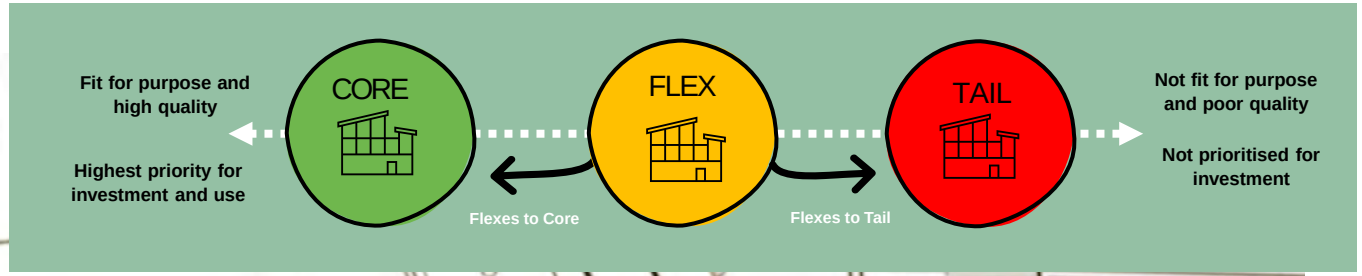
Our tail built infrastructure is not fit for purpose; it is poor quality, probably inflexible and likely cannot be adapted without great and unreasonable expense. It does not provide the right space and/or is not in the right place, and it is highly unlikely it can ever achieve net-zero. It does not, and will never be able to, deliver the ICB's infrastructure ambitions.

We will **phase out the use of our tail buildings**, focusing our attention on putting plans in place to provide an alternative infrastructure solution as soon as possible.

Where the service delivery is fundamental to the delivery of our clinical strategy, we will **prioritise investment into a replacement infrastructure solution.** All alternative solutions should be developed in line with our infrastructure principles and through taking a collaborative approach.

Tail buildings are unlikely to be suitable for alternative uses in their current form, but should be considered for use by other public sector bodies. Future land use should be considered in the context of local health need in line with our transformation ambitions, prior to any disposal.

(Two examples of our known tail buildings include Royal Preston Hospital and Royal Lancaster Hospital).



Section 3: How do we get there

Our evolving requirements for transformation and investment

This is **a snapshot of our evolving requirements** across our places (and localities) and does not include all our projects and programmes of work. We are constantly building on this, and I will be further shaped through our core, flex and tail work, refining our system and local needs and the associated capital requirement.

All (or multiple) places/ localities

- Decarbonisation, energy and climate response
- Medical equipment and technology
- General infrastructure investment into core and flex buildings (and tail when required for safety) plus backlog
- Digitsation
- Central, shared and supporting services (e.g. pathology, aseptic, workshops etc.)

Lancashire (North Lancashire)

- New hospital in Lancaster area (NHP)
- New community and primary care hubs in Lancaster
- PFI solutions for LSCFT
- Local investment shaped by place and neighbourhood needs

South Cumbria

- Investment required into health infrastructure at Furness General Hospital
- Local investment shaped by place and neighbourhood needs

Lancashire (East Lancashire)

- Investment needed at Burnley General Hospital (including diagnostics)
- Improved utilisation and potential reconfiguration required across LIFT portfolio
- Full strategy required for the future of the Whalley site (and investment identified)
- Local investment shaped by place and neighbourhood needs

Blackpool

- Investment into health infrastructure at Blackpool Victoria Hospital
- Improved utilisation across core community buildings
- Local investment shaped by place and neighbourhood needs

Lancashire (Central and West Lancashire)

- New hospital in Central Lancs/ Preston area (NHP)
- New community and primary care facilities and hubs required in West Lancashire, Preston and Chorley
- Local investment shaped by place and neighbourhood needs

Blackburn with Darwen

- Improved utilisation and potential reconfiguration required across LIFT portfolio
- Local investment shaped by place and neighbourhood needs

Section 3: How do we get there

Acute and hospital

We need new hospital infrastructure across our network to both enable transformation and reduce our backlog so we can deliver safe services today and into the future in line with our clinical strategy. This includes replacement hospitals in Preston and Lancaster as well as upgrades, refurbishments and new developments across existing sites, buildings and equipment. We need to undertake a detailed mapping of our network requirements, alongside our strategic catagorisations, and then ensure appropriate alignment of each of our provider estates strategies to ensure we are taking a system approach moving forward.

The New Hospital Programme

We are focused on the development of the required new hospital facilities we need to replace Royal Preston Hospital and Royal Lancaster Infirmary. Our new hospitals will be carbon neutral 'digital hospitals', that are at the cutting edge of healthcare infrastructure.

As well as investments into our buildings, we will develop options for how we use digital infrastructure and technology to support service delivery and operational buildings management; we will plan for the opportunities and challenges of a digitally mature hospital system and how this may impact our buildings in the future.

Mental health

We intend to create ever-increasing parity for mental and physical health services and we will reflect this in our infrastructure planning, with equal focus on our mental health requirements. We need to conclude the Whalley site transfer from Mersey Care NHS Foundation Trust to LSCFT and continue momentum around re-imagining the Whalley site for sustainable and integrated health and wellbeing; providing the right accommodation for LSCFT services, whilst supporting system, place and neighbourhood. We also need investment to re-provide accommodation at Blackburn, and imminently need to identify a way forward for the future of the LSCFT PFI sites across North Lancashire.

Learning disabilities & autism

Across our learning disabilities pathways, we intend to reduce the need for residents to be in hospital and this may mean we need increased community provision that may include the need for additional housing-based model.

We will look at the future capacity we need across Lancashire and South Cumbria as we repatriate more patients so they can receive the support they need closer to home, their friends and their families (this will begin with the provision of local LD beds (£32m capital scheme)).

Major equipment and technology

We need investment in major medical equipment across Lancashire and South Cumbria, with our core, flex and tail needing to expand to include catagorisation of medical equipment in order to develop a system wide strategic plan; from provision of major equipment, to maintenance and servicing, to a common technology platform.

Section 3: How do we get there

Re-thinking our out of hospital infrastructure

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

Primary care

Our local ambitions for integrating primary care respond to and reflect the offer set out in the Fuller report; streamlining access to care and advice when people need it; providing more proactive, personalised care with support from a multidisciplinary team of professionals, and helping people to stay well for longer.

The Fuller report clearly identifies a requirement for 'locally-led change' in order to deliver the ambitions for local integration for primary care. We will ensure that we build this localism into our plans at both place and neighbourhoods; whilst our NHS infrastructure will need to be fully aligned to this strategy, our local responses must be developed locally and at place via our Integrated Care Partnership. This will require both effective communication and ongoing good governance to ensure that resource, capacity and appropriate funding are available to enable change locally. We will need to create the frameworks and principles to that ensure that maximise benefits are realised across infrastructure at place; enabling a bottom-up and local place-based approach to be taken, within a broader ICB framework.

We will have locally driven solutions, developed our ICB framework and principles, alongside the right governance that enables strategic infrastructure development at place (extending this to include partners beyond the NHS).

We need to create the spaces (both physical and virtual) to enable neighbourhood teams to come together. Some of our hub models may be overwhelming virtual, but we will need the physical locations across the built infrastructure to allow staff to all meet in a single location as a large team when they need to. We need to find a solution to increasing capacity across primary care, so we have the right capacity to support our clinical strategy.

We need **significant investment** into our primary care built infrastructure (where possible, in hubs alongside community services), especially in Preston and Lancaster.

Section 3: How do we get there

Beyond primary care

We will consider and plan for the different types of infrastructure we need to create at place, taking a one-public-estate and integrated approach to creating the infrastructure of the future. We will have a core-built infrastructure, with accommodation provided across integrated hubs, health campuses, on our high streets, in the home and across our communities (from community centres and other community spaces, to supermarkets, to pharmacies).

Hubs – We need to develop a number of hubs (including in Preston and Lancaster) where community and primary care services will come together alongside other health provision (including the out of hospital services that need to be provided locally as part of the new hospitals programme model of care).

Community diagnostic centres (CDCs) – we need to expand our diagnostic capacity in the community, building on our existing CDCs.

Rehabilitation – we need to map our needs for different rehab models locally that enable people to be discharged from hospital for intensive recovery and rehabilitation.

Day hospitals – The development of day hospitals (like the Jean Bishop Centre in Hull) have the potential the support a reduction in hospital admissions, especially for people with complex needs and/or frailty; where people can go to be monitored, assessed and receive short-term care. The need to explore the potential development of day hospitals has been identified across the ICB, including in South Cumbria.

Health, wellbeing and community campuses – These types of campuses are not a new concept but are something we can do much more of; where we develop a mix of 'healthy' infrastructure such as primary care, housing with care, community centres and cafes, leisure, day-hospitals, etc. to support our health system transformation through a mixed economy model (with a blend of funding that is not reliant on purely NHS investment). We have real opportunity here to develop our thinking further; using surplus land across our NHS partners, with projects already being considered across several of our sites.

Health on the high street – Our high streets present us with a range of opportunities to create the health infrastructure of the future, especially with our increased focus on out-of-hospital/ non-acute infrastructure and place-based, population led services. We did 'health on the high street' during the pandemic and continue to explore options to bring more health to local communities through use of existing empty buildings.

Health at home – In the future, we will be just as likely to deliver and receive many of our health services at home. Building on the virtual wards and other telehealth services of today, we will continue to expand models to support people to manage conditions at home to improve health, reduce admissions and to take more control of their own care. Creating the right platforms and systems will be essential, along with a depth of consideration and planning around digital inequity (from skills and support, to access to equipment/ services to geographical WiFi and 4/5G connectivity).

Health in the virtual space - We will need to understand how increased virtual delivery impacts on our infrastructure and the wider considerations we will need to make. Digital equipment, technology, wearable and other connected devices will be fundamental to support the delivery of effective place-based models of care – improving choice and access for people and enabling more anticipatory care, prevention and self-care.

This work must be aligned to the core, flex and tail catagorisation of all community buildings, over the short, medium and long term.

Connectivity with LIFT end of term
Strategic alignment and localised plans will be particularly important in respect of the LIFT portfolio and planning for the longevity of buildings (either for use by the health system, or not).

Section 3: How do we get there

Other things we need

Digital connectivity at place – As our network of built infrastructure and the places we deliver care expand and evolve, we need to ensure we are embedding digital connectivity at the heart of our plans; for staff, patients and citizens.

Local autonomy of how we use space – We need as much local autonomy as possible so that our local buildings can enable our transformation flexibly and responsively. We need excellent relationships and collaboration with the NHS property companies, potentially considering taking the head-tenant and shareholding role back into the local NHS across the LIFT portfolio. Where we are using other leased space from either a private or public sector landlord, we need to ensure we have the appropriate flexibility in place to support our local places.

Appropriate lease and licence arrangements – we need occupancy agreements that are reflective of the NHS in 2023 (and beyond), where integration, flexibility and collaboration are at the heart of our delivery.

Alignment with the VCFSE– We need to develop a greater understanding of opportunities to support and be supported by the VCFSE, especially in relation to sharing space and partnership opportunities.

Alignment with social care - As we evolve our clinical strategy and we shift more care into the community, it is imperative we start to align our infrastructure plans with those of social care. As our network model starts to evolve, our system will become more reliant on us having robust approach to more prevention and self-management, but we will need a supporting and supportive social care system.

We need to build relationships and governance at place to build the locally-based infrastructure conversation. As part of this, we must consider residential care, specialist dementia facilities, supported and specialist housing (including extra care).

Considering the importance of good housing for health - We know that nationally the cost of poor housing to the health service is significant *(£1.4bn per annum nationally according to a 2021 BRE report).* As part of our infrastructure planning, we need to increase our efforts to actively promote improving local housing in a coordinated way across our health and care organisations. Areas such as cold homes, poor air quality, hazards, loneliness and tenancy concerns impact on poor physical and mental health, which in turn increase demand for services. We should make a positive impact to improve housing where we can; from working with partners, to potential land use for healthier and more appropriate housing, based on local needs.

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

Specialist housing - We also need to look at where we need to create more specialist housing for people who have different needs; from dementia to learning disabilities. We will also work with our local authorities to understand the plans for the development of housing with care (which provides multiple benefits to our health system) across our local places, enabling and supporting this where possible.

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

NHS key worker housing - We should consider our requirements for housing for our NHS staff in line with local workforce strategy and then map our needs across the ICB and integrate this into both our infrastructure delivery plans and investment strategy. The recent White Paper Delivering NHS Homes provides a number of areas for consideration.

Section 3: How do we get there

Enabler 1: Collaboration

As we have reiterated throughout this strategy, we must work as a system: we are collectively much stronger than the sum of our parts. We must work across our providers, our NHS property companies, our local authorities, academic institutions, industry and others to build on our current collaborations and to form new ones.

We should consider collaboration opportunities where we need **new developments** in our communities, exploring opportunities for co-development with social care facilities and affordable extra care. We should **strengthen our one public estate approach**. As we begin to work in closer collaboration with others, we will need to ensure that we are not inadvertently adding complexities to others' programmes – we want our input to be enhancing and creating new opportunities, not stifling others' progress.

We must **deepen our relationships with the NHS property companies**, NHS Property Services and Community Health Partnerships, who are an intrinsic part of our infrastructure network across our places in the community. Beyond the NHS, we will **engage with the market** to ensure the solutions we need are out there and our partners and the wider market are aware of what we are trying to do across our health system. This may mean we need discussion with funders, developers, tech providers, equipment manufacturers and electricity companies.

Sharing learning and replicating the things that have worked

We will share learning better across our NHS partners; for examples, we will use the learning from the new hospitals programme to filter into our wider infrastructure plans; from how we create big cross system discussions around infrastructure, to opportunities around smart buildings, to what a 'building of the future' looks like. As we plan, we can begin to adopt the proposed future ways of working across our core infrastructure; we do not wish to inadvertently create further building inequity through delaying the implementation of innovative approaches that will be part of our new hospitals. We will also share learning and take inspiration from other ICBs and Trusts; where something has worked well, we will try to adopt this locally.

Collaboration with our organisations; 'service' and 'estates'

We must start to actively manage clinical expectations and start a new two-way collaborative conversation - between infrastructure and service delivery to create a **truly symbiotic relationship**, where both clinical delivery and built infrastructure opportunities and limitations inform and shape each other. Over time, this relationship contributes to an increasingly flexible and responsive infrastructure

Collaboration across ICB infrastructure

Some are the areas of collaboration we need to focus on that we will pick up later in Section 3:

- Collaborate across our system partners to create the **workforce** we need for the future.
- We must collaborate to maximise our access to a range of **different funding solutions** as well as exploring joint ventures and public/private partnership opportunities
- **Opportunities at place** with partners, building on the work of the Local Asset Reviews.

> "We are collectively much stronger than the sum of our parts"

Section 3: How do we get there

Digital image from *Google Streetview, Google Maps (http://maps.google.com)*

Enabler 2: Leadership and governance

We **need to create a system-wide 'L&SC Infrastructure Board'** to progress the development and delivery of this strategy at the most senior level, focusing on strategic conversations from identifying future funding, to leading at-scale cross-system programmes of work around our long-term infrastructure needs.

Strategic Infrastructure Groups – These proposed place forums will be a re-invention of the Strategic Estates Groups. They must remain strategic, and Terms of Reference and membership should be carefully considered; with likely representation from NHS place leads, local authority, third sector, NHS property companies and the ICB strategic infrastructure team. As we develop our governance, we will need to ensure that we have clarity over where responsibility for planning of local place-based infrastructure sits and therefore what the group will be responsible for.

We need bold and brave leadership; there will be both innovative and difficult decisions to be made as our infrastructure is reimagined and our acute sites and community buildings are re-shaped over the next 15 years and beyond. Big investment will need to be made and new solutions will be needed to deliver our strategy, along with creative new partnerships and delivery models. We need to focus on the things we can shape, influence and do - both as NHS leaders and in our roles as civic leaders of anchor institutions.

We will need to be able broker discussions and develop solutions locally, regionally and nationally with a range of partners, agencies and organisations. We will need to be able to do these at system, place and neighbourhood level, reflective of our system in 2023 (See detail in Section 1).

We will need to work increasingly closely with colleagues at place to ensure that place and neighbourhood strategic infrastructure discussion is rooted locally, and built and digital infrastructure considerations are fully aligned with service development.

We will re-establish our governance forums, as well as having cross-system clarity around who is responsible for what as our system evolves and matures across system and place. We will need to ensure we curate spaces for strategic discussions at place with broader and different group(s) of stakeholders; with our ICB infrastructure governance arrangements enabling ICB capital planning to be informed and influenced by the right place stakeholders. And at the same time, ensuring we are able to maximise opportunities to impact health through wider infrastructure development.

If we take a place-footprint approach to our Strategic Infrastructure Groups, we must consider the potential complexity in relation to infrastructure and local development across the Lancashire place, where planning and regeneration sits at a district level. If we are going to develop a closer infrastructure relationship at place, this must include the leadership connectivity and the forums for these conversations with district councils as well as upper-tier authorities.

Section 3: How do we get there

Enabler 3: Investment

We know we need significant capital investment in our infrastructure, and we need NHS capital (here), but we also need a re-think of our capital and strategic investment planning. We will need to plan and prioritise collaboratively and tactically across the system to maximise use of NHS capital. We need clarity on our system requirements so we can take a system wide approach to both the identification of funding, and the development of our refreshed and updated pipeline for our investment requirements.

Pipeline of funding; getting more tactical with spend

We should begin by focusing on obtaining a greater and detailed understanding of what funding is already available and from where, and then become better at prioritising our requirements and at accessing appropriate funding. Our work in strategic categorisation will support us around prioritisation, but we need to ensure we have resource available to identify and bid for money.

With the right ICB resource, NHS capital and other funding or upcoming national and local grants will be signposted and communicated effectively to partners as part of a tactical and targeted approach; focusing on the right funds and working collaboratively to develop anticipatory business cases. As part of this, we will need to ensure appropriate skills are deployed to the right places across the system so as not to further widen infrastructure inequity.

A future approach to strategic and transformational investment

We need to be more commercially astute, and we need a 10-15+ year commercial and investment strategy that is flexible in nature. It should be a system-wide strategy that covers everything; from primary care, to innovative infrastructure solutions, to the long-term future of LIFT. We will need to develop robust strategies for the future as well as ensuring these are developed with procurement as well as NHS England and Treasury around how we develop these plans locally.

We know that NHS capital alone will not be able to support our transformation needs, so we will look at how else we can leverage resource and funding through partners to support the delivery of infrastructure to create a sustainable health system; from research funding, to enterprise funding, to private finance.

We will need to explore public-private partnerships and strengthen our relationship with local industry and the commercial sector. We need to be starting conversations with local pension funds, social funders and other funders around our future investment strategy across our whole system and health infrastructure pathways. In some instances, we should consider options and delivery models such as finance leases that enable the NHS to obtain long term ownership of strategic assets, following the initial lease period.

Delivery models and capital

Our capital requirements will drive our wider strategy in relation to service delivery; we may need to outsource certain services or provisions to reduce our capital investment requirements.

Local development

This strategy will also need to lead to a clear plan for required infrastructure investment. Under the Levelling Up & Regeneration Bill a mandatory Infrastructure Levy for development is proposed. Local areas will build up Infrastructure Delivery Strategies with ICB involvement. ICBs may need to ensure they are aware of what health infrastructure is required to support proposed housing development over the plan period.

We will work more closely with local authorities on our health infrastructure requirements, looking at everything from joint planning, to policy frameworks to influencing development decisions. We need to better progress opportunities to access Section 106 and Community Infrastructure Levy (CIL) monies to support our required health accommodation investments locally, where the NHS will engage more in the planning process, both to influence healthcare planning, and to argue for health to be a consideration in the formulation of local plans.

As we move forward, there will be a careful balance between the things we want to do and the things we need today. We cannot ignore that we will still need to make short term decisions and investments to some of our flex and tail buildings in order to keep patients safe, but we will avoid doing this as much as possible and any short-term investment will be the exception.

Section 3: How do we get there

Enabler 4: Partnerships

We cannot do any of this alone. We must grow and expand our partnerships to enable us to maximise transformation across our infrastructure.

We will strengthen and deepen our internal NHS partnerships, grow our existing partnerships beyond health and create new ones with a broader range of partners across system and place. We will work closely with other public sector organisations to together solve some our biggest infrastructure challenges. We will start to partner with other local anchor institutions to work on some of the systemic and societal challenges from climate change to health inequalities.

We will get increasingly comfortable working with others if we are to crease a sustainable health system with better health outcomes; local government, housing associations, the third and voluntary sector, SMEs, local anchor businesses, commercial partners, industry, pension funds and other funders will need to become part of our wider infrastructure network.

We must deepen our ICB relationships across the provider collaborative infrastructure teams and with the NHS property companies. We must work openly and transparently across our infrastructure partners to provide each other with clarity on local requirements to find deliverable solutions.

We will work more closely with our academic partners (including through Health Innovation North West Coast), and across our various learning networks to explore opportunities to partner with some of our brilliant local research facilities, to support us in our infrastructure journey around innovation.

Finally, we should not underestimate the time it takes to build these trusted partnerships; and we must take this into account in our timescales for some of our areas of work.

Section 3: How do we get there

Enabler 5: Data and intelligence

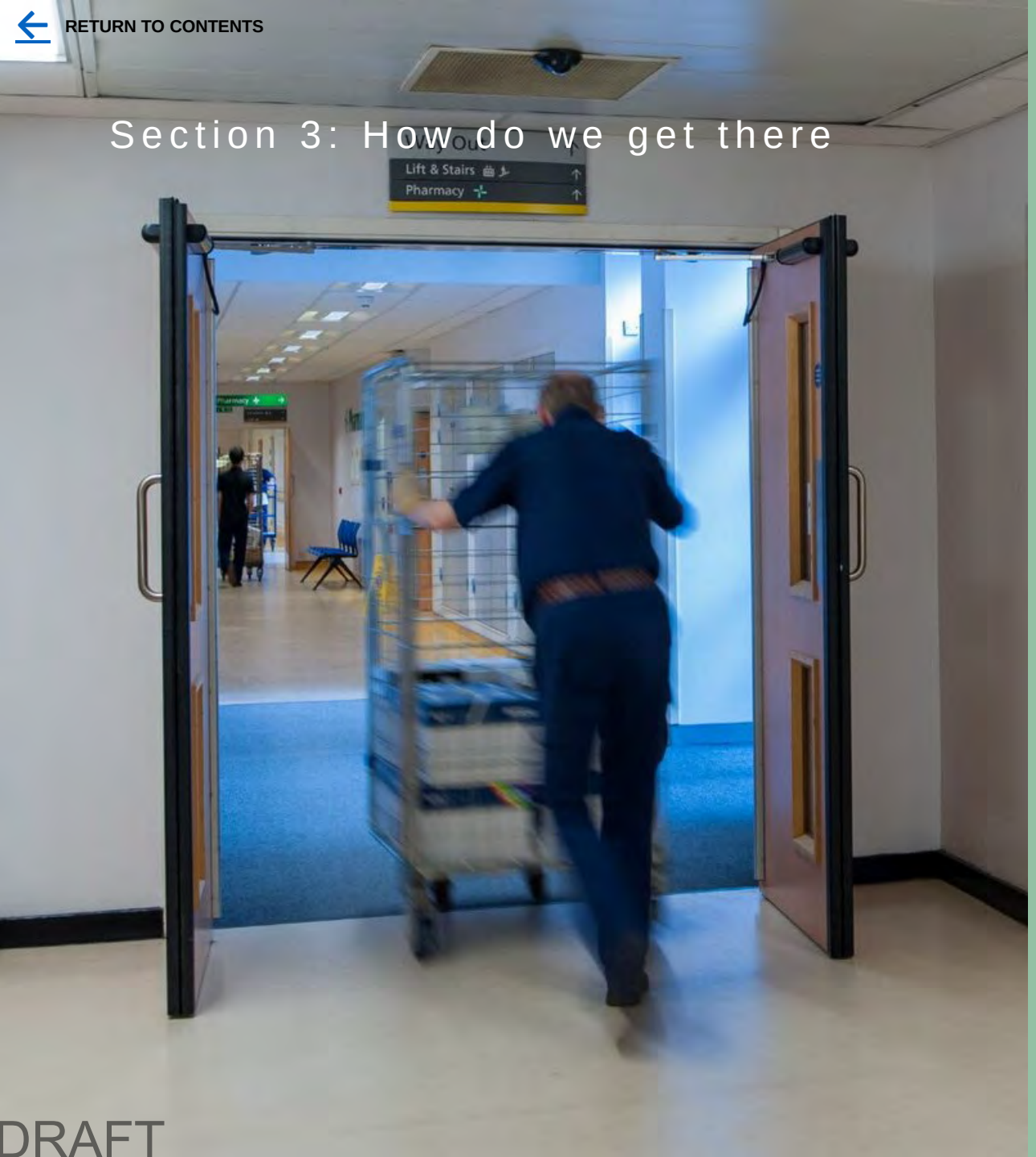
We should begin to further realise the impact of digital technology on our buildings and the potential for data and intelligence to transform how we operate in the future. We will align our digital strategy and digital care models with our built infrastructure and use our collective data more intelligently.

Data is fundamental to our future infrastructure; from strategic planning, to investment prioritisation, to our ongoing operational management. As our buildings and systems become more connected, we **will gather more and more data**. We will continually evolve our thinking to make best use of this data – being an intelligent analyst to **ensure we harness the power of data** to improve patient and staff experience across our whole infrastructure; improve our utilisation, target our investment towards the right places and improve our patient flows.

Today we already have a wealth of information across our infrastructure partners, that should start to use far better. As we move forward, and as our buildings become smarter and more intelligent, we should explore how we make the collection and analysis of our data automated. We will also understand how we connect our infrastructure data with other civic data sets and consider this alongside our infrastructure data and information, particularly in relation to programmes such as population health management. We can use property data in a more connected and intelligent way; using this to develop potential ideas for innovation across neighbourhood, system or place, potentially looking at opportunities for greater use of Department of Health and Social Care's SHAPE tool.

Initially, we will focus on utilising data for the following:

- Build a firm grounding for, and to inform, our infrastructure decisions and investment requirements in the short, medium and long term
- Guide and influence our strategic categorisation of our buildings into core, flex and tail
- Proactively manage our buildings and support our estates and facilities teams; ensuring that there is ongoing oversight and scrutiny of infrastructure performance
- Shape our requirements for the future
- Track our journey to net-zero
- Identify potential cost-reduction initiatives



Enabler 6: Infrastructure workforce

Our infrastructure workforce must begin to evolve into the estates and facilities workforce of the future; **where job roles and delivery footprints shift, and where digital systems, data, sustainability, intelligent buildings and zero-impact solutions will become as fundamental to many 'day jobs' as traditional facilities functions.** (Recent NHS England guidance sets out evolving requirements for estates roles in relation to sustainability.)

We will need a **consistent and system wide approach to estates and facilities delivery**, taking a 'single workforce' view, benefitting from economies of scale and a more streamlined service delivery model across our provider landscape, building on the work already being done in this space. We may re-think some of our estates and facilities job roles, looking where we can blend and re-shape roles and responsibilities to meet our needs.

We will need to ensure we **use our collective strategic infrastructure resource effectively**; identifying our gaps and associated risks as necessary. The ICB has extremely limited resource and its use should be prioritised towards areas that progress the implementation of our system vision.

We will need **additional resource to develop our strategic thinking**; we will need to map where there are skills across the system to support us to improve, evolve and transform our infrastructure. When we bring in specialist skills from other partners or the private sector, we will **maximise the learning and skill-sharing** amongst our own NHS staff, to add value and improve our understanding in specialist areas.

We should ensure we are **supporting primary care where there is a skills and/or capacity gap**, and we need to avoid increasing the inequity across primary are provision where there is disparity in skills and knowledge around where and how to access funding and develop bids. We will avoid not being able to invest in premises we know we need to invest in, because practices have not submitted bids for funding that is available.

Section 3: How do we get there

Enabler 7: User-ship and localism

As we have already discussed within this strategy, we need to build on our user-ship model, creating the right network of local infrastructure to support our system; from digital systems, to equipment, to the buildings and spaces we need.

The usership approach is three-fold:

- **We do not need to own the buildings we need for our NHS functions; we just need the right usership**
- **Where we do own things across our providers, we will use this NHS infrastructure as system resource**
- **The concept of user-ship extends to the use of our NHS infrastructure by others, in partnership and collaboration, to support health.**

In taking a user-ship approach, we will more easily be able to identify **opportunities for new types of accommodation**, with a wider range of options opened to us. User-ship should provide us with greater flexibility, which will be further enabled through better digital connectivity and adoption of smarter systems and technologies (considering everything from clinical rooms booking to building access). We should explore what local usership opportunities might be created as we develop our systems, especially those that will enable a more financially sustainable service delivery and building operation model. We will focus where we can on local solutions, grounded in place and with local partners.

Whilst we may not need to own buildings or equipment, we do need usership of accommodation to **enable flexibility and** we **must have local autonomy** of use, management and benefit (including for any NHS property company buildings). We must ensure that buildings are fit for purpose, safe and effective and we **should develop a set of common standards** in line with our infrastructure principles to ensure appropriate 'user-ship' of public assets. We will likely need local control and oversight in the management our digital systems and technology in order to deliver our infrastructure ambitions.

Section 3: How do we get there

Enabler 7: User-ship and localism

In line with our user-ship approach, we will continue to build on one-public-estate and will reignite this conservation at scale and across place; building on the work of the ICB in taking staff workspace in Lancashire County Council's County Hall and with Lancaster University at the Health Innovation Campus.

We will continue to prioritise other public sector buildings when we are developing local plans and we will work through our system-wide and local infrastructure forums to maximise opportunities. Beyond the 'estate', we will explore broader opportunities in relation to 'one-public-infrastructure' where we look at digital and other infrastructure alongside buildings.

As we move to a more supportive and preventative infrastructure, we will need to develop our user-ship approach further, enabling others to support the NHS through user-ship of our land and buildings for complimentary uses that support our NHS system.

User-ship and utilisation: Getting on top of our use of space

Space and capacity utilisation goes hand-in-hand with user-ship. We need to get on top of our space utilisation and we must be able to manage demand and capacity more effectively across our infrastructure; we have capacity across the system in theatres whilst we are unable to manage theatre demand in other areas; we have huge areas of void space in some of our best community buildings, and we have primary care networks unable to recruit to roles because of a lack of space, yet rooms in the buildings they work from are empty.

We seem to struggle with space utilisation and in matching space capacity with clinical demand. In order to do this, we will need to have the right digital systems to better align clinical scheduling with space utilisation – this is a core requirement for the short, medium and long term and should be considered with digital colleagues. We will need to create ever-improving mechanisms, systems and partnerships to enable us to make best use of what we already have across the NHS and the wider public sector.

The NHS Property Companies – Where we have poor utilisation within a building, we will need to work with the property companies to address how we 'unlock' this space. We must work openly and transparently to provide them with clarity on local community requirements to find deliverable solutions, especially in those areas where we currently have challenges. **The ICB and the property companies have a common goal; to shape the future of their buildings to support the local health system**. Across our LIFT buildings, we must start to plan for the end of the concessions and what happens with the buildings post 2030 and utilisation (as well as the right usership) must be at the heart of this conversation.

Occupancy models - We will need to enable more creative and flexible use of spaces within community buildings. Rigidity of demised space can become a restricting factor in local community use and in cross-partner working at a neighbourhood level. Work will need to continue around the inflexibility of existing lease and license arrangements that often stifles transformation and integration at a local level.

Section 3: How do we get there

Enabler 8: Creativity and innovation

We cannot simply default to doing the things we have done in the past in across our infrastructure workstreams. What we will need is appropriate and sustainable solutions; driven by increased creativity and greater innovation. We need to apply this way of working to improving the things we already do, to developing new infrastructure and more broadly, to shaping our future requirements.

Long term sustainability (including cost reduction) and creative innovation are not opposing forces; in fact, innovation is fundamental in the creation of an infrastructure to support our long-term future. We need to be more creative with the way we approach our infrastructure challenges, harnessing the ability to think more freely and make new, or deeper, connections. At the same time, we should re-frame the assumptions and patterns of working that hold us back.

We need to be imaginative, and we need to be more resourceful than we have ever been in how we work; in everything from our future use of land, to the partners we work with, to how we use our data, to our delivery models, to how we embed best practice, to how we fund infrastructure in the future.

We need to consider how we develop and embed the right culture of innovation across our staff and partners – where we encourage more innovative thinking across our whole workforce; welcoming ideas from everyone.

Section 4

The future

Section 4: The future

Our future: locally driven innovation and the art of the possible…

'We need to expand and extend this thinking more broadly to ensure we can enable generational transformation though infrastructure'

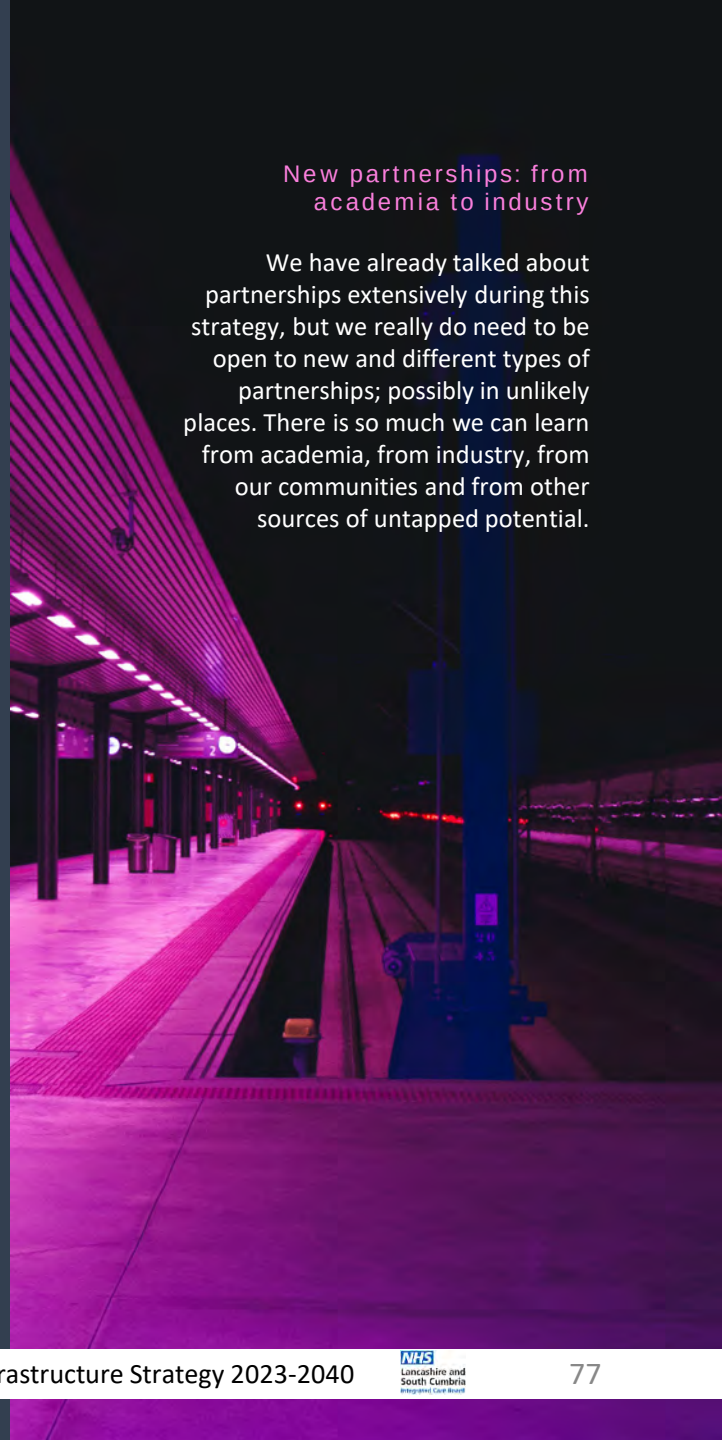
This section will consider; 'what else?' and 'what is next?'. What we have not considered as part of this strategy are some of the more significant technological, societal and economic shifts that will unquestionably impact our health service, and our associated infrastructure requirements to 2040 and beyond.

We have done some incredible 'futures' work as part of the new hospital programme, but we need to expand and extend this thinking more broadly to ensure we can enable generational transformation though infrastructure where it is within our influence and control to do so. We can look at the potential for exploring this type of transformation with our academic partners, amongst others.

We will consider the types of questions we will need to ask ourselves over the coming months and years as we plan for increasingly significant transformation and transition as we create the infrastructure for our future. We know that most of what we create over the coming years will still be there in 50+ years time, and therefore must be cognisant of what the future might look like.

Healthcare in 50 years

The truth is that we do not know where healthcare will be in 50 years, though we can make some sensible predictions based on what we know today. We should probably spend more time considering our infrastructure in the context of our collective future, considering what the people who will be 70+ years of age in 50 years' time might want and need and what services we will need to deliver. Today, we (perfectly understandably) design our infrastructure with the overwhelming focus on solving today's health pressures and crises, based on today's demographic. But we do not give equal focus (if any focus at all) on how we might solve the pressures of tomorrow through the way we design today. Where we can, should we not be designing for both today and tomorrow?



New partnerships: from academia to industry

We have already talked about partnerships extensively during this strategy, but we really do need to be open to new and different types of partnerships; possibly in unlikely places. There is so much we can learn from academia, from industry, from our communities and from other sources of untapped potential.

Section 4: The future

What might the future look like, and how do we create it?

Tomorrow's 70+ year olds - We need to think about the shifting habits of our younger populations; school children, millennials, Gen-Z, etc. We should ask: What does healthcare look and feel like to the 'Easyjet generation' and the 'Tik-Tok generation'? Where do they access services? How do they access services? Are we missing something in our infrastructure design today?

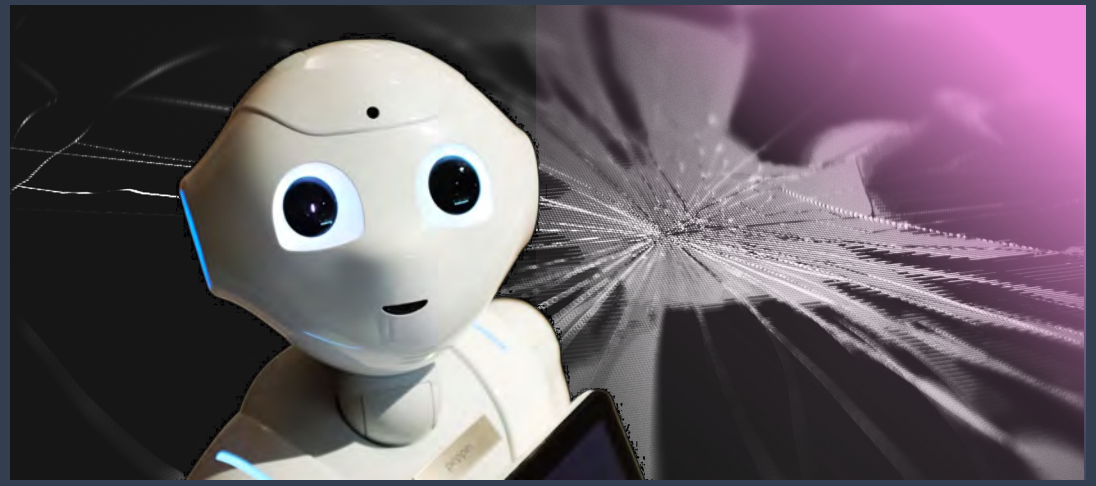
Our infrastructure's longer-term future is an area of work that will need more thought over the coming years. We have set out a list of questions as a conversation-starter to prompt discussion around infrastructure design for the future. This list is not exhaustive but has been developed from conversations held with stakeholders during the development of this strategy.

- Who does our horizon scanning? How do we learn about emerging technologies and innovative models?
- How do we track the benefits (financial, economic, capacity etc.) of future projects? What metrics do we use? How do we embed research in our pilots and other programmes?
- How do we incorporate evolving workforce considerations into our infrastructure planning – from the differing needs of oversees staff, to a future approach for key-worker accommodation, to spaces on hospital sites for staff wellbeing?
- Do we do enough for carers and families within our built infrastructure? Can we offer co-working and/ or spaces to relax outside the waiting rooms? What is the economic benefit of this?
- How do we use a deeper understanding of technology to make more things possible? How do we use technology to allow us to do things differently, not simply digitise the things we already do?
- What models of service delivery (and related infrastructure) are being developed around the world? We often look at the models of the USA and Scandinavia, but we should also look at models emerging in South, Southeast and East Asia. We should take inspiration from some of the innovation across Africa where extreme financial pressures have resulted in radical infrastructure innovation.
- How do we explore what ageing and living well looks like 50 years from now to inform the transition to a future place infrastructure for health, grounded in the expectations of Gen-Z?
- What is the future of wearable technology and remote monitoring as they become increasingly sophisticated? How does this affect our physical spaces in 10, 15, 25 years?
- How might the world – physical, environmental, virtual, digital, societal, personal and civic - come together in the future? What does this mean for health infrastructure?
- How do we align infrastructure at place with preventative medicine? Is there an infrastructure ask?
- Do we need to further explore the psychology of environment? Do we need to look at creating more 'normal' spaces in hospitals? How does green space play into this? How can we learn from some of the excellent examples across the world?
- Can we deploy digital wayfinding and patient apps in hospitals? Can we reduce waiting spaces, creating shared and central areas? Does this improve staff and patient wellbeing?
- How does healthcare connect to future identity in a world of virtual networks and connections, VR and AR? What does this mean for the places we provide healthcare?
- How do we create sustainable, zero-impact and financially affordable places to live that support and enhance the lives of our population who live with dementia?
- Do we need different spaces for staff and patient neurodiversity, gender-inclusivity? How do we expand inclusive design and strategy for the future?

Section 4: The future

What might the future look like, and how do we create it?

- Can we embrace health gamification through place; connecting prevention initiatives across the digital and physical worlds?
- How can we use infrastructure to create impactful prevention, in a way that creates a cultural behaviour shift in how we view our responsibility to our own health?
- How can you harness an NHS site to become truly self sustaining and zero-impact?
- Should we be thinking bigger around net-zero? Should we be aiming for carbon positive in some places? At a site level, what would a carbon positive NHS building look like?
- How do we create an ecosystem of circularity for health? How do we ensure we are making the right connections across partnerships, social value, people, place and delivery?
- What are the opportunities around smart living for health? How does/ should this contribute to circularity?
- What will biophilic design mean for our buildings and spaces? How important will this become over the next 40-50 years?
- What happens if the world continues to warm at its current rate? Are we/ our buildings equipped for this?
- Will our global and national funding structures remain the same? What might this mean?
- What can we learn from the best smart cities in the world? How has their built infrastructure evolved as digital connectivity ever-expands?
- What will the impact of scientific and technological advances be on our health services and our infrastructure delivery?
- Can we develop our own NHS building models?
- What does personalisation of medicine mean for infrastructure?
- Will the spaces we need be the same if/when we shift towards precision medicine?
- What will AI enable? How might we reshape our delivery using new technology – how can use of AI support our workforce strategies across infrastructure? How will it impact on our place-based health needs? On our diagnostic needs? How will predictive analytics influence our infrastructure?
- What does the future of work look like? Gen-Z and beyond are our workforce of the future; are we asking them what they want and need from us as an infrastructure employer?
- How can we harness the power of our patient insights to provide value to our infrastructure development?



For the benefit of health

Any areas we consider as part of our futures workstreams should be focused around the benefits to ‘population health’ through health infrastructure. As we explore test beds and projects, we should focus on benefits analysis so we can scale and replicate across Lancashire and South Cumbria (and beyond).

Testing the future

We have the opportunity to test our futures thinking today. Not necessarily always at scale, or in areas where we need big and new investment, but through site redevelopment, through partnering, through our required building projects and in designing our infrastructure workstreams. We need to start testing some of the more radical approaches today in order to support our long-term transformation.

We should be ‘thinking big’ around innovation and exploring the art of the possible, especially with our academic partners. We should be targeting bidding for innovation funding where we have identified projects that we can explore some of this futures thinking; ensuring we are embedding innovation and creativity in our plans for today.

We should also look at all opportunities to support this type of work though partnership with others.

Section 5

Next steps

Section 5: Next steps

Recommendations and next steps for Autumn 2023 →

These are the initial recommendations for the areas we should focus on during 2023.

Governance

- Developing the right governance; at system and at place to enable local autonomy and empowerment within an ICB framework. A system wide risk register should be developed
- Mapping the responsibilities of the ICB, place, provider collaborative and at an organisational level. Need complete clarity on who is responsible for what and this should form part of the governance, with a matrix developed and agreed by all parties.
- We need to bring our partners on board and start socialising this strategy with local authority partners to ensure we can support all our strategic ambitions and our governance arrangements.

Clarity on network and out of hospital requirements

- Work with the ICB and clinical teams to agree our proposed clinical model (with variations based on the outcome of the new hospital programme if we do not have certainty on this in a timely manner).
- Develop a framework and set of principles for primary care, to support Fuller and neighbourhood development (and in line with the principles within this strategy).

Data and intelligence

- Collating our data and existing intelligence beyond that which has been collated in the development of this strategy, and agree how we are going to maintain and update this moving forward in the short term. Data will be used to inform strategic site classification.
- Undertake a data analysis exercise to identify potential costs savings or areas of efficiency, where these are not already being progressed.

RETURN TO CONTENTS

Section 5: Next steps

Strategic site catagorisation

- Undertake a system catagorisation of buildings as core, flex and tail; for provider infrastructure across the network model and for all other NHS sites (see Appendix 2).
- Update this ICB Infrastructure Strategy to include a full profile of our core, flex and tail strategy and our future investment requirements plans
- Develop draft and hight level 'site development strategies' for all provider infrastructure and any other identified key strategic sites. Where there is likely to be surplus land or buildings, start to map potential opportunities for health's benefit, aligned to this strategy, progressing work where appropriate (considering Section 4: The Future).
- Begin conversations around the future of the ICB's relationship with LIFT and its portfolio of buildings.

Our investment requirements

- Review, update and refresh our short-term and our long-term capital requirements, including updating these requirements (post-core, flex and tail catagorisation) across primary care, community, out of hospital, provider sites (including Whalley), technology.
- Identifying what funding is out there that the NHS can bid for and communicate this through our forums to enable system mobilisation to bid for funding. If we need support with this, identify the resource requirements.
- Identify areas where we may have alternative options to capital investment through alternative delivery models.
- Start the development of a commercial and investment strategy to develop options and opportunities for the investment requirements in digital, technology, equipment and buildings. This needs to include ways that we can make the required improvements to our infrastructure even if NHS capital is not available to the timescales needed.

Workforce

- Undertake a skills and experience mapping exercise across our ICB partners to identify the depth and breadth of our existing infrastructure workforce.
- Identify resource requirements for implementation of this strategy.

Develop an estates and infrastructure blueprint, and map required delivery plans for end 2023 onwards.

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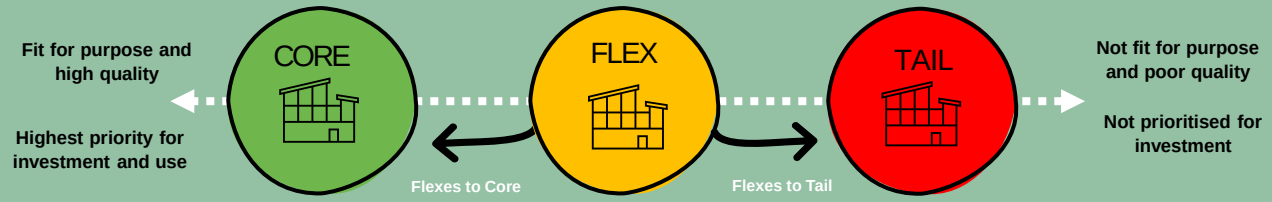
Appendix 1 –Lancashire and South Cumbria strategic infrastructure catagorisation: Proposed approach



We propose our catagorisation should take a multi-phase approach, where each building is given 'dual catagorisation', initially from a building perspective, followed by a service delivery perspective.
The proposed catagorisation approach considers governance structures of the ICB; noting the importance of alignment with the new hospital programme, the provider collaborative and the place devolution deal. This approach exemplifies the symbiotic relationship between clinical design and existing infrastructure (where the future of both must be informed by the other). The proposed Phases can run in parallel and, whilst interdependent on each other, our proposal is to run them as two separate yet connected workstreams. They can broadly be segmented into:

- **PHASE ONE: Provider infrastructure** (in-hospital premises and any other premises determined to be part of phase one)
- **PHASE TWO: Out of hospital infrastructure** (including community premises belonging to our LSC providers)

The two phases reflect differing levels of complexity around sites and buildings, and the greater availability of information for the providers' built infrastructure in comparison the wider out of hospital infrastructure. It also echoes the current stages of development around service and future clinical delivery (including NHP, connected acute services and community care). It reflects the pending completion of the PCN Toolkit (and future primary care estates strategies) that will need to feed into place and out of hospital infrastructure planning and catagorisation. Finally, it considers the impact of the place integration deal and its impact on strategic estates planning for community provision across place to ensure that robust plans can be developed in line with non-infrastructure timescales.

Phase One – Our provider infrastructure

- Dual catagorisation of core, flex and tail for provider sites (against both its holistic building condition and service need)
- Focused on tertiary and some secondary services
- Includes catagorisation of sites, with differing catagorisation of different buildings/ zones/ areas on each site.

Proposed workshop(s) approach to be taken where facilitated discussion is had and the estate is 'planned' for the future in line with developing service strategy, with potential locations being informed by existing site challenges and opportunities. This will be completed by a core group who will work objectively and as a system to identify a proposed route forward for each site, in line with system requirements across L&SC.

Proposed that this workshop is properly facilitated, with a small and focused group, with core attendance being from the ICB and the provider collaborative, with representation from a range of disciplines.

The output of the workshops will be an early system estates plans for tertiary and secondary services and an emergent site development plan for each site; from which, more robust investment/ divestment requirements, delivery plans and detailed site strategies can be developed by the end of the year and into 2024. Phase One can then inform and will itself be further be informed by the Phase Two work across out of hospital workstreams.

Phase Two – Out of hospital infrastructure

- Catagorisation of core, flex and tail of NHS property company sites, provider and GP community premises (against both its holistic building condition and service need)
- Focused on primary and some secondary services
- Catagorisation of each premises individually.

Proposed desktop review completed to initially catagorise each premises, informed by existing property data and led by a small core group from across the ICB, provider collaborative and each of the NHS property companies. The CHP led primary care estates work can inform the initial catagorisation of primary care infrastructure, along with any follow-on programmes. This Phase Tow will develop a draft catagorisation, for further testing and review at place, in line with local place strategies for health delivery locally. Following the draft catagorisation, a workshop approach to be taken where facilitated discussion is had and the estate is 'planned' for the future in greater detail, in line with service strategy. This should be done across a place footprint (with each locality within Lancashire undertaking its own focused session). Proposed that this workshop is properly facilitated, with small and focused groups, with core attendance being from the relevant place and the ICB, with representation from the local provider(s) a from across a range of disciplines.

The output of the workshops will be an early place estates plans for primary and secondary services; from which, more robust investment/ divestment requirements can be developed by the end of the year.

Appendix 2 –Example of Ramboll report (extract only)

RAMBOLL

2.1 Site Overview

A visual (non-intrusive) site survey was carried out on 10th November 2022 to review the condition of the Hospital buildings along with the energy infrastructure.

Based on the site visit, and review of available information for site, the following typology groupings have been proposed:

Single storey 1970's
- Collection of one storey structures
- Relatively poor construction, primarily felt roofs

Historic construction 1950-60's
- Solid wall brick construction
- Naturally ventilated

Modern additions ~2011
- Building fabric insulated in line with prevailing regulations at the time, insulated cavity wall
- Dedicated AHUs for ventilation
- Heating via radiant panels in circulation spaces

Residential area
- 1960 or 70s construction, solid brick wall
- Individual boilers to each property

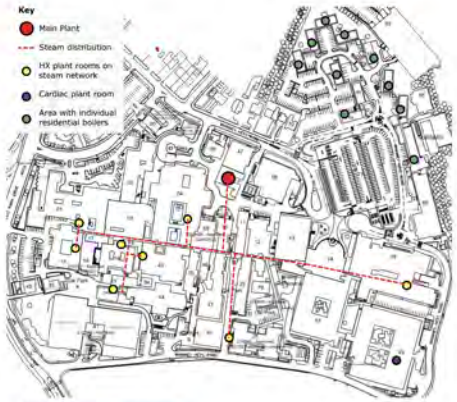
Energy centre and Estates
- Estates/facilities offices

Summary of building fabric and servicing strategy of the site

Ramboll 2

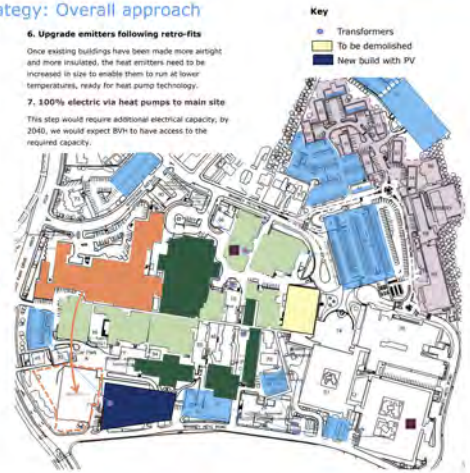
RAMBOLL

2.2 Energy Infrastructure



RAMBOLL

4.1 Decarbonisation Strategy: Overall approach



Appendix 3 –Blank capital template (from NHS)

TO FOLLOW

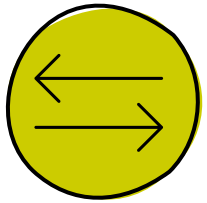
Appendix 4 –Lancashire and South Cumbria ICB capital requirements breakdown

TO FOLLOW

Appendix 5 –Where are we now (summary)

WHERE ARE WE NOW

Our infrastructure is transformational



Transformation is our overarching principle.

Infrastructure is an enabler that supports the delivery of our three strategic infrastructure ambitions:

1. Change the way organisations work together and how the NHS provides services to improve our financial situation.
- reshaping infrastructure to enable a different type of service delivery
- having a more efficient, effective and streamlined infrastructure

2. Move care closer to home, work with partners to prevent disease and reduce inequalities

3. Enable a standardised, network model of care for the delivery of our clinical strategy

- We are developing our NHP, but we do not know how our NHP model is going to impact our network requirements from an infrastructure perspective. We have no plan for implementing NHP innovation across out wider infrastructure
- We have a hospital centric focused infrastructure
- We have inefficiencies across our infrastructure provision that could be streamlined
- We do not have plans for what we need to do across place; but we know we need to provide new built infrastructure in many areas.
- We need new medical equipment
- We do not have a plan in place for end of concessions for PFI and LIFT.
- We have not yet categorised our buildings as core flex and tail.
- We have not refreshed our investment requirements – we cannot do this until we have a system-wide, prioritised plan, informed by core, flex and tail and our infrastructure priorities.

Our future is digital, smart and intelligent

- We are in the process of procuring an EPR; soon all our providers will have an electronic patient record.
- We are working on creating a 'digital hospital' through our NHP
- We are rolling our more technology for at home monitoring; including virtual wards
- We are not fully exploiting or benefitting from the potential for smart buildings; especially in relation to utilisation, preventative maintenance, cost reduction, carbon reduction and targeting investment.
- We have not fully mapped the interconnectivity between the digital and physical worlds of infrastructure

We have usership of the right infrastructure

The right infrastructure is:

- **Safe and good quality**
- **The right size, in the right place**
- **Flexible, adaptable and responsive**
- **Is aligned with our other principles**

- We have some excellent buildings, often with poor utilisation – we still struggle to unlock underused space
- We have lots of very poor buildings – we must invest in new hospitals, we need new community infrastructure and we need increase capacity in primary care.
- We have examples of great usership; from leisure to OPE to community, but these are not at scale.
- We don't understand what is out there to use

Our future is green and environmentally sustainable

- We have completed our ICB and provider green plans, setting out our direction of travel to ne-zero carbon.
- The ICB have worked with Ramboll to review of provider sites, rating buildings in relation to decarbonisation
- We are designing net-zero carbon hospitals as part of the NHP
- Working through the impact of the net zero building standard
- We do not have plans for biodiversity on our site
- NWAS are working on the electrification of the ambulance fleet
- We have increased our EV chargers
- We do not have a long-term investment strategy and need to map responsibilities of prop cos

Our future infrastructure is affordable and financially sustainable

- We have reduced our building footprint by over 8%, but our costs continue to rise.
- We do not have the right infrastructure to support prevention at scale yet
- We have an excellent example at Burnley where we have used land to develop an affordable extra-care to reduce pressure on our hospitals (capital not NHS).
- We spend a lot of money on energy and have not seen the impact in the data of the price increases
- We have a lot of replication of space for 'back office' function, corporate functions and clinical delivery that could be done at scale.

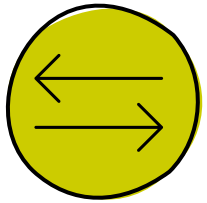
Our infrastructure shapes healthier places

- We have some examples where we are working at place to support our partners and better health outcomes; from Covid vaccine centres to MSK delivery in leisure centres.
- We do not have established forums to have the strategic conversation across place and infrastructure.
- We have not mapped and articulated the ICB's role as a civic leader in the infrastructure conversation
- There is lots of guidance out there; Health on the High Street, Putting Health into Place, Building for Health. And
- NHS buildings are still seen as 'hard to access'– perception and potential bureaucracy is a blocker to use
- Several strategic NHS sites for health

Appendix 6 –Where we need to be (summary)

WHERE WE NEED TO BE

Our infrastructure is transformational



Transformation is our overarching principle.

Infrastructure is an enabler that supports the delivery of our three strategic infrastructure ambitions:

1. Change the way organisations work together and how the NHS provides services to improve our financial situation.
- reshaping infrastructure to enable a different type of service delivery
- having a more efficient, effective and streamlined infrastructure

2. Move care closer to home, work with partners to prevent disease and reduce inequalities

3. Enable a standardised, network model of care for the delivery of our clinical strategy

- Have complete clarity on our core, flex and tail buildings; with a 15+ year investment and divestment strategy, aligned to our transformation objectives over the same time periods.
- Have smaller hospitals, but more health provision (and supporting infrastructure) in our communities.
- With enough infrastructure investment to enable us to shift our service delivery and prevention models
- Effective cross-partner systems that enable us to use our infrastructure optimally; from energy use, to resource deployment, to clinical staff access, to space utilisation.
- Be working with a range of different partners to create a healthier infrastructure at place; the NHS being an influencer, enabler, facilitator, supporter, championing (and sometimes deliverer).
- Have a culture of creativity and innovation in infrastructure
- Attracting brilliant staff to work across our infrastructure workstreams in the future.

Our future is digital, smart and intelligent

- Have a deep understanding of the connection between the digital and physical worlds and have evolving strategies and plans that reflect this.
- Have shifted our built infrastructure requirements to reflect our digital NHS.
- Have the right systems in place to support our infrastructure (and wider NHS) workforce to make best use of our built infrastructure.
- Use IoT to monitor our buildings
- Be active in the adoption (where appropriate) of new technologies.
- Use technology and its potential to reimage HOW we do things, not just digitse the things we already do.

We have usership of the right infrastructure

The right infrastructure is:

- **Safe and good quality**
- **The right size, in the right place**
- **Flexible, adaptable and responsive**
- **Is aligned with our other principles**

- Have a completely organisationally agnostic infrastructure.
- Have minimal issues with occupancy and flexible use.
- Use the right infrastructure to support our left-shift (the psychology of space)
- Have use of a range of buildings, actively supporting local communities through use of their space
- Use our shared user-ship principles
- Have a flexible and adaptable infrastrucuture

Our future is green and environmentally sustainable

- Be net-zero by 2040.
- Have a depth and breath of understanding of our infrastructure performance, through data
- Use our green spaces for the community
- Use of land to support net-zero
- Be considering – 'what is next'

Our future infrastructure is affordable and financially sustainable

- Have an excellent relationship between infrastructure and clinical strategy – with infrastructure strategy embedded at the earliest stage.
- Have a streamlined, cross-system estates and facilities function
- Shared back office functions
- Cross-partner medical equipment contracts, maintenance etc.
- Using our land and buildings to deliver short, medium and long term fiscal benefits to the health and care system.
- Have robust and considered commercial strategies, benefitting from long term ism (considering LIFT, PFI, net-zero etc)

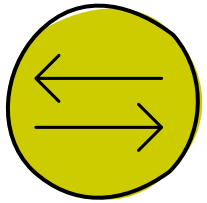
Our infrastructure shapes healthier places

- Active in using infrastructure to reduce health inequalities
- Work with local communities to develop opportunities (from use of space to the development of our workforce)
- Have robust place and neighbourhood strategies.

Appendix 7 –How do we get there (summary)

HOW DO WE GET THERE

Our infrastructure is transformational



Transformation is our overarching principle.

Infrastructure is an enabler that supports the delivery of our three strategic infrastructure ambitions:

1. Change the way organisations work together and how the NHS provides services to improve our financial situation.
- reshaping infrastructure to enable a different type of service delivery
- having a more efficient, effective and streamlined infrastructure

2. Move care closer to home, work with partners to prevent disease and reduce inequalities

3. Enable a standardised, network model of care for the delivery of our clinical strategy

- Strategically mapping our core, flex and tail buildings and aligning this/ using this to shape service models
- Investing in new infrastructure across acute, MH, LD&A and out of hospital and neighbourhoods.
- Developing a commercial strategy to support investment in the short, medium and long term
- Give a more substantial focus to primary care, community , MH and LD&A needs; shifting from a hospital-centric infrastructure
- Taking a more prevention-focus view to infrastructure decisions
- Identifying and progressing recurrent cost savings across estates and facilities workstreams
- Implementing an integrated data system to maximise utilisation, capacity use and improve performance through analysis
- Working with partners to deliver the 'non-NHS' infrastructure requirements that enable a left shift
- Think creatively and innovatively around how we 'do more with less'.

Our future is digital, smart and intelligent

- Build our understanding of the interplay between the physical and digital worlds
- Understand the impact of a digital NHS on our services and buildings
- Ensure we have appropriate investment identified for digital systems (from virtual monitoring equipment, to buildings systems)
- Use IoT and available technologies – connecting these with systems
- Education and development of workforce
- Consider the impact of new and emerging technologies and how we can use these – e.g. AI

We have usership of the right infrastructure

The right infrastructure is:

- **Safe and good quality**
- **The right size, in the right place**
- **Flexible, adaptable and responsive**
- **Is aligned with our other principles**

- Work with local partners, using the one-public-estate principles
- Make more intelligent choices about infrastructure; support local places and prevention where possible
- Develop a set of principles of user-ship to share with partners
- Unblock challenges around occupancy and utilisation
- Ensure all future infrastructure is flexible and adaptable

Our future is green and environmentally sustainable

- Build on the Ramboll work and identify investment requirements
- Ensure net-zero plans are at the heart of core, flex and tail and the resulting site development strategies (including NWAS)
- Ensure we are tracking available funding and are in a position to bid with a pipeline of requirements
- Work with academic institutions to understand innovation and research potential for a greener NHS
- Consider how we use our land
- Expand our thinking beyond net-zero; consider biophilic design and working, biodiversity and greenspace.

Our future infrastructure is affordable and financially sustainable

- Establish a new symbiotic relationship; work with clinical leads to make best use of infrastructure
- Use digital systems and technology to manage buildings and plan future needs
- Streamline infrastructure services
- Work across place to support local partners – the L&SC £
- Review and consolidate supporting facilities – consider different models for service/ building provision
- Make best use of land and buildings for health system financial/ fiscal benefit
- Partner with the right people
- Develop commercial and funding strategies locally (LA, pension funds)

Our infrastructure shapes healthier places

- Use infrastructure to help reduce health inequalities; by supporting local community groups and businesses (using their space and vice versa)
- Consider future use of land to improve health outcomes
- Align infrastructure workforce development with local talent and opportunity pathways
- Consider the Building for Health and Putting Health into Place principles – learn from what has already been done
- Develop integrated place and neighbourhoods infrastructure plans that support a local approach to the delivery of this strategy